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Opportunity
Village
917 South First Street
Las Vegas, Nevada 89101

Tour → February 6

City/State: Las Vegas, NV

Event: Opp. Village

Date: 1-31-92

OFFICE OF PRESIDENTIAL ADVANCE

CONTACT SHEET

Name	Office	Phone Number
Presidential Advance Office		202/456-7565
Presidential Advance Fax Number		202/456-2820
LEO TOMEU	PRESIDENTIAL ADVANCE	202/456-7565
JOHN HERRICK	PRESIDENTIAL ADVANCE/PRESS	202/456-7565
PEGGY HAZELRIGG	PRESIDENTIAL ADVANCE	202/456-7565
Michele Nix	WH Speechwriting	202/456-7750
JOHN WISSLER	MARINE CORPS AIDE TO THE PRESIDENT	202-395-1747
Jim Curtis	White House Communications	202-395-4040
PETER VARLEY	WHITE HOUSE COMMUNICATIONS	202-757-5533
JOE SAITTA	U.S.S.S.	702-388-6571
STEVE CALVERY	USSS	202-395-4011
RICK WADSWORTH	USSS.	702-388-6571
→ ROGER PELTYN	OPPORTUNITY VILLAGE CHAIRMAN OF THE BOARD	702-385-5300
→ *Mike Morrissey	Opportunity Village Board.	702-382-4000

OPPORTUNITY VILLAGE INDUSTRIES

ADDRESS: 307 West Charleston
Las Vegas, NV 89102

TELEPHONE: (702) 384-8170, Extension 312

CONTACTS: Chairman of the Board: Mike Morresey
Executive Director: Lila Holdsworth

Opportunity Village is a private nonprofit organization providing services for approximately 200 people with developmental disabilities. It has been in operation since 1954. In addition to sheltered workshop experience, clients may also be assigned to enclaves in local service and manufacturing agencies. Pay varies according to the time and skills of the clients for "piece work" to $8.50 per hour for full time employment.

Approximately 85 percent of funding is from contracts and various fund raising events. The funding is provided by Community Training Center of Nevada through contractual arrangements. Recreational services are arranged through contracts with Las Vegas. Opportunity Village also has a number of Thrift Store outlets and boutiques which provide training and income. About 50 to 60 percent of the clients live in area homes, with others in foster homes, independent living apartments and supervised group living situations.

A grant of $1.5 million was received from the Leid Foundation which will be applied to the cost of constructing a new multi-million dollar facility. A fund raising activity enables contributors to buy personalized bricks and tiles for a special campus walkway called the "Walk of Fame." The new facility will allow the program to provide services for more "behaviorally difficult" clients in addition to providing cafeteria training and expanded adult activity services. The first phase of is expected to be completed in late 1992.

Tour

Michelle

ES

DEPARTMENT OF HEALTH & HUMAN SERVICES

ADMINISTRATION FOR CHILDREN AND FAMILIES
Office of the Assistant Secretary, Suite 600
370 L'Enfant Promenade, S.W.
Washington, D.C. 20447

JUL 23 1991

TO: The Secretary
Through: DS _____
COS _____
ES _____

FROM: Deputy Assistant Secretary
for Children and Families

SUBJECT: The Secretary's Visit to Opportunity Village, Operated by the Association for Retarded Citizens, Las Vegas, Nevada, July 24, 1991 -- BRIEFING

PARTICIPANTS:

Outside the Department:

Karen Stansfield, Director, Client Programs, Opportunity Village

Terry Astrada, Deputy Director, Client Programs, Opportunity Village

Mike Husted, Chief Executive Officer, Opportunity Village (4 years)

Laura McBride, Marketing Coordinator (2 years)

Jerry Bauer, Workshop Manager (5 years)

Larry Brown, Assistant to the President of Las Vegas Valley Water District - 12 year Opportunity Village Board Member

Roger Peltyn, President, Martin & Peltyn Structural Engineers - 5 year Opportunity Village Board Member

Mike Morrissey, President, Morrissey Insurance Company - Chairman of Opportunity Village Board and 4 year Opportunity Village Board Member

Mike Costell, Vice President, Pacific First Mortgage Company - 9-year Opportunity Village Board Member

Inside the Department

The Secretary

BACKGROUND:

Opportunity Village is a private nonprofit organization that provides services for approximately 200 individuals who are developmentally disabled. It has been in operation since 1954.

In addition to receiving employment experience by working in sheltered workshops, clients may also be assigned to enclaves in local service and manufacturing agencies. Pay varies according to the time and skills of the clients and can be based upon "piece work" or hourly wages of up to $8.50 for full time employment.

Approximately 85% of Opportunity Village's funding is from contracts and various fund raising events. Funding is provided by the Community Training Center of Nevada through contractual arrangements. Recreational services are arranged through contracts with the city of Las Vegas. Opportunity Village also has a number of Thrift Store outlets and boutiques which provide training and income.

About 50% to 60% of the Opportunity Village clients live in area homes with their families. The remainder live in foster homes, independent living apartments and supervised group living situations.

DISCUSSION

Opportunity Village recently received a grant of $1.5 million from the Leid Foundation. These funds will be used toward the cost of constructing a new multi-million dollar facility. The first phase is expected to be completed in the fall of 1992. This new facility will allow the program to provide services for client's who are more "behaviorally challenging." It will also provide a cafeteria to be used for cafeteria employment training. The new facility will also make it possible to expand adult activity services.

ISSUES OF CONCERN

Lack of public transportation remains a major obstacle in developing and implementing work and training opportunities for clients.

Donna N. Givens

Attachment

Tab A - Article: OPPORTUNITY VILLAGE, A Better Place Today: A Better Place Tomorrow

Opportunity Village

A Better Place Today;

A Better Place Tomorrow.

• • •

OPPORTUNITY VILLAGE

Opportunity Village Association for Retarded Citizens is a private nonprofit organization offering a complete program of services to Southern Nevadans with mental retardation.

Incorporated in 1954, Opportunity Village presently serves the needs of over 300 educable, trainable individuals on a daily basis. A variety of programs are offered, including vocational evaluation and training, sheltered employment, social skills training, job placement and leisure-time activities.

Client/employees are provided with individualized programming designed to develop both vocational and social adjustment. Prescriptive programming formulates specific behavioral objectives and goals with the resultant program development, assessment and follow-up. Programs and vocational training are designed to treat the whole person emotionally, socially to adjust to the "world of work." Client/employees enjoy the dignity of earning a living and interacting with other members of the community.

The work training areas are located at Opportunity Village Industries at 307 West Charleston. The building houses the contract service area, the sewing area, and all button facilities. Tours of the facility are offered to the public by appointment. The Opportunity Village Thrift Stores in Las Vegas and Henderson generate a major portion of the income for Opportunity Village by selling merchandise donated by residents throughout Southern Nevada.

Under the direction of the C.E.O., Opportunity Village's production managers, behavioral technicians and staff directors work together to provide the highest quality training for intellectually handicapped citizens.

Opportunity Village Association for Retarded Citizens is a member of the Association for Retarded Citizens of the United States and is governed by an elected Board of Directors comprised of dedicated business, professional and community leaders. The board confers with the C.E.O. at regular monthly meetings in making operational decisions, determining policy and approving expenditures.

The largest community training center in the State of Nevada, Opportunity Village derives its income from the contract services of Opportunity Village Industries, sales from the thrift stores, from numerous fund-raising events and from corporate and individual contributions.

Opportunity Village has made a great impact on Southern Nevada and has enormous potential. With the support of the community, Opportunity Village can continue to provide much needed work training for retarded and multi-handicapped citizens in the years ahead.

ADMISSION

Admission to Opportunity Village is facilitated by the State of Nevada, Desert Developmental Center which open cases and maintain a waiting list. The school district also refers clients through the vocational transition coordinator. Currently, Opportunity Village is working out a transition program whereby students can work for a brief period under the supervision of Opportunity Village and school district personnel.

After referral, the Case Management department schedules an appointment where a personal interview with parents, guardians and the client helps Opportunity Village staff determine the most appropriate placement within our agency.

Once accepted into the program, each client/employee is provided with individual prescriptive programming to enhance his or her social and vocational adjustment. This highly individualized planning is designed around specific behavioral objectives and goals with resultant program development, assessment and follow-up.

Vocational evaluations are provided to all new client/employees. Results of these tests are used to determine ideal placement at Opportunity Village and to project vocational potentials.

Each new client/employee at Opportunity Village is scheduled to work for a behavioral technician who provides on-the-job training and guidance in both social skills required for the specific job environment. Behavioral technicians keep daily records of each client/employee's performance and are actively involved in the programs for all client/employees.

Each client/employee is also assigned to a behavioral programmer, a skilled professional who works with both the department head and the behavioral technician in creating and implementing the individual's prescriptive program.

As evaluation records show progressive achievement, the client/employee is taught new skills to better qualify him or her for a job in the business community.

EDUCATION PROGRAM/REHABILITATION

The main objective of the Opportunity Village Education Program is to provide an opportunity for developmentally disabled adults to acquire the social and survival skills necessary to live and work more closely to the mainstream of our community.

Essential skills taught include use of money, personal grooming, community awareness, social skills, sexual awareness, communication, self-help and survival academics.

Staff are highly trained in behavioral management. Technicians gather data daily, participate in Interdisciplinary Team Meetings and work with the Vocational Transition Manager to assist with placement and movement along the levels of training.

Clients may be initially placed in the adult activity center but may be moved to the adult transition area within the main work shop or to enclaves in the community under the supervision of an Opportunity Village staff member.

An individual program is developed for each client/employee designed with the concept of normalization - the principle which promotes the availability of normal conditions of life to handicapped individuals. Input for the development of each program is derived from programmers, parents and guardians, technicians and other concerned persons. Opportunity Village management and staff work closely with Desert Development Center, group home, parents and guardians to assure the best quality of life and a work activity environment which has meaning for each of our clients.

INDUSTRIAL CONTRACT TRAINING

The occupational training program in the sheltered workshop at Opportunity Village helps develop the maximum vocational and social potential of client/employees in this area of production.

Contracts from business and industry provide on-the-job training for mentally retarded and multi-handicapped adults. In filling these contracts, client/employees are taught sewing, assembling, packaging, collating, machine operation and light manufacturing.

Client/employees learn job skills and the required social attitudes expected of them in a work environment. Their efforts are continuously evaluated and analyzed by a qualified staff member. Evaluations are based on daily records of performance and used for future programming.

OVARC client/employees are trained in a broad range of skills and technologies essential for employment in today's industrial market. Work is compensated on a piece-rate basis commensurate with productivity.

The total training concept applied in the industrial workshop at Opportunity Village gives each client/employee the opportunity to function effectively according to his aptitude, to enjoy fulfillment through achievement and take his rightful place in the community.

JOB PLACEMENT

The ultimate goal of all programs at Opportunity Village is to realize the greatest potential of all client/employees. In furtherance of this goal, a Job Placement section has been established with the responsibility of actively seeking appropriate jobs within the community for OVARC employees.

When client/employees reach the point at which their programmers think they are ready and qualified for competitive employment, such recommendations are made to the Job Developer.

Opportunity Village's Job Development Department has options for enclave placements as well as competitive employment. This has resulted in over 100 clients successfully placed, on a long-term or temporary basis, in the community during the past two years.

Once placed on a job, the employee will progress through the normal advancements of that position. The Job Developer will assist in any problems between employee and employer to ensure client support. Continual follow-up is maintained between the Job Developer, employer and the client/employee to ensure the job is working out to everyone's satisfaction.

To date community response to hiring clients of OVARC has been excellent - a positive sign that the adult mentally retarded can become taxpayers rather than tax consumers.

Questions regarding job placement should be directed to the Job Developer who is available to answer any and all inquiries.

HENDERSON NEVADA'S INDUSTRIAL CENTER
HOME NEWS
e 41, 6th Edition Henderson, Nevada THE COMMUNITY'S NEWSPAPER 25¢ 22 Water St. 564-1881 Thursday, Jan

COVETED AWARD—Former Presidential Press Secretary James Brady, center, joins Opportunity Village officals Mike Morrissey, left, and Mike Husted in Washington. Morrissey holds a prestigious award presented by Brady on behalf of the J.M. Foundation. For story and photos, see page 8.

carf
COMMISSION ON ACCREDITATION OF REHABILITATION FACILITIES

Alan H Toppel • Executive Director

November 13, 1989

Mr. Michael F. Husted
Chief Executive Officer
Opportunity Village ARC
917 South First Street
Las Vegas, NV 89101

Dear Mr. Husted:

I am so pleased to write to you on behalf of the Commission on Accreditation of Rehabilitation Facilities to offer our congratulations to your organization for winning the distinguished Search for Excellence Award.

Since the inception of the Search for Excellence program, the Commission has viewed this level of prestigious acclaim within our industry to be comparable to the Nobel Prize. We strongly believe that no greater honor can be bestowed than the recognition afforded by one's peers. Who is in a better position to understand, evaluate and determine the epitome of performance than all those committed to the same lofty ideals.

The Commission is proud of its role as participant in this unique program sponsored by the J.M. Foundation. We know first hand, of the Foundation's rich history and tradition of promoting quality services for this Nation's disabled population. Unquestionably, given the J.M. Foundation's exceptional reputation in our field and the demanding requirements established for even being considered for this award, it is reasonable to say that few other events in your organization's vast accomplishments will ever surpass this monumental achievement.

Your success is one that can be shared not only by everyone committed to your organization, but also the massive network of specialized programs around the country. However, the real benefactors of your exemplary work are people with disabilities! Ultimately, it is the extent to which you positively touch people's lives that is what the Search for Excellence is about, and this truly cherished prize is forever yours.

Once again, congratulations to you, your staff and Board.

Sincerely,

Alan H. Toppel
Executive Director

AHT/mp

101 N Wilmot Rd • Suite 500 • Tucson, Arizona 85711 • (602) 748 1212 • Voice/TDD

American Medical Association

Physicians dedicated to the health of America

515 North State Street
Chicago, Illinois 60610
(312) 464-5000

Date: 2-3-92

To: Jeannie Buxton
White House
202 | 456 - 6218

From: JACK SEGAL
PUBLIC INFORMATION OFFICER
(312) 464-5970

Total pages (Including cover sheet): 14

Reply fax number: (312) 464-4189 or 5839

Regarding: Please see attached materials - *'s indicate answers to specific questions you asked

Fax Transmission

Undergraduate Medical Education

Educational Programs in US Medical Schools

Harry S. Jonas, MD; Sylvia I. Etzel; Barbara Barzansky, PhD

Historical review of the medical education issues of *JAMA*, first published in 1901, allows us to identify decades of intense change interspersed with periods of relative stability. The 1960s was a decade of rapid growth and expansion in response to a then national priority—increasing the number of physicians in the United States. The number of medical schools grew from 86 in the 1960-1961 academic year to 103 in 1970-1971, and the entering class size increased from 8298 to 11 348. This growth continued during the 1970s, and by the 1980-1981 academic year there were 126 medical schools and 17 204 entering students. To support this explosive growth, various liaison committees responsible for the accreditation of medical education were redesigned. Also associated with the expansion of medical education during the late 1960s and early 1970s was an intense burst of curricular innovation.

By 1980, the growth phase was flattening, and governmental concern shifted from attempting to increase the number of physicians to influencing their distribution. In the 1980 *JAMA* medical education issue, C. H. William Ruhe, MD, described increased fiscal restraints that were leading medical schools "to consider or to implement reductions in class size," an event that has not materialized to a significant degree.

The 1980s can be characterized as a time of reappraisal in medical education. Calls for reform were heard throughout the decade. A 1989 survey by the Robert Wood Johnson Foundation indicated that a majority of medical educators believed that "fundamental changes" were needed, suggesting a "restlessness" among educational leaders.

While predicting the future is hazardous, the 1990s may well be called the "decade of accountability," with an emphasis on evaluating educational outcomes. This will be coupled with retrenchment and, perhaps, significant "downsizing," which will result from the environment of fiscal restraint that continued in the late 1980s. Many sources of funding for medical education have been limited. Many state-supported schools are experiencing budgetary restrictions as an outgrowth of precarious state financial conditions. Private schools can no longer rely on tuition increases as a major source of budgetary support. Limitations on research funding have had a major impact on both privately and publicly supported schools. In contrast, income generated by patient care services has assumed a more dominant role in financing medical education.

Curricular ferment continues among the 126 schools accredited by the Liaison Committee on Medical Education (LCME), suggesting that the various studies calling for reform are having an effect. Fewer didactic lectures, more small-group teaching, increased supervision of students learning clinical skills, more interdisciplinary efforts that emphasize making the basic science components of the curriculum relevant to the clinical practice of medicine, a greater emphasis on social and ethical issues, and renewed efforts to evaluate student performance all appear to be occurring, to some degree, in the vast majority of US medical schools. This tendency for change is supported by a recent addition to the LCME standards for accreditation of medical education programs leading to the doctor of medicine degree, which calls for integrated institutional responsibility for the design and management of a more coherent and coordinated curriculum with appropriate oversight.

Although a precipitous decline in applicants to US medical schools continued in the 1980s, the current decade is beginning with a rather dramatic resurgence in the number of applicants. It is difficult to explain this trend reversal. This resurgence of applicants, however, should not deter us from working diligently with college and high school counselors and developing informative and attractive educational materials on the merits of medicine as a career. Medical educators also have a responsibility to assist in the development of programs in the primary and secondary schools that bring science back into the mainstream of the US educational system.

Growth in the number of medical school faculty continues at a rapid pace. This growth is almost exclusively among clinical faculty rather than faculty in the basic sciences. There has been a 43% growth in total faculty numbers between academic years 1980-1981 and 1989-1990, a 3% to 6% range in growth rate annually since 1985, and a 3.4% increase between academic years 1986-1987 and 1989-1990. This continued faculty growth is far out of proportion to the total student enrollment, which declined 0.2% from 1989 to 1990, and reflects the ever-present demand on medical schools to fund their budgets by expanding faculty who are productive in attracting research grants and, particularly, to expand clinical faculty who can

Dr Jonas is director and Dr Barzansky is assistant director, Division of Undergraduate Medical Education; Ms Etzel is assistant editor, Department of Directories and Publications; all are from the American Medical Association.

provide enhanced patient care services and directly benefit faculty practice plans. Income generated from patient care services to fund medical schools continued to represent a larger and more dominant share of total medical school budgets.

Stresses in the medical education system have affected the governance and administration of medical schools. Turnover of deans and department heads remains high, causing concern about potentially negative effects on the way medical schools function. Another serious concern, the continued failure of medical schools to increase significantly both the numbers and percentages of enrolled minority students, remains a problem, requiring major efforts to achieve success in this area.

The following report on undergraduate medical education, compiled from data collected through the 1990-1991 LCME Annual Medical School Questionnaire Part II, highlights the trends in medical school faculty, students, and curriculum and provides data on some key issues of current interest.

ACCREDITATION

The LCME is the official accrediting body of the educational programs leading to the doctor of medicine degree and is recognized for this purpose by the US Department of Education and by the Council on Postsecondary Accreditation. (For a list of LCME members, see Appendix I.)

The criteria by which the LCME accredits programs in the United States and in Canada, in cooperation with the Committee for the Accreditation of Canadian Medical Schools, are published in *Functions and Structure of a Medical School; Standards for Accreditation of Medical Education Programs Leading to the MD Degree.* (For copies of the revised 1991 edition, write to the LCME Office, American Medical Association, Division of Undergraduate Medical Education, 515 N State St, Chicago, IL 60610; or write to the LCME Office, Association of American Medical Colleges, Office of Accreditation, One Dupont Circle, NW, Washington, DC 20036.)

As of July 1, 1991, there were 125 US programs and 16 Canadian programs fully accredited to award the doctor of medicine degree. One US program, that of the University of Minnesota-Duluth School of Medicine, is fully accredited to offer only 2 years of basic medical sciences. For a complete list of medical schools in the United States conducting accredited programs as of July 1, 1990, see Appendix II, Table 1. For a list of Canadian medical programs accredited jointly by the LCME and the Committee for the Accreditation of Canadian Medical Schools, see Appendix III, Table 1. Other tables in Appendix III provide information on enrollment, faculties, and curricula in Canadian medical schools.

Table 1.—Number of Full-time Faculty and Medical Students in US Medical Schools

	Academic Year				
	1986-1987	1987-1988*	1988-1989	1989-1990	1990-1991†
Full-time faculty	63 991	68 709	70 908	72 323‡	74 807
Medical students	66 142	65 742	65 150	65 091	64 988

*Howard University, Washington, DC, did not provide information; 1986-1987 data were used for this school.
†Hahnemann University, Philadelphia, Pa, and the University of Texas, Galveston, did not provide information; 1989-1990 data were used for these schools.
‡The University of Louisville, Ky, did not provide information; 1988-1989 data were used for this school.

Table 2.—Full-time Faculty Positions by Discipline and Academic Rank in US Medical Schools and Percentage of Budgeted Positions Vacant, 1990-1991

Department	No. of Full-time Budgeted Positions Filled*					No. (%) of Vacant Positions
	Professor	Associate Professor	Assistant Professor	Instructor and Other	Total	
Basic Science						
Anatomy	828	736	573	161	2298	85 (3.7)
Biochemistry	993	455	481	174	2003	85 (4.1)
Microbiology	657	488	467	160	1782	58 (3.1)
Pathology	1289	1185	1521	424	4399	250 (5.4)
Pharmacology	692	405	405	141	1643	74 (4.3)
Physiology	813	541	417	128	1899	74 (3.7)
Other	451	359	445	176	1433	34 (2.3)
Subtotal	5621	4169	4309	1366	15 465	660 (4.1)
Clinical Science						
Anesthesiology	474	638	1838	705	3655	205 (5.3)
Dermatology	160	119	207	55	591	28 (5.0)
Family medicine	259	474	1035	337	2105	153 (6.7)
Medicine	3929	3722	6417	2667	16 735	892 (5.1)
Neurology	534	544	929	291	2168	107 (4.7)
Obstetrics and gynecology	679	598	1165	554	2996	265 (8.1)
Ophthalmology	370	309	428	229	1336	77 (5.4)
Orthopedics	271	226	495	197	1089	97 (8.2)
Otolaryngology	230	175	322	157	884	42 (4.5)
Pediatrics	1558	1770	3054	1008	7388	534 (6.7)
Physical medicine	97	114	358	172	741	42 (5.4)
Psychiatry	1281	1331	2572	1141	6425	328 (4.9)
Public health and preventive medicine	264	251	327	117	959	48 (4.8)
Radiology	1156	1140	2030	647	4973	301 (5.7)
Surgery	1660	1307	2248	620	5835	394 (6.3)
Urology	164	92	130	30	466	18 (3.8)
Other	177	229	493	188	1087	72 (6.2)
Subtotal	13 243	13 039	24 008	9062	59 352	3601 (5.7)
Total	18 864	17 198	28 317	10 428	74 807	4261 (5.4)

*Hahnemann University, Philadelphia, Pa, and the University of Texas, Galveston, did not provide information; 1989-1990 data were used for these schools.

MEDICAL SCHOOL FACULTY

Between academic years 1986-1987 and 1990-1991, the number of full-time medical school faculty members increased 17%, while the total number of medical students decreased 2% (Table 1). For academic year 1990-1991, the ratio of full-time faculty members to medical students was 1.15:1, while in academic year 1986-1987, the ratio was 0.97:1. The percentage increase in the number of full-time faculty members varied across departments, with the clinical disciplines increasing more than the basic sciences. Between academic years 1986-1987 and 1990-1991, the number of full-time faculty members increased as follows: anatomy 6%, biochemistry 12%, microbiology 4%, pathology 9%, pharmacology 0%, physiology 1%, anesthesiology 27%, family medicine 17%, internal medicine 28%, obstetrics and gynecology 18%,

pediatrics 22%, psychiatry 13%, and surgery 19%.

The number of full-time faculty positions (filled and vacant) in the 1990-1991 academic year by discipline and academic rank is shown in Table 2. In addition to 15 455 full-time faculty members in the basic sciences, there were 965 paid part-time and 6669 volunteer (unpaid) faculty. The number of full-time clinical faculty members was 59 352, with an additional 8825 paid part-time and 117 214 volunteer faculty. The total number of medical school faculty was 208 480, an increase of about 5000 from academic year 1989-1990.

Of the number of full-time faculty positions, 5.4% were vacant as of January 1, 1991. For the past 8 years, the number of vacant faculty positions has averaged 5% of total full-time positions. Turnover in department head and dean positions remains high. In the 1990-1991 academic year, there were 182 department chair appointments in 123 schools, an average of 1.5 per school (range, 0 to 5 appointments per school); as of January 1, 1991, there were 285 departments with acting or unfilled department chairs, an average of 2.3 (range, 0 to 7 per school). Between July 1990 and July 1991, there were 17 changes in deans, including the naming of permanent deans, changes in acting or interim deans, and status changes from acting to permanent dean. Four dean retirements were announced, effective August 1991 or later; as of June 1, 1991, approximately 10% of US medical schools had interim or acting deans.

In addition to teaching medical students, medical school faculty have educational responsibilities for 18 278 enrolled degree candidates in master's degree or doctoral programs in the 124 US medical schools reporting in the 1990-1991 academic year and an additional 5619 postdoctoral students or nondegree fellows (Table 3). Medical school faculty also teach about 57 000 residents and about 12 000 clinical fellows and may teach students from other health professions. (The number and types of students taught by the faculty of each reporting institution are given in Appendix II, Table 2).

CLINICAL TEACHING FACILITIES

Undergraduate and graduate medical school teaching was conducted in 1913 clinical facilities, of which 98 were owned by a medical school, 887 had a major affiliation, 698 had a limited affiliation, and 328 had an affiliation with a medical school for graduate medical education only. Over the past 10 years, the number of owned institutions has fluctuated from a high of 111 in the 1988-1989 academic year to a low of 87 in the academic years 1982-1983 and 1984-1985.

Table 3.—Enrollments for Advanced Degree and Postdoctoral Studies and Number of Degrees Awarded in Selected Basic Science Departments, 1990-1991*

	Enrollment			Degrees Conferred†	
Department	MA	PhD	Postdoctoral	MA	PhD
Anatomy	156	3072	711	134	385
Biochemistry	139	2972	1302	129	429
Microbiology	257	2857	585	141	364
Pathology	147	738	519	61	120
Pharmacology	140	1688	721	68	276
Physiology	274	1376	756	168	223
Other	1945	2507	722	591	278
Totals	3058	15 220	5619	1272	2095

*Hahnemann University, Philadelphia, Pa, and the University of Texas, Galveston, did not provide information.
†Estimated in April 1991.

Table 4.—Application Activity Over 20-Year Period

Academic Year	No. of Applicants*	Total No. of Applications*	Average No. of Applications per Person*	No. of Accepted Applicants*	Applicant Acceptance Ratio*	First-Year Enrollment
1970-1971	24 957	146 797	6.0	11 500	2.2	11 348
1980-1981†	36 100	330 888	9.2	17 146	2.1	17 204
1981-1982	39 727	339 975	8.8	17 286	2.1	17 320
1982-1983	35 730	334 897	9.4	17 294	2.1	17 230
1983-1984	35 200	319 340	9.1	17 209	2.0	17 175
1984-1985	35 944	331 937	9.2	17 194	2.1	16 992
1985-1986	32 893	307 427	9.3	17 229	1.9	16 929
1986-1987	31 323	295 744	9.4	17 092	1.8	16 778
1987-1988	28 123	266 900	9.5	17 027	1.7	16 686
1988-1989	26 721	259 442	9.7	17 108	1.6	16 781
1989-1990	26 915	235 797	9.5	16 975	1.6	16 749
1990-1991	29 243	290 488	9.9	17 206	1.7	16 803‡

*Data from *Medical School Admission Requirements*, Association of American Medical Colleges, Section for Student Services.
†Ponce (Puerto Rico) School of Medicine and the University of South Dakota, Sioux Falls, did not provide first-year enrollment data; 1979-1980 figures were used for these schools.
‡Hahnemann University, Philadelphia, Pa, and the University of Texas, Galveston, did not provide first-year enrollment data; 1989-1990 figures were used for these schools.

MEDICAL STUDENTS

Applicants

The relatively steady decline in the number of applicants to US medical schools during the 1980s (Table 4) halted for the class entering in 1989 and has begun to reverse. Between 1989 and 1990, the number of applicants increased about 9%. Of the 29 243 applicants in 1990, 17 206 were accepted, an acceptance rate of about 59%. The Association of American Medical Colleges reports about 33 000 applicants for the class entering in 1991. Speculation on the reasons for the increase in the number of applicants includes the possibility that the economic environment is making alternative careers, such as business, less attractive.

For 1990, the applicant pool consisted of 11 785 women (40.3%) and 17 458 men (59.7%). There were 3172 underrepresented minority applicants (blacks, Mexican Americans, mainland Puerto Ricans, and American Indians), an increase of 4% from 1989. Of these, 1612 (51%) were accepted.

Admissions Criteria

The mean premedical grade point average for new students admitted in 1990 was 3.40 (on a 4.0 scale), which is close to the entering average of 3.41 for 1989 and 3.42 for 1988. Of admitted students, 45% had a grade point average of 3.5 or above on a 4-point scale, an increase from 1989 (Table 5). An additional 45.2% of admitted students had a grade point average from 3.0 to 3.49.

Applicants at 121 schools were required to take the Medical College Admission Test (MCAT) for entry into the first year of the program, leaving five schools without an MCAT requirement. The mean MCAT scores are identical to those for students entering in 1989, halting a gradual decline that began in the mid-1980s (Table 6). This is the last year that comparative data will be available; the new MCAT examination, ad-

Table 5.—Premedical Grade Point Averages of Entering Medical Students, 1986-1990

Entering Year	Premedical Grade Point Average*			
	A (3.50-4.00)	B (2.50-3.49)	C (≤2.50)	Unknown
1986	41.6	48.4	1.9	3.9
1987	42.6	49.4	1.9	2.1
1988	44.6	49.0	2.1	4.3
1989	43.7	52.7	2.3	1.3
1990	45.0	52.4	2.2	0.4

*Four-point scale.

Table 6.—Mean Medical College Admission Test Scores of Accepted Applicants*

	Academic Year				
	1986-1987	1987-1988	1988-1989	1989-1990	1990-1991
Part 1: science knowledge					
Biology	9.6	9.9	9.6	9.6	9.6
Chemistry	9.8	9.6	9.4	9.3	9.3
Physics	9.8	9.5	9.4	9.3	9.3
Part 2: science problems	9.7	9.6	9.4	9.3	9.3
Part 3: skills analysis—reading	9.0	8.9	8.7	8.7	8.7
Part 4: skills analysis—quantitative	8.9	8.8	8.7	8.6	8.6
No. of accepted applicants who took MCAT	16 598	16 518	16 514	16 364	16 542
Total No. of accepted applicants	17 092	17 027	17 109	16 975	17 206

*Data from *AMCAS Admissions Action Summary*, Association of American Medical Colleges, Section for Student Services.

Table 7.—Medical School Students and Graduates Over 20-Year Period

Academic Year	No. of Schools	Enrollments			Graduates
		Total	First Year*	Intermediate Years†	
1970-1971	103	40 487	11 348	20 165	8974
1980-1981‡	126	65 497	17 204	32 626	15 667
1981-1982	126	66 485	17 320	33 180	15 985
1982-1983	127	66 806	17 230	33 832	15 624
1983-1984	127	67 443	17 175	33 941	16 327
1984-1985	127	67 080	16 992	33 779	16 318
1985-1986	127	66 604	16 929	33 464	16 129
1986-1987	127	66 142	16 779	33 527	15 838
1987-1988§	127	65 742	16 685	33 109	15 887
1988-1989	127	65 150	16 781	32 749	15 620
1989-1990	127	65 081	16 749	32 998	15 335
1990-1991‖	126	64 986	16 803	32 684	15 499¶

*First-year enrollment includes students repeating the year.
†Intermediate years include final-year students who did not graduate.
‡Ponce (Puerto Rico) School of Medicine and the University of South Dakota, Sioux Falls, did not provide information; 1979-1980 enrollment were used for these schools.
§Howard University, Washington, DC, did not provide information; 1986-1987 data were used for this school.
‖Hahnemann University, Philadelphia, Pa, and the University of Texas, Galveston, did not provide information; 1989-1990 data were used for these schools.
¶Estimated in April 1991.

Table 8.—Number of New First-Year Students and MD Graduates Projected by Medical Schools*

Academic Year	First-Year Class	MD Graduates
1991-1992	15 946	16 002
1992-1993	15 946	16 142
1993-1994	15 950	16 247
1994-1995	15 953	16 169
1995-1996	15 956	16 162

*Hahnemann University, Philadelphia, Pa, and the University of Texas, Galveston, did not provide information.

ministered in April of 1991, has changed considerably in content, format, and scoring. The new examination consists of four components, biological sciences, physical sciences, verbal reasoning, and a writing sample. Scores for the first three segments range from one to 15, and the writing sample is scored from "J" (lowest) to "T" (highest).

Enrollment

The 64 986 medical students enrolled in the 126 medical schools for the 1990-1991 academic year represent the lowest total enrollment over the past 10 years. First-year enrollment increased slightly. The estimated number of graduates increased by 163 as shown in Table 7. Enrollment included 64 363 US citizens and permanent residents of the US, 106 Canadian citizens, and 517 citizens of other countries. The number of foreign students in US medical schools has not significantly changed over the past several years. The US medical schools have projected no significant increases or decreases in the number of first-year students expected to enroll each year or in the number of graduates through the next 5 years (Table 8). Despite these projections, significant changes in enrollment could result from state legislative actions to change the number or size of medical schools.

Entering Students

Of the students entering medical school in 1990, 88% possessed baccalaureate degrees and 7.9% had master's or doctoral degrees. An average of 69% of entering students were residents of the state in which the school was located. In privately supported schools, an average of 44% of entering students were state residents; in schools identified as wholly public, 86% of entering students were state residents. Information on the number of new in-state and out-of-state students entering the first-year class in each medical school is contained in Appendix II, Table 2.

Table 9 shows some changes over the past 5 years in the composition of the first-year class. The number of white (non-Hispanic) men has continued to decline, while the numbers of white (non-Hispanic) women and black (non-Hispanic) men have fluctuated. The number of black (non-Hispanic) women has generally increased, and the numbers of men and women who were Asians or Pacific Islanders have risen steadily.

Women in Medical Schools

The percentage of women applicants rose to 40.3% of the total applicants in the 1990-1991 academic year (Table 10). Of the women who applied to medical school, 56.5% were admitted. The number of women entering medical school also continues to increase. Of the class entering in 1990, 38.7% were women. However, the percentage of women entrants varied widely by school, from a low of 18.4% to a high of 53.2%. Of all medical students enrolled, 36.2% were women, with a range of 17.3% at some schools to 51.3% at others. Of the 15 499 expected doctor of medicine graduates, 36% are women. (The number of women enrolled and graduated by each school is given in Appendix II, Table 2.)

Table 9.—Five-Year Trend in Selected First-Year* Medical Students

Academic Year	Whites (Non-Hispanic)		Blacks (Non-Hispanic)		Asians/Pacific Islanders	
	Men	Women	Men	Women	Men	Women
1986-1987	8043	4324	567	581	969	630
1987-1988	8216	4363	572	602	1179	676
1988-1989	8015	4327	536	651	1301	769
1989-1990	7985	4416	535	662	1406	849
1990-1991†	7487	4347	567	701	1562	974

*Includes repeaters.
†Hahnemann University, Philadelphia, Pa, and the University of Texas, Galveston, did not provide information; 1989-1990 data were used for these schools.

Table 10.—Women in US Medical Schools Over 20-Year Period

Academic Year	No. (%) of Women Applicants*	No. (%) of Women in Entering Class	No. (%) of Total Women Enrolled	No. (%) of Graduates
1970-1971	2734 (10.9)	1256 (11.1)	3894 (9.4)	827 (9.2)
1980-1981†	10 644 (29.5)	4970 (28.9)	17 373 (26.5)	3892 (24.8)
1981-1982	11 673 (31.6)	5343 (30.8)	18 555 (27.9)	3891 (25.0)
1982-1983	11 885 (32.7)	5445 (31.6)	19 627 (29.3)	4229 (26.7)
1983-1984	11 961 (33.9)	6858 (32.9)	20 635 (30.7)	4617 (28.3)
1984-1985	12 476 (34.7)	5705 (33.6)	21 287 (31.7)	4898 (30.0)
1985-1986	11 562 (35.1)	5728 (34.2)	21 624 (32.5)	4930 (30.8)
1986-1987	11 267 (36.0)	5886 (35.0)	22 032 (33.4)	5092 (32.1)
1987-1988‡	10 411 (37.0)	6097 (36.5)	22 539 (34.3)	5256 (33.7)
1988-1989	10 254 (38.4)	6205 (37.0)	22 902 (35.1)	5225 (33.5)
1989-1990	10 546 (39.2)	6404 (38.2)	23 501 (36.1)	5197 (33.9)
1990-1991§	11 796 (40.3)	6499 (38.7)	24 164 (37.2)	5584 (38.0)‖

*Source: *Medical School Admission Requirements*, Association of American Medical Colleges, Section for Student Services.
†Ponce (Puerto Rico) School of Medicine and the University of South Dakota, Sioux Falls, did not provide enrollment information; 1979-1980 enrollment figures were used for these schools.
‡Howard University, Washington, DC, did not provide enrollment information; 1986-1987 enrollment figures were used for this school.
§Hahnemann University, Philadelphia, Pa, and the University of Texas, Galveston, did not provide enrollment information; 1989-1990 data were used for these schools.
‖Estimated in April 1991.

Students From Minority Groups

Table 11 contains data on the racial and ethnic distribution of medical students. For purposes of comparison, in the first-year class in 1981-1982 academic year, there were 973 (5.9%) black students, 67 (0.4%) American Indian and Alaskan native students, 262 (1.6%) Mexican American students, 332 (2%) Puerto Rican students, 214 (1.3%) other Hispanic students, and 674 (4.1%) Asian and Pacific Islander students. Except for Asians and Pacific Islanders, both the numbers and percentages of enrolled minority students have not changed significantly in the past 10 years. This lack of progress in increasing minority student representation in US medical schools deserves priority attention and commitment of significant resources.

Three schools, Howard University in Washington, DC, Meharry Medical College in Nashville, Tenn, and Morehouse School of Medicine in Atlanta, Ga, admitted 15.9% of all first-year black medical students in 1990-1991, approximately the same percentage as in 1989-1990. Six other schools (Wayne State University in Detroit, Mich; University of Illinois at Chicago; University of Medicine and Dentistry of New Jersey-New Jersey Medical School, Piscataway; State University of New York at Brooklyn; University of Michigan, Ann Arbor; and Case Western Reserve University in Cleveland, Ohio) admitted an additional 15.9% of the total first-year black students in the 1990-1991 academic year. Thus, nine schools enrolled about one third of all first-year black students.

Students Admitted With Advanced Standing

The number of students who transferred into an LCME-accredited medical school in the 1990-1991 academic year was 827, about 1% of the total students enrolled (Table 12). The number of students who transferred from one LCME-accredited medical school to another was 851, with the majority transferring into the third year of the curriculum. Of these 851 students, 43 transferred from a school accredited to offer only the first 2 years of the doctor of medicine program. The number of students (159) who transferred from other graduate and professional degree programs and from schools of osteopathic medicine returned to levels of the 1988-1989 and 1987-1988 academic years, dropping from a high of 249 in 1989-1990.

In the 1989-1990 academic year, 117 students transferred with advanced standing from a foreign medical school to a US medical school, continuing a declining trend in such transfers. Of the transfers from foreign schools, about 89% were US citizens.

Fifth Pathway Programs

The Fifth Pathway, a program that has been steadily declining in US schools over the past several years, provides another route to graduate medical education for US students from foreign medical schools who have completed premedical education in the United States and have completed all but the internship and/or social service components of the foreign medical education program. In the 1990-1991 academic year, only seven US medical schools accepted students for a Fifth Pathway clinical experience. The schools reported that 290 applications for Fifth Pathway had been received, a decrease of 125 applications from the previous year. Sixty-seven students were enrolled in a Fifth Pathway program between July 1990 and April 1991.

Student Attrition

The publication date for this issue requires that information on attrition be reported for the 1989-1990 academic year.

In the 1989-1990 academic year, 900 medical students (1.4% of total enrollment) withdrew or were dismissed. Reasons given for withdrawal or dismissal were academic (37.0%); transfer to another institution (26.1%); personal, including financial and health (16.4%); career change or change in motivation for medicine (14.8%); and miscellaneous (5.7%). These percentages are comparable to those for the 1988-1989 academic year. Of the total withdrawals or dismissals, 409 (45.4%) were first-year students, 283 (31.4%) were second-year students, 181 (20.1%) were third-year students, and 27 (3%) were fourth-year students.

In the 1989-1990 academic year, 1473 students (2.3% of the total enrollment) were on leave of absence. Reasons given for taking leaves of absence were poor academic performance or remediation (17%); academic enrichment, research, or study for another degree (34.4%);

Table 11.—Race and Ethnic Background of Medical School Enrollees, 1990-1991*

	No. (%)		
	Men	Women	Total
First-year enrollment†			
Blacks (not of Hispanic origin)	557 (3.4)	701 (4.2)	1258 (7.6)
American Indians or Alaskan natives	45 (0.3)	30 (0.2)	75 (0.5)
Mexican Americans	172 (1.0)	102 (0.6)	274 (1.6)
Puerto Ricans	132 (0.8)	93 (0.5)	225 (1.3)
Puerto Ricans (mainland)	60 (0.4)	43 (0.2)	103 (0.6)
Other Hispanics	177 (1.0)	135 (0.8)	312 (1.8)
Asians or Pacific Islanders	1552 (9.2)	974 (5.8)	2526 (15.0)
All other students‡	7599 (45.2)	4421 (26.3)	12 020 (71.5)
Total	10 304 (61.3)	6499 (38.7)	16 803 (100.0)
Graduates			
Blacks (not of Hispanic origin)	401 (2.6)	510 (3.3)	911 (5.9)
American Indians or Alaskan natives	29 (0.2)	14 (0.1)	43 (0.3)
Mexican Americans	167 (1.0)	87 (0.6)	254 (1.6)
Puerto Ricans	134 (0.9)	81 (0.5)	215 (1.4)
Puerto Ricans (mainland)	43 (0.3)	18 (0.1)	61 (0.4)
Other Hispanics	177 (1.1)	100 (0.6)	277 (1.7)
Asians or Pacific Islanders	1035 (6.7)	597 (3.8)	1632 (10.5)
All other students‡	7929 (51.2)	4177 (26.9)	12 106 (78.1)
Total	9916 (64.0)	5584 (36.0)	15 499 (100.0)
Total enrollment			
Blacks (not of Hispanic origin)	1878 (2.9)	2337 (3.6)	4215 (6.5)
American Indians or Alaskan natives	152 (0.2)	120 (0.2)	272 (0.4)
Mexican Americans	686 (1.1)	420 (0.6)	1106 (1.7)
Puerto Ricans	534 (0.8)	334 (0.5)	868 (1.3)
Puerto Ricans (mainland)	215 (0.3)	154 (0.2)	369 (0.5)
Other Hispanics	715 (1.1)	456 (0.7)	1171 (1.8)
Asians or Pacific Islanders	5319 (8.2)	3212 (4.9)	8525 (13.1)
All other students‡	31 927 (48.2)	17 131 (26.4)	48 458 (74.6)
Total	40 822 (62.8)	24 164 (37.2)	64 986 (100.0)

*Hahnemann University, Philadelphia, Pa, and the University of Texas, Galveston, did not provide enrollment information; 1989-1990 data were used for these schools.
†First-year enrollment data includes students repeating the year.
‡All other students includes whites (not of Hispanic origin) and non-US citizen foreign students of various race and ethnic backgrounds.

Table 12.—Number of Students Who Transferred

Academic Year	From 2-Year Schools	From One MD-Granting School to Another	From Other Degree Programs	From Foreign Medical Schools	Total
1986-1987	50	270	119	208	647
1987-1988*	48	308	133	133	640
1988-1989†	48	331	152	167	698
1989-1990	38	423	249	130	840
1990-1991‡	43	308	159	117	627

*Howard University, Washington, DC, did not provide information.
†The University of Tennessee, Memphis, did not provide information.
‡Hahnemann University, Philadelphia, Pa, and the University of Texas, Galveston, did not provide information.

personal, including financial and health (41.4%); and miscellaneous (7.2%). Of the students taking leaves of absence, 333 (22.6%) were first-year students, 439 (29.8%) were second-year students, 553 (37.5%) were third-year students, and 148 (10%) were fourth-year students.

Students on a Decelerated Schedule

Table 18 contains data on students repeating the 1990-1991 academic year, during which 1075 (1.7%) of all enrolled medical students and 591 (3.5%) of all first-year students repeated all or part of a school year. In all other years of the curriculum, 1.0% (484 students) were repeating all or part of the year.

In the 1990-1991 academic year, 1030 students (1.6% of the total enrollment) were on a reduced schedule, ie, taking fewer than average courses per semester. Approximately 76% of the students on such a schedule were in the first or second year of medical school. Reasons for choosing a reduced schedule included poor academic performance (37.2%), inadequate academic preparation (15.9%), family responsibilities (10.1%), pursuit of advanced studies for gifted students (6.3%), poor health or physical impairment (4.6%), and "other" (25.9%).

Specialty Choice of Graduates

For students expected to graduate in the 1990-1991 academic year, 13 943 (89.9%) participated in the National Resident Matching Program. Of the students participating, 12 985 (93.1%) matched into graduate year 1 positions. Of the 15 499 potential graduates, 46.9% accepted primary care residency positions in family medicine, internal medicine, pediatrics, obstetrics and gynecology, and the combined program in internal medicine/pediatrics. About 45% of graduates chose residency positions in the same state as the medical school from which they obtained their doctor of medicine degrees and 53% of graduates chose residencies in another state; 258 fourth-year students chose not to take a residency after graduation. The main reasons given for not pursuing a residency were to engage in research (38%), pursue another degree (14%), personal (9%), and maternity leave or child care (9%).

Student Services

While 110 schools had a formal program to educate students about infectious disease prevention and exposure before they have patient contact, 13 schools reported they had no formal program. Medical students were required to be immunized for rubeola in 112 schools, for rubella in 115 schools, for mumps in 100 schools, for polio in 87 schools, and for chickenpox in 31 schools. Immunization for hepatitis B was required for medical students at 60 schools, an increase of 10 schools from the previous year. In 20 schools, the hepatitis B vaccine is available free of charge or is covered by school-sponsored health insurance; in 27 schools, the vaccine is available at a reduced cost, and in 12 schools, students pay full price for the vaccine.

Medical schools reported availability of the following services: student ombudsman (63 schools), assigned faculty advisor (107 schools), personal counseling service (121 schools), peer counseling (81 schools), organized self-help group (51 schools), organized spouse support group (61 schools), health promotion seminars (80 schools), fitness facility (100 schools), and stress management seminars (83 schools).

The average tuition and fees for first-

Table 13.—Race and Ethnic Background of Students Who Repeated the 1990-1991 Academic Year

	First-Year Class		All Other Classes	
	Total Enrolled*	No. (%) Repeating	Total Enrolled*	No. (%) Repeating
Blacks (not of Hispanic origin)	1268	165 (13.0)	2947	116 (3.9)
American Indians or Alaskan natives	78	7 (9.3)	197	6 (3.0)
Mexican Americans	274	26 (9.5)	834	20 (2.4)
Puerto Ricans	225	10 (4.4)	643	11 (1.7)
Puerto Ricans (mainland)	103	11 (10.7)	266	6 (2.3)
Other Hispanics	312	14 (4.5)	859	11 (1.3)
Asians or Pacific Islanders	2525	70 (2.8)	5989	78 (1.3)
All other students†	12 020	288 (2.4)	36 439	236 (0.6)
Total	16 803	591 (3.6)	48 183	464 (1.0)

*Hahnemann University, Philadelphia, Pa, and the University of Texas, Galveston did not provide information; 1989-1990 enrollment data were used for these schools.
†All other students includes whites (not of Hispanic origin) and non-US citizen foreign students of various race and ethnic backgrounds.

year students in private medical schools were $18 756 in the fall of 1990. For publicly supported institutions, the average tuition and fees were $4242 for in-state residents and $14 982 for out-of-state residents. Compared with 1985 costs, tuition and fees have risen an average of 33% for private schools, 48% for in-state students in publicly supported schools, and 67% for out-of-state students in publicly supported schools.

THE MEDICAL CURRICULUM

The minimum time needed to complete the curricular requirements leading to the doctor of medicine degree ranges from 112 to 176 weeks; the average is 153 weeks. Medical schools commonly have a 4-year program, though seven schools offer certain students an option to graduate in 3 years. Instruction averages 37 weeks in the first year, 35 in the second, 46 in the third, and 36 in the fourth. The average number of weeks per year has not changed from the 1989-1990 academic year. Thirty-two schools have a combined baccalaureate-medical program, most commonly as an optional track.

On average, nine clerkships are required of every student during the clinical years. The average number of weeks given to required clerkships during the third and fourth years is 12.6 in internal medicine; 7 in obstetrics and gynecology; 7.5 in pediatrics; 6.4 in psychiatry; and 9.3 in general surgery. All 125 degree-granting schools have one or more required clerkships in these specialties; 72 schools have one or more required clerkships in family medicine (average duration, 5.6 weeks) and 64 schools have required clerkships in one or more surgical specialties (average duration, 5.2 weeks).

The average percentage of required clerkship time that students spend in the outpatient setting varies by specialty as follows: family medicine (90%), pediatrics (37%), obstetrics and gynecology (28%), psychiatry (20%), surgery (15%), and internal medicine (13%). In 88% of reporting schools, students in required internal medicine clerkships have no outpatient experience.

Students at 117 schools have opportunities to take one or more clinical rotations in a rural setting. At 28 schools these experiences are required and at 89 schools they are optional.

In the final curricular period, the average amount of elective time is 28 weeks. The average maximum amount of time students are permitted to spend taking electives outside their own medical school and its affiliated hospitals is 15 weeks. The average amount of time students actually spend taking such outside electives is 7 weeks. In only 17 schools do students take an average of 10 or more weeks of electives at another institution.

Medical schools offer students the opportunity to earn graduate and professional degrees in addition to the doctor of medicine degree. They can earn a combined doctor of medicine and doctor of philosophy degree in 108 schools, a combined doctor of medicine and master's degree in 42 schools, a combined doctor of medicine and doctor of jurisprudence degree in 10 schools, and a combined doctor of medicine and master of public health degree in 29 schools.

The number of schools using innovative instructional formats has been increasing. One hundred five institutions (99 in the 1989-1990 academic year) make use of self-instruction, 120 (117 in 1989-1990) use computer-assisted instruction, and 100 (94 in 1989-1990) use problem-based learning in the preclinical years. The extent to which these methods are used is not known.

(Information about the curricular placement of special topics such as biostatistics, substance abuse, epidemiology, geriatrics, nutrition, prevention and health maintenance, and utilization review and quality assurance can be obtained from the Division of Undergraduate Medical Education, American Medical Association, 515 N State St, Chicago, IL 60610.)

EVALUATION OF STUDENT PERFORMANCE

The grading system for required courses is a letter grade in 45 schools, pass-fail in 29 schools, honors-pass-fail in 26 schools, and a numerical grade in 16 schools. For clerkships, the grading system is a letter grade in 43 schools, honors-pass-fail in 20 schools, a numerical grade in 13 schools, and pass-fail in eight schools. In 86 schools, students also receive a narrative evaluation of their clerkships. In 38 schools, students are given a class rank by year, based on a composite of all their grades; in six schools students receive a class rank in each course.

The clinical assessment techniques used in clerkships include observations by faculty members (122 schools), observations by residents (121 schools), chart review (112 schools), oral examinations (99 schools), paper-and-pencil patient management problems (57 schools), computer simulations (42 schools), multiple station examinations with simulated patients (26 schools), and multiple station examinations without simulated patients (17 schools). In introduction to clinical medicine courses, the clinical assessment techniques include repeat observations by faculty members (106 schools), paper-and-pencil patient management problems (37 schools), repeat observations by residents (32 schools), multiple station examinations with simulated patients (32 schools), chart review (32 schools), oral examinations (29 schools), computer simulations (12 schools), and multiple station examinations without simulated patients (10 schools). As part of a final, comprehensive evaluation, 30 schools used oral examinations, 11 schools used multiple station examinations with standardized patients, and nine schools used multiple stations without standardized patients.

Ninety-seven schools require students to take Part I of the National Board of Medical Examiners (NBME) examination, and 70 schools require a passing grade for advancement or graduation. Ninety-one schools require students to take the NBME Part II examination, and 49 schools require a passing grade for advancement or graduation. A study or review period for the NBME Part I examination is provided by 107

schools, and 29 schools schedule similar periods for the NBME Part II examination. Of the 89 schools that require students to take both NBME Part I and Part II, 45 require a passing score on both examinations.

The NBME has introduced new examinations in 1991, the Comprehensive Part I examination was offered in June 1991 and the Comprehensive Part II examination will be offered in September 1991. In contrast to the NBME Part I and NBME Part II examinations, the new comprehensive examinations are designed to be broadly based and integrated, with less of a discipline orientation. These examinations will be replaced by a single, uniform examination for medical licensure with the administration of Step 1 of the US Medical Licensing Examination beginning in June 1992.

Students are required to take one or more NBME subject tests by 106 schools. For basic science subjects, the anatomy shelf test is required in 11 schools, the behavioral science shelf test in 13 schools, the biochemistry shelf test in 29 schools, the microbiology shelf test in 34 schools, the pathology shelf test in 31 schools, the pharmacology shelf test in 29 schools, and the physiology shelf test in 26 schools. For clinical subjects, the medicine shelf test is required in 84 schools, the obstetrics and gynecology shelf test in 72 schools, the pediatrics shelf test in 63 schools, the psychiatry shelf test in 52 schools, and the surgery shelf test in 57 schools. In general, the number of schools requiring basic science shelf tests has decreased slightly from 1989 to 1990 and the number of schools requiring clinical shelf tests has increased slightly.

CURRICULUM EVALUATION

The results of NBME examinations are used for curriculum evaluation in 119 schools, although not all of them require students to take the examination. Other sources of data used for curriculum evaluation include scores on departmental examinations (106 schools), comments from the Association of American Medical Colleges Graduation Questionnaire (121 schools), assessment of the performance of graduates in residency training (90 schools), and assessment of the performance of graduates in practice (14 schools). Data from performance based assessment of student skills and abilities are used for program evaluation in 55 schools.

SUMMARY

One noteworthy finding for the 1990-1991 academic year is the increasing number of applicants to medical school, coupled with stabilization in the credentials of accepted applicants. This increase appears to be reversing the downward trend of the 1980s. The percentages of women and total minority students in the entering class increased from the previous year.

The prevalence of instructional formats such as problem-based learning and computer-assisted instruction illustrates that medical schools are willing to experiment with educational innovation. A number of schools are in the process of curriculum review, which may lead to important changes. The financial support offered by private foundations interested in curriculum innovation, for some, will be an added stimulus for change.

While the majority of medical schools continue to require that students take the examinations and the subject tests of the NBME, evaluation formats that test clinical skills are receiving increased attention. The number of schools using multiple station examinations (often with standardized patients) is rising. The impact of the new US Medical Licensing Examination on medical school curricula should be analyzed in the future.

Although steady increases have been reported in the number of medical school faculty members, especially clinical faculty, there is little information about how these faculty members apportion their time between teaching, research, and patient care. The assumption is that the increases are primarily driven by medical schools' need to provide clinical services, which are a source of income. Another explanation for faculty increases could relate to the need for more faculty involvement in educational innovations such as problem-based learning and new methods of clinical skills evaluation, which are relatively more faculty-intensive. Continued monitoring of the growth in clinical faculty will be necessary, as will more careful analysis of how medical school faculty spend their time. Since medical school faculty who have heavy involvements in teaching frequently do not receive appropriate recognition or reward, it will also be interesting to examine the effectiveness of diverse incentives used by the schools to reward teaching faculty. An appropriate reward system for teaching is important if undergraduate medical education is to command a high priority in institutions awarding the doctor of medicine degree.

Table 52. **Professional Liability Insurance Premiums per Self-Employed Physician (in Thousands of Dollars), 1990**

	Number of Responses	Mean	Standard Error	25th Percentile	Median	75th Percentile
All Physicians	2111	14.5	0.3	5.0	9.0	18.0
Specialty						
General/Family Practice	508	7.8	0.3	4.0	7.0	10.0
Internal Medicine	421	9.2	0.9	5.0	7.0	10.0
· General Internal Medicine	266	9.0	1.3	5.0	7.0	9.0
· Cardiovascular Diseases	50	10.9	1.2	7.0	10.0	14.0
· Other	105	8.8	0.9	5.0	7.0	10.0
Surgery	522	22.8	0.7	11.0	18.0	31.0
· General Surgery	151	24.6	1.2	16.0	24.0	31.0
· Otolaryngology	48	17.6	1.6	10.0	14.0	27.0
· Orthopedic Surgery	104	35.5	1.9	20.0	35.0	45.0
· Ophthalmology	106	9.6	0.5	6.0	9.0	12.0
· Urological Surgery	39	15.8	1.3	10.0	15.0	22.0
· Other	74	27.8	1.9	16.0	25.0	37.0
Pediatrics	145	7.8	0.4	5.0	7.0	9.0
Obstetrics/Gynecology	160	34.3	1.6	22.0	30.0	43.0
Radiology	89	11.5	0.9	6.0	9.0	14.0
Psychiatry	158	4.5	0.2	3.0	4.0	5.0
Anesthesiology	110	20.8	1.0	13.0	19.0	26.0
Pathology	43	7.7	0.9	4.0	6.0	8.0
Other Specialty	155	9.5	0.6	4.0	7.0	12.0
· Emergency Medicine	45	12.7	1.2	7.0	10.0	16.0
· Other	110	8.2	0.7	4.0	6.0	10.0
Geographic Area						
New England	107	19.8	2.3	5.0	10.0	27.0
· Massachusetts	40	23.8	4.5	6.0	11.0	36.0
· Other	67	17.5	2.5	5.0	9.0	20.0
Middle Atlantic	327	16.1	0.9	6.0	10.0	20.0
· New Jersey	81	16.8	1.5	7.0	10.0	26.0
· New York	132	18.1	1.8	6.0	12.0	17.0
· Pennsylvania	114	13.0	1.3	5.0	8.0	18.0
East North Central	323	15.1	0.7	6.0	10.0	22.0
· Illinois	99	17.9	1.3	9.0	12.0	36.0
· Michigan	65	13.8	1.5	6.0	10.0	21.0
· Ohio	86	17.4	1.5	6.0	13.0	25.0
· Other	75	10.3	1.0	5.0	8.0	15.0
West North Central	127	13.6	1.0	7.0	10.0	18.0
South Atlantic	426	15.4	0.8	5.0	9.0	20.0
· Florida	137	18.9	1.6	8.0	12.0	25.0
· Other	289	13.7	0.8	4.0	8.0	17.0
East South Central	129	15.1	2.5	4.0	8.0	18.0
West South Central	220	11.2	0.7	4.0	7.0	14.0
· Texas	148	11.6	0.9	4.0	7.0	14.0
· Other	72	10.4	1.1	3.0	7.0	14.0
Mountain	101	18.7	2.3	6.0	11.0	25.0
Pacific	351	10.9	0.5	5.0	8.0	15.0
· California	256	10.6	0.5	5.0	8.0	15.0
· Other	95	11.6	1.0	5.0	8.0	14.0
Practice Arrangement						
Solo Practice	1109	13.0	0.4	5.0	8.0	16.0
Two Physician Practice	250	16.6	1.1	6.0	10.0	24.0
Three Physician Practice	196	16.4	1.5	5.0	9.0	18.0
4-8 Physician Practice	391	16.4	0.7	6.0	11.0	22.0
Over 8 Physician Practice	164	15.6	1.9	6.0	10.0	18.0

Source: 1991 Socioeconomic Monitoring System core survey. See beginning of this section, the introduction, and appendices for a discussion of the survey sample, definitions, and computation procedures. Statistics are not reported if the number of responses is less than 25.

Table 55. Mean Professional Liability Premiums (in thousands of dollars) per Self-Employed Physician, 1982-1989[a]

	1982	1983	1984	1985	1986	1987	1988	1989
All Physicians	5.8	6.9	8.4	10.5	12.8	15.0	15.9	15.5
Specialty								
General/Family Practice	3.5	4.2	4.6	6.8	7.3	8.9	9.4	9.0
Internal Medicine	3.7	4.5	4.9	5.8	7.1	8.4	9.0	8.2
Surgery	9.9	11.0	13.3	16.6	21.3	24.5	26.5	25.8
Pediatrics	2.9	3.9	3.4	4.7	6.3	7.1	9.3	7.8
Obstetrics/Gynecology	10.8	14.0	19.0	23.5	29.3	35.3	35.3	37.0
Census Division								
New England	5.5	6.6	7.1	9.8	10.7	17.9	18.2	17.7
Middle Atlantic	7.4	8.9	10.4	12.9	14.9	17.0	15.5	18.1
East North Central	5.3	6.9	7.6	10.7	13.4	13.9	14.8	16.1
West North Central	5.2	4.8	8.0	10.1	13.6	15.4	19.2	15.8
South Atlantic	5.6	6.1	8.6	11.3	14.4	15.5	18.4	15.6
East South Central	4.5	5.7	6.3	9.7	10.1	12.6	13.5	15.6
West South Central	4.2	5.2	5.5	7.0	8.1	11.9	13.4	11.3
Mountain	5.5	6.2	7.5	8.1	12.0	16.1	16.8	19.4
Pacific	6.8	8.6	9.9	11.1	12.8	14.4	14.4	12.7
Type of Practice								
Solo	5.6	6.5	7.9	9.5	11.9	14.0	14.3	13.7
Non-solo	6.0	7.5	9.2	11.8	14.0	16.2	17.8	17.7
Location								
Nonmetropolitan	4.4	5.1	7.1	7.6	10.9	14.2	13.6	13.5
Metropolitan--								
Less than 1,000,000	5.9	6.5	7.8	10.1	12.3	14.1	15.6	15.6
1,000,000 and over	6.1	7.8	9.2	11.6	13.8	16.0	16.6	16.0
Physician Age								
Less than 36 years	4.6	5.2	6.2	8.7	9.5	12.0	11.0	12.7
36-45 years	6.1	7.0	8.5	10.4	13.0	14.8	16.5	15.0
46-55 years	6.4	7.7	9.4	11.6	14.8	16.1	17.0	17.5
56-65 years	5.6	7.0	8.7	10.8	12.4	16.6	16.9	16.3
66 or more years	4.5	5.9	6.5	8.5	10.3	10.7	11.4	11.8

Source: 1983-1990, AMA Socioeconomic Monitoring System core surveys. The population from which samples are drawn includes only active nonfederal patient care physicians, excluding residents.

a. Data, other than in the specialty breakdown, are based on responses from physicians in all specialties. All data are weighted to adjust for nonresponse bias. This will cause figures to differ from those reported in previous editions of this volume. See Appendix B for information on weighting and computation procedures. See Appendix D for information on definitions.

Malpractice Premiums
Going up average of
15% per year
- OMB

THE COS

A central aspect o
has been their role in c
direct cost associated wi
premiums paid for liabili
measured PL cost. Howeve
changes in practice patte
with claims that are not
measured as premiums.

Although major components of PL costs are difficult to measure directly, all of the costs associated with PL are reflected in the fees and utilization rates for physician services. This observation provided the basis for a methodology developed by Reynolds, et al. ["The Cost of Medical Professional Liability" Journal of the American Medical Association 257 (May 22,1987) 2776-2781] for estimating total PL costs. This report employs that methodology to provide estimates of the trend of PL premiums and other PL costs during the 1980s.

Estimates of PL costs per physician are derived from data collected in American Medical Association Socioeconomic Monitoring System (SMS) annual core surveys. Aggregate PL cost estimates were extrapolated from estimates of the share of total costs per physician associated with PL based on the SMS data using statistics from the U.S. Health Care Financing Administration (HCFA) on national expenditures on physician services. HCFA reported a major revision of the national health expenditure series in 1986, accounting for some difference in results reported below from those reflected in the original study by Reynolds, et al.

Average Professional Liability Insurance Premiums Paid by Physicians

The average amount of premiums paid by physicians for PL insurance increased from $5,800 in 1982 to $15,500 in 1989 for an annual rate of increase of 15.1%. As shown in Table 1, this rate of increase was greater that of all other major components of medical practice costs.

The more rapid growth of PL insurance premiums than other practice costs caused the share of the total cost of physician services accounted for by premiums to grow from 3.1% in 1982 to 4.8% in 1989. However, the 1989 share represents a decline from a peak share of 5.5% occurring in 1987.

The growth in average PL premiums paid by physicians from 1982 to 1989 is contrasted with general inflation and physician fee inflation in Table 2. Through 1987, premiums increased substantially more rapidly than both general prices and fees. The rate of growth in premiums moderated in 1988 and

---

Center for Health Policy Research, American Medical Association, Chicago, Illinois, September 1990.

premiums fell slightly in 1989. Still, the level of premiums was substantially higher relative to physician fees and the general price level in 1989 than at the beginning of the decade.

Total Professional Liability Costs

Total PL costs are obtained by adding the cost of practice changes and claims costs not covered by insurance to premiums. Results in Reynolds, et al. showed that the preponderance of PL costs other than premiums were due to changes in practice patterns. These changes include such behavior as ordering more tests, spending more time with patients, and increasing record-keeping efforts. Collectively, these types of practice changes made in response to the PL risk are often termed "defensive medicine." Application of the term "defensive medicine" in this context, however, should not be regarded as implying any judgment about the benefit or lack of benefit associated with practice changes. Rather, it should be regarded as covering behavior that physicians perceive will reduce their exposure to the risk of a claim. In the present analysis, it was not possible to quantify defensive medicine costs separately from claims costs not covered by insurance, but it seems likely that they still are the dominant factor contributing to overall PL costs.

In 1989, total PL costs related to physician services in the United States were $20.7 billion, accounting for 17.6% of total expenditures on physician services. Of the $20.7 billion total PL cost, only $5.6 billion was due to PL insurance premiums. This indicates that the role of PL in contributing to health care costs is considerably underestimated by confining attention to premiums.

Table 3 illustrates how PL costs have contributed to growth in expenditures on physician services during the last decade. In 1982, actual total expenditures on physician services were $53.8 billion. Without PL costs, expenditures would have been $47.3 billion, or 12.1% lower. By 1989, aggregate expenditures on physician services grew to $117.6 billion, but would have been only $96.9 billion without PL costs. These results imply that, in contrast to the actual average annual growth rate of expenditures on physician services from 1982 to 1989 of 11.8%, the growth rate would have been only 10.8% in the absence of PL costs.

In 1989, total PL costs declined for the first time in the 1980s. The decrease occurred entirely in the costs other than PL insurance premiums. Although aggregate premiums were unchanged, the decline in average premiums paid for physicians suggests a slight diminution of PL risk facing the average physician. A reduction of some defensive medicine practices in response to the diminished PL risk probably explains the decline in the PL costs.

Summary

Professional liability costs accounted for 17.6% of spending on physician services in 1990. Most of these costs were due to defensive medicine practices. PL costs have also had a major impact on the growth of the cost on physician services in the 1980s. Although increases in PL costs may have peaked in 1988, they still remain at a substantially higher level than earlier in the decade.

plcost.pap\rr

American Medical Association

Physicians dedicated to the health of America

515 North State Street
Chicago, Illinois 60610
(312) 464-5000

ADDITIONAL PAGE

Date: 2-3-92

To: Jeannie Buxton
White House
202 | 456 - 6218

From: JACK SEGAL
PUBLIC INFORMATION OFFICER
(312) 464-5970

Total pages (Including cover sheet): 14

Reply fax number: (312) 464-4189 or 5839

Regarding: Please see attached materials - ✱s indicate answers to specific questions you asked

✱ Projected graduates for 1991-92 is guestimated to be between 15,300 and 15,600

Fax Transmission

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01. Memo	J. bunton to The Boss, re: Las Vegas Speech. (2 pp.)	02/03/92	P-5	

Collection:

Record Group: Bush Presidential Records
Office: Speechwriting, White House Office of
Series: Speech File, Backup
Subseries:
WHORM Cat.:
File Location: University Medical Center - Las Vegas, NV - Health Information 2/6/92 [2]

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3 FEBRUARY 1992

MEMO SMEMO FOR THE BOSS

FROM: J. BUNTON JB

SUBJECT: LAS VEGAS SPEECH

GEE, MY FIRST MEMO FROM BRUCE SPRINGSTEIN.

ANSWERS:

1) WE CONSULTED/ MET WITH LEADERSHIP OF THE MEDICAL COMMUNITY [INCLUDING HEAD OF AMA - JAMES TODD] HANNS THINKS THAT MIGHT TURN SOME PEOPLE OFF- SO HE LEFT IT AT LEADEHRSIP OF MEDICAL COMMUNITY

2) PLAN WON'T EFFECT COST OF ENTRY ITNO MEDICAL FIELD, UNLESS SOME OF THESE NEW BREEDS GIVE UP THEIR BEEMERS FOR RUGGED AMERICA LIKE DR. JOEL FLEISHMAN DID IN SICILY, ALASKA.

   IT WILL HELP IF ANY OF THE STUDENTS GO ON TO BE A PART OF THE NATIONAL HEALTH SERVICE CORPS -- WHICH EITHER WILL PAY SCHOLARSHIP OR RE-PAY A STUDENT LOAN IN RETURN FOR FULLFILLING A COMMITMENT TO PRACTICE IN A MEDICALLY UNDERSERVED AREA. [WAITING ON FIGURES FOR NUMBER OF THESE TYPE FOLK CURRENTLY IN NEVADA/ OR OPENINGS/NEED] POTUS ASKED FOR $120 MILLION [19 PERCENT INCREASE] IN THIS YEAR'S BUDGET FOR THIS PROGRAM -- TO EXPAND TRAINING OF PHYSICIANS

3) DR. JOEL FLIESCHMAN.

4) UNDER THIS PLAN THE NUMBER OF UNINSURED AMERICANS WILL GO FROM 13% [34.7 MILLION] TO 2% [4.9 MILLION] --- DECLINE SIGNIFICANTLY. "WER'RE AT THE POINT WHERE WE CAN DECLARE VICTORY," SAID HANNS.

MORE TO FOLLOW. AMEN.

THERE ARE CURRENTLY 13 VACANCIES IN NEVADA FOR HEALTH CARE PROVIDERS IN THE NATIONAL HEALTH SERVICE CORPS, BROKEN DOWN AS FOLLOWS:

\
6 PHYSICIANS
4 NURSE PRACTICIONERS
3 PHYSICIAN ASSISTANTS

THERE IS A HEALTH CARE PROFESSIONAL SHORTAGE IN 24 GEOGRAPHIC AREAS IN NEVADA

MORE MORE TO FOLLOW: LIKE NAMES OF THESE SMALL TOWNS, GEOGRAPHIC PROXIMITY TO LAS VEGAS. INFO PER PAT NORRIS 301-443-2900 AT NAT'L HEALTH SERVICE CORPS.

From Petersmeyer.

I keep coming back to what works for this country. We must make comprehensive health care reform that corrects the system's weaknesses without destroying its strengths. America's health care strengths include the freedom of individuals to choose physicians, hospitals and health plans; diversity and flexibility in the financing, organization and delivery of care; the best educated and most skilled physicians and health professionals in the world; millions of volunteers who assist in providing quality health care; world leadership in biomedical research; dramatic technological innovation and leadership in new methods of assuring quality care.

For Las Vegas.

My comprehensive four-point plan meets every one of these common-sense tests. Here's how:

Point one: we will make health **care** more **accessible** by making health **insurance** more **affordable.** For low-income individuals and families, I propose a health insurance **credit** -- up to $3,750 dollars a year to guarantee people, even people too

poor to file taxes, the ability to purchase private health insurance. That will put in their hands a certificate or voucher worth more than $300 dollars a month. They can use it to buy into the plan their employers offer but they could never afford -- or they can shop for whatever private plan suits them best.

That's the American commitment to choice at its best.

For middle-income individuals and families, I propose a health insurance **tax deduction** of $3,750. / American families with incomes under $80,000 will receive new help from either the credit or the tax deduction. Let me tell you what that means: new help to purchase health insurance for 95 million Americans.

Once again, this insurance will be portable: people who change jobs would have insurance regardless of their health -- and this is important -- or their family's health.

But best of all, my plan will bring health care **coverage** to 30 million uninsured Americans -- **security** / to people who for far too long have had to do without. //

That's the first point in my four-point plan: access.

Point two: we will **cut the runaway costs** of health care by making the system more **efficient**. Today, I'm asking you to learn a new acronym: HIN -- Health Insurance Networks. / Insurance costs obey the "law of large numbers:" The larger the group being insured, the lower the cost per individual. "Pooling" lowers insurance costs -- and significantly cuts administrative costs. HIN's will provide incentives for small companies to do what Cleveland's C.O.S.E. [COZY] group has done -- when it

brought 10,000 small businesses together to make a joint purchase of health care.

Another way to drive costs down: make everyone a better health care consumer. Right now, most people pay more attention to the price of toothpaste than the comparative costs of health care. People don't waste much time thinking about the costs of their care -- but in the end, we all pay the price. We need to follow the lead of initiatives like Cleveland Health Quality Choice -- programs that give people "shopping" for health care a kind of "blue book" for medical costs. // Innovations like these will help all of us keep the costs of quality health care as low as possible.

Point Three: we will wring out **waste and excess** in the present system. We've targeted medical malpractice for reform. It's time to put an end to these astronomical, sky's-the-limit lawsuits. // You shouldn't have to pay a **lawyer** when you go to the **doctor**. //

Right now, people do just that: high malpractice premiums mean higher doctors' bills, higher hospital costs -- costs passed along to the patient. / I have challenged the health insurance industry to cut red tape -- to share common forms, and to simplify and speed up claims processing. Here's a challenge for the next four years: There is no reason almost all health insurance claims can't be processed electronically. That single step would eliminate a mountain of health care paperwork and pare back costs.

Fourth and finally, we will get the **growth** in federal health programs **under control**. Right now, government health care programs can claim a dubious distinction: they are the fastest growing parts in the federal budget. / We must bring runaway costs under control. We won't cut benefits -- we can make real savings simply by reducing the rate of **increase**.

Efficiencies like this will help our reform plan pay for itself. //

The federal government should also give states the flexibility to design new universal access programs for the poor -- programs that will provide quality services to all their citizens. I've just met with the Governors -- they want flexibility, and we'll give it to them. States will be able to use new federal resources to design programs that work -- not one-size-fits-all solutions imposed by Washington.

Providing affordable care, efficient care, / wringing out excess and waste and controlling federal growth: these four points will create the kind of market-based reform plan that will give Americans the kind of health care they want and deserve -- and put an end to the worry that keeps them awake at night.

Remember what people want. People want quality care / care they can afford / care they can count on.

Fall 91 33,351 Applicants to Med. School

16,211 Enrolled fall 1991

52%

Assoc. of Amer. Med. Schools

Memo

To Jeanne

Date 2/3/92 Time 2:50

WHILE YOU WERE OUT

M Maureen McLaughlin

of Dept. of Education

Phone 401-0182

Area Code Number Extension

TELEPHONED	✓	PLEASE CALL	
CALLED TO SEE YOU		WILL CALL AGAIN	
WANTS TO SEE YOU		URGENT	
RETURNED YOUR CALL	✓		

Message Jay Lefkowitz

Operator mf

AMPAD EFFICIENCY® 23-021 CARBONLESS

A rabid Texan she promptly told him at great length about the beauty of the plains, the wild flowers, the rivers and lakes. To clinch her case she pointed to the beautiful scenery outside the window.

"I'll admit it's laid out pretty," he said. "How long's it been dead?" —Doris Kesinger

NOT LONG AGO I was hospitalized by a severe case of hepatitis, a liver ailment which often turns one's skin a jaundiced yellow. (And I am a girl who never did look well in yellow.) Feeling a bit more chipper one morning I decided to go down to the hospital newsstand for the morning paper. I spruced myself with a little powder and lipstick and made my way to the elevator. The sole other occupant was a fine-looking intern—tall, dark and handsome — and my heart fluttered as I noticed him looking at me with interest. Modestly I glanced away. But as the elevator descended and I became more and more aware that he was gazing at me, I wished I'd applied my make-up more carefully. Then he inched closer, and I just knew he was going to speak to me. Pleased, I waited. He leaned forward, looked deep in my eyes and said triumphantly, "Liver?" —Jane Porter

Doctor's Dilemma

SIGN IN clinic waiting room: "Ladies in the Waiting Room Will Please Not Exchange Symptoms. It Gets the Doctors Hopelessly Confused." —Ollie M. James in Cincinnati *Enquirer*

WHILE IN the hospital for the birth of our son, I shared a room with a young mother whose obstetrician was reserved and businesslike. On one of his visits, trying to make conversation, she said, "Doctor, they certainly keep you busy, don't they?"

"Yes," he said quietly, without looking up from his notes. "I have too many men working for me." —Mrs. Ralph P. Stilphen

"IT WAS about 2 a.m. and I wakes up feeling awful," tells Jimmy Durante, "so I calls my doctor ta come right over. It's a terrible night out so I apologizes ta him when he comes.

" 'Dat's all right,' says the doc. 'I got another patient in the neighborhood—so I can kill two boids with one stone.' "

A FRIEND of mine was going into surgery. They wheeled him in all wrapped up in sheets and lifted him onto the operating table. In the glare of the lights, surgeons and assistant surgeons, anesthetists and surgical nurses in their gauze masks crowded around. Sterilizers were hissing. Oxygen tanks stood ready. They began peeling the sheets off and as they removed the last of the presurgical preparations and got down to his bare torso they found a piece of adhesive tape pasted to his skin. Written on it was the reminder, "Think." —Braven Dyer, quoted by Art Ryon in Los Angeles *Times*

WHEN I was taken to the hospital after an auto accident the doctor, after examining me and putting my leg in a cast, said that I could go home the next day. In the morning, however, he announced, "I think you'd better stay another day to see if something new turns up. I didn't know how bad you were banged up until I read about the accident in the newspaper." —Harlow Landphair

THE PROPRIETOR of an art gallery in London, showing pictures to a customer who didn't know what he liked, tried out a landscape, a still life, a portrait and a floral piece, all without results. "Would you be interested in a nude?" he finally asked.

"Good heavens, no," said the visitor. "I'm a physician." —*The English Digest*

NURSE comforting a patient: "Don't let the doctors frighten you. Doctors are like politicians —they view with alarm so they can point with pride!" —From the motion picture *With a Song in My Heart* (20th Century-Fox)

The judges, knowing its origin, gave the sculpture first prize. It turned out to have been made from a block of stable salt. And the sculptress who had fluted it so neatly with soft curves was the exhibitor's family cow! —Edmund Mulcahy, Jr.

AN M.I.T. STUDENT went home for a vacation and left his car parked behind his dormitory. Some of the young engineers who remained at school that vacation took it apart, lugged it piece by piece into the dormitory.

When the owner came back to school he found his car assembled and parked in his room. —Joe Harrington in Boston *Post*

Oh, Doctor!

If you still have your tonsils and appendix at 30, chances are you're the doctor.

ROBERT BENCHLEY, who always had a sneaking suspicion that doctors were only one step ahead of the public as far as knowledge went, and that they could be thrown off balance by anything completely unexpected, had a chance to test this theory in 1940. He came down with pneumonia and his doctor gave him one of the new "miracle" sulfa drugs. He took the pills as directed and then, one afternoon before the doctor was due to call, he and Charles Butterworth broke open a pillow and, with library paste, glued the feathers all over him, from the waist down.

When the doctor arrived he examined Benchley's chest, asked him how he was feeling and if the pills had done any good. Benchley said he thought they had, then added, as he threw back the bedclothes, "But I don't know quite what to make of this. Is *this* all right?"

—*Robert Benchley, A Biography*, © 1955 by Nathaniel Benchley (McGraw-Hill)

THE MORNING after my operation, though I was barely conscious of what was going on, my nurse insisted on changing me from the hospital gown to one of my own, brushed my hair carefully, powdered my face and added a touch of lipstick. Stepping back, she surveyed her handiwork with evident satisfaction.

"There!" she said, and added confidentially, "Dr. Culpepper simply *hates* to see his patients look sick." —Mrs. Milton W. Edwards

TWO SISTERS who have a tearoom in a small Virginia town depend greatly on Mary, an old family retainer, and when she failed to show up for several days they went to investigate.

"My sister's in the hospital," Mary explained. "They operated on her and she's mighty sick."

The sisters expressed their sympathy and asked what the trouble was.

"I don't know, ma'am. The doctah just cut her open and help himself." —Mrs. William M. Lewis

WITH FIVE children in rapid succession, I'd been a regular caller at the obstetrician's office. Then came a gap of three years before I again pushed open his waiting-room door and greeted his nurse. She looked startled.

"Why, Mrs. Clifford," she exclaimed, "I'd put you on our inactive list." —Mrs. Paul C. Clifford

A COUNTRY DOCTOR in northern Ontario left his ancient Model-T Ford in front of the village drugstore and on his return found several of the youths who customarily loitered there making merry at the old car's expense. As he climbed up into the well-worn driver's seat the doctor inspected the group carefully, then leaned out and said, "The car's all right, boys—it's paid for. You"—and the doctor looked deliberately from one boy to another—"are not." —Joan Morris

CHATTING WITH the proprietor of a curio shop in San Francisco's Chinatown, a tourist asked if China had good doctors. "We got plenty good doctors in China," the saffron sage replied. "Hang Chang is best. He save my life."

"How was that?" asked the tourist.

"Me velly sick, call Dr. Hang Kin. He give medicine make me sicker. Call Dr. San Sing. Give more medicine make me more sick. I feel I gonna die. Bimeby call Dr. Hang Chang. He gone somewhere else. No come. Save my life." —*The Wall Street Journal*

OUR NEW medical officer, young and very green, was doing his best to ignore the baby-blue eyes of his patient, the prettiest civil service employe in headquarters. With great dignity he prepared to give her a routine checkup and in the process dropped his stethoscope.

"Is anything the matter, sir?" she asked sweetly, enjoying his discomfiture.

"Of course not," he replied, collecting himself and his equipment. "Now then," he ordered in his most professional tone, "deep breathely!" —W. W. Wright

THE DOCTOR had finished the examination and was ready to give his professional advice. "Quit smoking and drinking, go to bed early every night and get up at the crack of dawn," he said. "That's the best thing for you."

"Frankly, Doc," the patient answered, "I don't deserve the best. What's second best?"

—"Our Town" in White Plains, N.Y., *Reporter Dispatch*

AT THE DOCTOR'S for an after-baby checkup, I was being given a lecture for not getting enough rest. But with a new baby to keep me up at night and a two-year-old to chase all day, I didn't see what I could do about it.

"You've *got* to rest," the doctor said sternly, "both for your own good and for the welfare of your family."

Knowing his wife had a new baby, I blurted out, "Does *your* wife?"

"No," he replied blandly, "but she's not my patient." —K. E. C.

THE DOCTOR diagnosed the Anglo-Indian colonel's illness as hydropsy. What was that? Too much water in the body, the doctor explained. The whiskey-drinking Briton was indignant. "But I've never drunk a drop of water in all my life, Doctor!" He paused. Then, sadly, he concluded, "Must have been the ice." —NANA

Icecapades

I WAS TRUDGING up the steep and snowy driveway of the Portland Hospital. Suddenly WHOOSH!—something shot by me like a streak. It was a nurse, sitting up straight as a dart, her dark-blue cape streaming out behind her. Then another figure zipped by, and another. There wasn't a sled in sight, and I was completely baffled about what carried them so smoothly over the snow. But as I watched, one of the nurses landed in a snowbank halfway down the hill. Getting to her feet she gaily brushed herself off, reached down to retrieve a white enameled bedpan, settled herself on it and whizzed on down the hill. —Jean Wells Jerabeck

ON A WINTER morning when the streets of New York were slick with ice, I saw a man sitting in the middle of the sidewalk. Thinking he must be hurt I asked, "May I help you up?"

"No, thank you," he laughed. "I'm just sitting here to melt the ice on this particular spot." He moved aside for a moment. There under the ice was a five-dollar bill which he was hatching.

—R. M. Geis

ON ONE OF Portland's iciest days a little woman was seen walking uphill gripping what looked like a walking stick. Actually it was a plumber's helper. She'd thrust the suction cup down in front of her at arm's length and walk up to it. Then she'd yank it up with a wet squoosh and shove it ahead of her again for another leg of her treacherous journey. —William Moyes in Portland *Oregonian*

the development. The next day I asked her how the party had gone. I knew she had planned it in the grand manner with a magician and ventriloquist.

"Times have changed even more than I ever dreamed," she said. "The children said they were sick of looking at magicians and ventriloquists on television. All they wanted to do all afternoon was slide down my banisters!" —Margaret B. Link

REMEMBER WHEN the only difficult thing about parking a car was getting the girl to agree to it?

—Randy Merriman, quoted in Milwaukee *Journal*

ONCE YOU COULD fix a broken chair with a length of wire. Today the chair *is* a length of wire. —Marjorie Murch Stanley in *Quote*

BARGING IN next door one afternoon to borrow a cup of sugar I found my neighbor sitting in her darkened living room watching a movie on television.

"Come in," she said—and burst out laughing. "I was just thinking how little things change. Here I am playing hooky from my housework to watch the same movie I played hooky from school to see!" —Joy Gallagher

THE WORLD started going to smash about the time it abandoned the hand-cranked ice-cream freezer, the finest device ever invented for teaching youth that work has its rewards. —Cleveland *News*

"WHEN I WAS your age, young lady," her mother said sternly, "a nice girl didn't think of holding a man's hand."

"But, Mother," the daughter protested, "nowadays a nice girl *has* to hold a man's hand."

—*Expanding Circle*, quoted in *Woodmen of the World Magazine*

MAN gazing into liquor-store window to companion: "Remember the fun it was fighting a cold before the antihistamines?"

—Fritz Wilkinson cartoon in *Collier's*

For the Health of It

Speaking of ailments—don't. —Hot Springs, Ark., *Sentinel-Record*

HUSBAND TO wife trying on fur coat: "For heaven's sake, Ruth, there are other ways to fight a cold!"

—Franklin Folger cartoon, Chicago Sun-Times Syndicate

A WALKING virus case blaming vitamins and the new drugs for his uncertain status: "I've been sick on my feet now for two months. I'm too strong to get sick and too weak to get well."

—Hugh Park in Atlanta *Journal*

WHEN HIS doctor advised a change of climate the eastern city-dweller went looking for a healthful place to live in the Southwest. In one small Arizona town he approached an old-timer sitting on the steps of the general store.

Preventive Medicine

MY GREAT AUNT had raised nine children on a Michigan farm, fed them and the farm hands, done all her own housework and helped with the outdoor chores. And she had never been ill in her life. Finally her family doctor asked her secret. "I constantly see young women," he said, "who have only one or two children and whose homes are full of gadgets to lighten work, but who suffer from nervous exhaustion or psychosomatic aches and pains. How is it that you managed never to have a nervous breakdown?"

"You know, Doctor," she replied, "I've always *wanted* to have a nervous breakdown. But every time I was about to get around to it, it was time to fix somebody a meal." —Beach Conger

"Say," he asked, "what's the death rate around here?"
"Same as it is back east, bub," came the answer. "One to a person." *The Crucible*

MATRON TO greeting-card clerk: "Do you have a get-well card that hints she's not as sick as she thinks she is?"
—Corka cartoon in *Farm Journal*

ANYBODY WHO can swallow a pill at a drinking fountain deserves to get well. —Richard Armour

OVERHEARD ON a Madison Avenue bus: "He's been quite sick. He has that disease—I've forgotten the name—where the red popsicles eat up all the white popsicles." —Mrs. W. K. Rienecke

HUSBAND TO wife opening envelope as he serves her breakfast in bed: "It's a get-well-quick card—from me!"
—Don Tobin cartoon, King Features

EPITAPH ON the grave of a hypochondriac: "I *told* you I was sick!" —Phil Stone in Toronto *Telegram*

Jalopies I Cursed and Loved

Condensed from Holiday
John Steinbeck

ONE SUNDAY afternoon I drove from Garrison-on-Hudson to New York, one unit in a creeping parade of metal, inching along bumper to bumper. Every so often we passed a car pulled off the road with motor trouble, its driver and passengers waiting patiently for a tow car or a mechanic. Not one of the drivers seemed even to consider fixing the difficulty himself.

I began to think of old times and old cars. Understand, I don't want to go back to those old dogs. I love the fine efficient car I have. But in those days you fixed your own car or you didn't go anyplace.

The first car I remember in the little town where I was born was, I think, a Reo with a chain drive and a steering bar. It was owned by a veterinary who got himself a bad name for owning it. He seemed disloyal to horses. We didn't like that car. We shouted insults at it as it splashed by. Then, gradually, more automobiles came into town. We didn't have a car for many years. My

Holiday July '54. © 1954 by The Curtis Pub. Co.
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THE WHITE HOUSE

WASHINGTON

January 30, 1992

MEMORANDUM FOR ROGER B. PORTER

FROM: CHARLES E.M. KOLB

SUBJECT: Health Care Speech

I wanted to offer some suggestions about the President's health care speech next week in Cleveland.

First, the speech should make it crystal clear that the country is at a crossroads in health policy. At issue is whether we will preserve the private health care system with government and individual choice playing a role to increase that system's efficiency, or whether we will adopt the Foley/Kennedy version of a government-managed, national health care system. In my view, the President should define the differences between the two approaches and do so through stark contrasts.

Second, one way to make the contrast is to characterize the Foley/Kennedy approach as one doomed to failure -- just as the government-run, command-and-control economies of the former Soviet Union and Eastern Europe collapsed. Why would Americans ever favor -- or even flirt with -- the Democrats' approach, particularly when the rest of the world (i.e., all those newly emerging democracies) is headed in a free-market direction?

Third, highlight the fact that our approach to health care reform is consistent with the way we handled childcare (and other choice-driven policy models such as education, homeownership, entrepreneurial capitalism etc.). We should invite Congress to work with us to build on past mutual triumphs such as childcare.

Fourth, keep it simple when it comes to the details. If people on "Jeopardy" can't name the Treasury Secretary, I'll bet they won't recognize (and can't remember) "play or pay." People who pay attention to the speech will think in terms of the bottomline: what will the President's proposals mean for me and my family. Rather than speak about the details (which should be covered in the White Paper and Fact Sheet), the President should describe approaches/principles and outcomes. Those are what people will remember.

Hope these thoughts are helpful.

cc: Hanns Kuttner

HIP OATH!

Encyclopedia Americana (1989)

and *Coan Prenotions*. Most of these treatises are thought to have been the work of Hippocrates himself.

The second group consists of a series of largely technical surgical works. *Wounds in the Head, Fractures,* and *Joints* traditionally have been placed among the genuine works with some scholars attributing *Fractures* to grandfather Hippocrates. *Surgery, Instruments of Reduction* (*Mochlion*), and *Bones* are evidently abridgments of larger works.

The third group includes essays, incomplete works, and compilations representing highly speculative theories on physiology and disease. In contrast to this group are the polemical works *Ancient Medicine* and *Sacred Disease* (epilepsy), which attack the intrusion of hypothetical speculation into medicine and concepts of the divine origin of disease, respectively.

Finally, there are a large number of miscellaneous treatises that express the thought of various other schools.

J. D. DE C. M. SAUNDERS, M. D.
University of California, San Francisco

Further Reading: Heidel, William A., *Hippocratic Medicine*, ed. by I. Bernard Cohen (Ayer 1981); Lloyd, G. E., ed., *Hippocratic Writings*, tr. by J. Chadwick and W. N. Nann (Penguin 1984); Smith, Wesley D., *The Hippocratic Tradition* (Cornell Univ. Press 1979).

HIPPOCRATIC OATH, hip-ə-krat'ik, the most famous of the Hippocratic documents. It has served as an ideal for the professional attitude and ethics of physicians to the present. The authorship and historical origin of the oath are so obscure that even the date of its composition is placed variously from the 6th to the 1st century B. C.

The Hippocratic Oath consists of two parts. The first, or covenant, is the solemn agreement concerning the relationship of apprentice to teacher and the obligations enjoined on the pupil. The second part constitutes the ethical code. Much of the oath shows the influence of Pythagorean ethics of the post-Hippocratic period.

J. B. DE C. M. SAUNDERS, M. D.
University of California, San Francisco

THE HIPPOCRATIC OATH

I swear by Apollo the physician and Aesculapius and health and all-heal and all the gods and goddesses that according to my ability and judgment I will keep this oath and this stipulation—to reckon him who taught me this art equally dear to me as my parents, to share my substance with him and relieve his necessities if required, to look upon his offspring in the same footing as my own brothers and to teach them this art if they shall wish to learn it without fee or stipulation and that by precept, lecture, and every other mode of instruction I will impart a knowledge of the art to my own sons and those of my teachers and to disciples bound by a stipulation and oath according to the law of medicine but to none others. I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to any one if asked nor suggest any such counsel, and in like manner I will not give to a woman a pessary to produce abortion. With purity and with holiness I will pass my life and practice my art. I will not cut persons laboring under the stone but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter, I will go into them for the benefit of the sick and will abstain from every voluntary act of mischief and corruption, and further, from the seduction of females or males, of freemen and slaves. Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge as reckoning that all such should be kept secret. While I continue to keep this oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times, but should I trespass and violate this oath, may the reverse be my lot.

HIPPODAMUS, hi-pod'ə-məs, was a Greek city planner of the 5th century B. C. According to Aristotle, Hippodamus (Hippodamos in Greek) originated the idea of planning cities in a gridiron pattern, with streets set at right angles to each other; such patterns, however, have been found in cities built before his time. One feature Hippodamus originated was the division of a city into three sections, one each for sacred and public buildings and one for private homes.

Hippodamus was born in Miletus and put his theories into practice in the reconstruction of that city in 475 B. C., after the Persians had sacked it. He next drew up plans for the port city of Piraeus, where the "Hippodamian Agora" was named for him and where excavations have uncovered portions of the gridiron layout. Hippodamus is also credited with the plan of the town of Thurii, Italy, founded in 443 B. C.

HIPPODROME, hip'ə-drōm, historically, an open-air racecourse, with tiered seats, for horse or chariot races. The term also has been used to designate an indoor or outdoor circus and an arena for equestrian performances.

The earliest hippodrome was at Olympia, Greece. Other cities (such as Delphi in Greece, Alexandria in Egypt, and Antioch in Syria) also had hippodromes, but the most famous were the Circus Maximus in Rome and the Hippodrome in Constantinople (now Istanbul, Turkey).

Design. The usual shape was oblong with one end semicircular, resembling the letter U with a closed top. Ordinary spectators sat along the tiered sides and curve, but dignitaries watched from above the offices (stables, dressing rooms, apartments) at the straight end, where the races started and ended. In some hippodromes the oval track was divided for most of its length by a low wall (*spina*), adorned with monuments, statues, seven stone eggs (at one end), and seven stone dolphins (at the other end). Attendants removed the dolphins and eggs—emblems symbolic of Poseidon (Neptune) and Castor and Pollux, Greco-Roman deities associated with horses—to keep count of the laps. Other hippodromes had for a *spina* merely a row of monuments, around the last of which at either end the competitors turned. Since no rules prevented fouling and upsetting of rivals, the most thrilling action occurred at the turns where contestants jockeyed for position. Hippodromes usually had a covered promenade around the top.

Rome and Constantinople. Only estimates for the dimensions and capacity of the Circus Maximus of Rome and the Hippodrome of Constantinople exist. The Circus Maximus was perhaps 695 yards (635 meters) long and 165 yards (150 meters) wide; its original capacity was between 70,000 and 80,000 spectators, but in the later empire it held about 250,000 persons.

The Hippodrome in Constantinople was 129 yards (118 meters) wide and between 400 and 460 yards long (366 and 420 meters); it accommodated from 60,000 and 100,000 spectators in 30 to 40 tiers of marble seats. Begun by Emperor Lucius Septimius Severus in either 197 or 203 A. D. and completed under Emperor Constantine I in 330, it was despoiled of its artistic treasures between 1204 and 1261, when Latin Christians occupied Constantinople. The famous group of four bronze horses, placed over the imperial loge, was taken to Venice, Italy, where it still adorns the principal portal of St. Mark's Cathedral.

After the Turks capture
1453, the Hippodrome serve
building material. Only thr
row of about a dozen monu
site; the Column of Empe
Porphyrogenitus; the Obelis
mosis (Thutmose) III, er
Theodosius I; and the celel
umn. The last, of bronze
(now headless) twining aro
Delphi as a memorial of th
(479 B. C.), was imported by
Hippodrome's brick walls,
faced with Corinthian colu
trances, of which one comm
adjacent palace by a spiral s
The full program normal
chariot races, 2-horse chariot
horse races. Wrestling, boxi
ing, and gladiatorial combats
added. The Hippodrome was
lic exhibitions, religious festi
criminals, and political demo

P. R.
P

HIPPOLYTE, hi-pol'i-tē, in Gr
the queen of the Amazons a
Ares. As his ninth labor, Her
her golden girdle, or belt, fo
When he arrived at the lan
Hippolyte graciously promised
But the goddess Hera, an e
since his birth, convinced the
come to kill their queen. Th
their weapons, and Hercules,
had been betrayed by Hippol
In another account, Hippo
led an invasion against Attica
by Theseus, who married her.

HIPPOLYTUS, hi-pol'i-təs, S
early Christian ecclesiastical
and martyr. Probably from t
the empire, Hippolytus was a
3d century Rome. Of a rig
bent, he opposed Pope Calli
the penitential discipline, an
heresy and innovation. Suppo
tial circle, Hippolytus was c
217, the first in history. In
Emperor Maximinus Thrax, he
were banished to Sardinia. H
parently reconciled with the
in 235.
Under Pope Fabian (died
of Pontian and Hippolytus we
and buried in Rome. Both ar
ters. The statue of Hippolyt
1551, with a list of his writin
is probably the actual statue
berents.
Hippolytus' writings, mo
speculative, include long treat
ous heresies. He wrote a c
Creation to 234 A. D. and a d
Anti-Christ. Among his Bibl
commentary on Daniel is the
egetical work from the early
celebrated work is the *Apostolic*
provides precious insights into t
His feast is kept on August, 3

ALFRED C.
The Catholic Univ

Hippocrates. Medical thought had reached this stage and had partially discarded the conceptions based upon magic and religion by 460 BC, the year that Hippocrates is said to have been born. Little is known of his life, and there may, in fact, have been several men of this name, or Hippocrates may have been the author of only some, or none, of the books that make up the *Hippocratic Collection*, or the *Corpus Hippocraticum*. Ancient writers held that Hippocrates taught and practiced medicine in Cos, the island of his birth, and in other parts of Greece, including Athens, and died at an advanced age.

Whether Hippocrates was one man or several seems immaterial. The works attributed to him were written by someone, and they do indicate a stage in the progress of medicine. For convenience, Hippocrates is referred to in the following material as if he were known to be one man who wrote all the works of the *Hippocratic Collection*. Some of the works, notably the *Aphorismi* (*Aphorisms*), were used as textbooks until the 19th century. Admittedly they contain much that is obsolete, but they embody a code of teaching and principles that are surprisingly modern. The first aphorism is, "Life is short, and the art long; opportunity fleeting; experiment dangerous, and judgment difficult." This is followed by a large number of brief comments on diseases and symptoms, many of which remain true. The thermometer and the stethoscope were not then known. Employing only his own powers of observation and of logical reasoning, Hippocrates had an almost uncanny ability to foretell the course of the malady, laying more stress upon the expected outcome, or diagnosis.

On the mainland, close to Cos, was a rival school of Cnidus, the members of which were apt to confuse symptoms and diagnosis; they insisted upon naming the disease and treating it and were not concerned with prognosis or with causes. Hippocrates had no patience with the idea that disease was a punishment sent by the gods. Writing of epilepsy, then called "the sacred disease," he said, "It is not any more sacred than other diseases, but has a natural cause, and its supposed divine origin is due to man's inexperience. Every disease," he continued, "has its own nature, and arises from external causes." He noted the effect of food, of occupation, and especially of climate in causing disease, and one of his most interesting books, entitled *De aëre, aquis et locis* (*Air, Waters and Places*), would today be classed as a treatise on human ecology. Pursuing this line of thought, Hippocrates stated that "Our natures are the physicians of our diseases" and that this tendency to natural cure should be fostered; he laid much stress on diet and the use of few drugs. He knew well how to describe illness clearly and concisely and recorded failures as well as successes; he viewed disease with the eye of the naturalist and studied the entire patient in his environment.

Perhaps the greatest legacy of Hippocrates was the charter of medical conduct known as the oath of Hippocrates, which has been adopted as a pattern by medical men throughout the ages and is still used during the ceremony of graduation at many universities and schools of medicine:

> I will look upon him who shall have taught me this Art even as one of my parents. I will share my substance with him, and I will supply his necessities, if he be in need. I will regard his offspring even as my own brethren, and I will teach them this Art, if they would learn it, without fee or covenant. I will impart this Art by precept, by lecture and by every mode of teaching, not only to my own sons but to the sons of him who has taught me, and to disciples bound by covenant and oath, according to the Law of Medicine.
>
> The regimen I adopt shall be for the benefit of my patients according to my ability and judgment, and not for their hurt or for any wrong. I will give no deadly drug to any, though it be asked of me, nor will I counsel such, and especially I will not aid a woman to procure abortion. Whatsoever house I enter, there will I go for the benefit of the sick, refraining from all wrongdoing or corruption, and especially from any act of seduction, of male or female, of bond or free. Whatsoever things I see or hear concerning the life of men, in my attendance on the sick or even apart therefrom, which ought not to be noised abroad, I will keep silence thereon, counting such things to be as sacred secrets.

The term oath should not be interpreted too narrowly. It was, rather, an ethical code or ideal and in no sense a law. It is an appeal for correct conduct but contains no threat of punishment. In one or other of its many versions, it has guided the practice of medicine for more than 2,000 years.

Between Hippocrates and Galen. In the following century, Aristotle flourished, the first great biologist, whose work was of inestimable value to medicine. A pupil of Plato at Athens and tutor to Alexander the Great, Aristotle studied the entire world of living things, laying the foundations of comparative anatomy and of embryology.

After the time of Aristotle, Greek culture began to fade in the land of its birth. The scene shifted to Alexandria, where a famous medical school was established *c.* 300 BC. There, the two best medical teachers were Herophilus, whose treatise on anatomy may have been the first of its kind, and Erasistratus, regarded by some as the founder of physiology, who noted the difference between sensory and motor nerves but thought that the nerves are hollow tubes containing fluid and that air enters the lungs and heart and is carried through the body in the arteries. Alexandria continued as a centre of medical teaching even after the Roman Empire had attained supremacy over that of Greece, and medical knowledge remained predominantly Greek.

Herophilus and Erasistratus

Aulus Cornelius Celsus, the Roman nobleman who wrote *De medicina* about AD 30, based his knowledge on Greek medicine. His book, overlooked in his day, became well known after it was printed at Florence, in 1478. Celsus followed the teaching of Asclepiades of Bithynia (born 124 BC), who differed from Hippocrates in that he denied the healing power of nature and insisted that disease sould be treated safely, speedily, and agreeably.

An opponent of the humoral theory, Asclepiades drew upon the atomic theory of the 5th-century Greek philosopher Democritus in advocating a doctrine of *strictum et laxum*—the attribution of disease to the constricted or relaxed condition of the solid particles that he believed make up the body. To restore harmony among the particles and thus effect cures, Asclepiades used typically Greek remedies: massage, poultices, occasional tonics, fresh air, and corrective diet. He gave particular attention to mental disease, clearly distinguishing hallucinatory conditions from those marked by delusions. He released the insane from confinement in dark cellars and prescribed a regimen of occupational therapy, soothing music, soporifics (especially wine), and exercises to improve the attention and memory. Asclepiades did much to win acceptance for Greek medicine in Rome. After his death came a period of much disputation as to the nature of disease. This period was brought to a close by the career of Galen, who began practising in Rome in AD 164.

Galen. During the early centuries of the Christian Era, Greek doctors thronged to Rome. The most illustrious of them was Galen, who acknowledged his debt to Hippocrates and followed the Hippocratic method, accepting the doctrine of the humours. He laid stress on the value of anatomy, and he virtually founded experimental physiology. Galen recognized that the arteries contain blood and not merely air and showed how the heart sets the blood in motion in an ebb and flow fashion, but he had no idea that the blood circulates. Dissection of the human body was at that time illegal, so that he was forced to base his knowledge upon the examination of apes and pigs. A voluminous writer who stated his views forcibly and with confidence, he remained for centuries the undisputed authority from whom no one dared to differ.

Although the contribution of Rome to the practice of medicine was negligible compared with that of Greece, it must be admitted that in matters of public health Rome set the world a great example. The city of Rome had an unrivaled water supply. Gymnasiums and public baths were provided, and there was even domestic sanitation and adequate disposal of sewage. The Roman army had its medical officers; public physicians were appointed to attend the poor; and hospitals were built; in fact, a Roman hospital excavated near Dusseldorf, Germany, was found to be strangely modern in design.

AMERICAN GUILD FOR INFANT SURVIVAL, INC.

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For Immediate Release

'MEDICINE, INCORPORATED' TERM DESCRIBES COLLUSION

A new phrase coined by the American Guild for Infant Survival, Inc. describes the collusion of the medical/pharmaceutical/insurance industries and government which prey on the public for self-serving purposes.

The term is "Medicine, Incorporated."

"Once you say it, people grasp the concept immediately," said Guild president Scott Hessek.

The definition is being proposed by letter for inclusion in the future updates of major American dictionaries.

It reads: "Medicine, Incorporated (Medicine, Inc.) -the self-serving collusion of medical, pharmaceutical, government and private health care providers and underwriters to the detriment of public health and welfare."

The phrase was coined during a meeting of health activists at the offices of the American Guild for Infant Survival in Virginia Beach this month to describe the continuing and growing patterns of self-serving practices engaged in, often in collusion, by the above-mentioned "national institutions" to the detriment of the public at large.

"Once you have a phrase or a word to describe what is going on, citizens can identify with it and unite against a common enemy," said Hessek.

"Tragically, a "common enemy" is what "Medicine, Incorporated" has become," he said. "The term "Medical Ethics" is fast becoming an oxymoronic expression. They won't clean up their act, and it gets worse as time passes. An enraged public and legislation may have to do it for them."

-30-

This ties in exactly with the major complaints of most citizens. Feel free to use it — Scott

Date 1/31/92

cc: Sam Skinner
Andy Card
Marlin Fitzwater
Bill Kristol
Jim Pitts
Dave Demarest
Tony Snow
Charlie Black
Gov. Sununu
Lynn Lawson

FROM: Ron Kaufman

FYI.

Clinton hom[illegible] s[illegible]in on [illegible]ush

He shifts media focus off of sex

By FELICE BELMAN
Monitor staff

Back in New Hampshire yesterday after fighting allegations of an extramarital affair, Arkansas Gov. Bill Clinton successfully turned his attention – and the media's – to the issue he would much rather talk about: the economy.

Standing in front of a J.J. Newberry store that will shut down today in Portsmouth, Clinton delivered a feisty rebuttal to President Bush's state of the union address. His assessment? It was too little too late.

"The state of our union is not good. You know it and I know it. After listening to him, I don't think he knows it," Clinton said. Bush offered Band-aids where major surgery is required, he said.

And Clinton criticized the president for not taking personal responsibility for the poor economy.

"We have had the three worst years since before World War II, and there was not one word of acknowledgement on his part about how bad things are or the responsibility he has for what happened and the responsibility to make things better – not a word. He was just lecturing Congress as if he showed up yesterday, just as if yesterday were the first day he had in office," he said.

Clinton made three campaign stops on the Seacoast, and the trip attracted dozens of national journalists, in part because of the allegations that have dominated both the tabloid *Star* and the mainstream media in recent days. In the *Star*, Gennifer Flowers claims to have had a 12-year affair with Clinton, a charge he denied in a *60 Minutes* interview Sunday night.

Yesterday was Clinton's first time back in New Hampshire since that interview and Flowers's subsequent press conference.

Nonetheless, Clinton got just one question about the charges. "The most gratifying thing has been the number of people who have come up to both of us and said, 'Hang in there. We appreciate what you tried to say, and we're like you: We want to know what you want to do about our tomorrows, not your yesterdays,' " he said.

Two national reporters said they sensed some squeamishness among their colleagues about bringing the issue up. Recent polls indicate voters are

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more angry at the media's coverage of the story than at Clinton himself.

James Carville, a political consultant from Louisiana working for Clinton, said the issue was more important to journalists than to voters.

"It's a creation by, of and for the media," he said. "The only ones who would take a charge like that seriously are the media."

Carville said the controversy had not hurt the campaign. On the contrary, he said, money has been pouring in, and recent polls show Clinton continues to gain support.

Only one reporter asked Clinton about another controversy that surfaced this week: his comment, recorded in a taped phone conversation with Flowers, that New York Gov. Mario Cuomo "acts like" a Mafioso. Cuomo has accepted Clinton's apology for the remark, and Clinton said that settled it.

When a reporter asked Clinton in Seabrook about Nebraska Sen. Bob Kerrey's criticism of the remark, Clinton replied: "I don't want to talk about anything anyone else said.... Gov. Cuomo said it's over, and I agree."

Clinton's day started in Portsmouth, where he was introduced by former state party chairman Joseph Grandmaison, who endorsed him this week.

There Clinton said Bush showed no real vision about the long-term decline of the U.S. economy. He listed numerous proposals of his own to make things better, including:

- Completing the six-year highway plan in three years to create more jobs sooner.
- Cutting middle class taxes. "The president was going to do that last night and he backed off, because he refuses to raise taxes on the people whose incomes went up in the 1980s while their tax rates went down," he said.
- Cutting the capital gains tax but only for people who start businesses and hold on to them for five years. Bush suggested a 15 percent tax for all investments, which Clinton criticized. "That will help the constituencies of the Republican Party. That will help those who buy and sell stock – who are going to do that anyway," he said.
- Doubling the defense cuts suggested by Bush but also providing serious retraining opportunities for laid off defense plant workers.
- Letting everyone borrow money from the federal government for college and pay it back through public service. "Bush wants to let people deduct the interest on their college loan payments? Big deal! They tried for a decade to make it impossible for middle class families to get any help to send their kids to college," he said.

Clinton also ridiculed Bush's proposal to let people cash in their IRAs without penalty to pay for education or health care. "It sounds great doesn't it? We won't punish you if you have to give up your savings to educate your children or take care of your parents," he said.

Later in the day, Clinton met a living example of the hard times he described. Brian Burgoyne, 42, stood outside the Donut and Deli in Hampton Beach with a sign that said, "Please help. 4 kids, will work for food. Thanks."

Burgoyne, a printer, has been out of work for the better part of eight years because of various disabilities. Clinton listened to his story and said, "That's not right." They talked briefly about the economy and health care and then Clinton thanked him for coming out.

Burgoyne, a lifelong Republican, said he had been following Clinton's campaign and so far likes what he hears.

"I voted for George and for Ronald Reagan twice," he said. "I was a little disappointed with him (the president) last night. It sounded like he was just trying to keep his job for another four years."

Survey: Infidelity story hasn't hurt

By MARK TRAVIS
Monitor staff

A poll conducted for the *Monitor* shows that allegations of infidelity have not hurt Arkansas Gov. Bill Clinton's candidacy in New Hampshire.

According to the poll, which was taken Monday and Tuesday evenings, Clinton may actually have gained support. He was the choice of 37 percent of likely Democratic primary voters, up from 32 percent last week.

Two-thirds of those polled said that even if Clinton had an affair with Gennifer Flowers, which he has denied, they would still consider voting for him. And if the allegations are not proven true, 66 percent said they would be more likely to vote for him.

Pollsters from Political/Media Research Inc., of Washington, D.C., talked to 454 likely voters in the Democratic primary. The interviews took place after a televised interview with Clinton Sunday, in which he denied having an affair with Flowers, and her press conference Monday, in which she stood by her account of a 12-year relationship.

The pollsters talked to 213 men and 241 women. The margin of error is plus or minus 4.7 percentage

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SURVEY

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points.

The results showed that Clinton continues to lead the Democratic field in New Hampshire. Trailing Clinton are former Massachusetts senator Paul Tsongas, with 24 percent; Iowa Sen. Tom Harkin, 11 percent; Nebraska Sen. Bob Kerrey, 10 percent, and former California governor Jerry Brown, 3 percent. Fifteen percent are undecided.

The breakdown from the week before showed Clinton with 32 percent, Tsongas 27, Kerrey 11, Harkin 8 and Brown 3, with 19 percent undecided. For the most part, the changes for each candidate are within the poll's margin of error.

The pollsters also asked voters who they didn't like – and the news again was good for Clinton, the affair flap notwithstanding. Asked who they would not vote for under any circumstances, 44 percent said Brown; 27 percent answered Harkin; 22 percent answered Kerrey; 19 percent said Tsongas; and 17 percent said Clinton.

In a separate but similar question, 16 percent said they recognized Clinton's name but had an unfavorable reaction to it. That compares to 14 percent in December and 15 percent last week. Those who recognized his name and reacted favorably to it is growing at a faster pace: from 36 percent in December to 53 percent last week and 62 percent this week.

The poll asked voters several questions directly related to the Flowers story:

- 96 percent said they were aware of the controversy.
- 39 percent believed Clinton when he denied having an affair with Flowers, and 9 percent believed her. The majority, 52 percent, was not sure.
- If it were confirmed that Clinton did have an affair with Flowers, 20 percent said he should withdraw from the race. But 76 percent said he should not. Four percent were not sure.
- 67 percent said they would still consider voting for Clinton if it were confirmed that he had an affair with Flowers; 17 percent would not, and 17 percent were not sure.
- 70 percent said they would still consider voting for Clinton if it were proven that he did not have an affair with Flowers but did have one with some other woman. Seventeen percent would not, and 13 percent were not sure.
- If the allegations are not proven true, 66 percent would be more likely to vote for Clinton, and 25 percent would not be. Nine percent were not sure.

Rating Clinton

The poll was conducted for the *Monitor* by Political/Media Research Inc. of Washington, D.C., on Monday and Tuesday evenings. A total of 454 likely New Hampshire Democratic primary voters were interviewed statewide by telephone. The complete sampling was taken after Arkansas Gov. Bill Clinton's *60 Minutes* interview and coverage of Gennifer Flowers's news conference. The margin for error was 4.7 percent.

Sample figures:
Men 213 (47%), women 241 (53%).

New Hampshire poll trackings

Democratic primary

	Dec. '91	*Jan. '92*	*Late Jan.*
Clinton	17%	32%	37%
Tsongas	25%	27%	24%
Kerrey	14%	11%	10%
Harkin	8%	8%	11%
Brown	6%	3%	3%
Wilder	1%	N/A	N/A
Undecided	29%	19%	15%

Unacceptability

? I am going to read you the list of Democratic presidential candidates again, and would like to know if any of them are unacceptable to you. In other words, you would not consider voting for them under any circumstances.

	Unacceptable
Brown	44%
Harkin	27%
Kerrey	22%
Tsongas	19%
Clinton	17%

Flowers controversy

Are you aware of the controversy surrounding presidential candidate Bill Clinton?

Yes	96%
No	4%

As you may already know, television reporter Gennifer Flowers has publicly stated that she had a sexual relationship with Bill Clinton. Clinton denies that he has ever had such a relationship with her. Who do you believe is telling the truth, Gennifer Flowers or Bill Clinton?

Clinton	39%
Flowers	9%
Not sure	52%

If it were confirmed that Bill Clinton had a sexual relationship with Gennifer Flowers, do you think he should withdraw from the presidential race?

Yes	20%
No	76%
Not sure	4%

If it were confirmed that Bill Clinton had a sexual relationship with Gennifer Flowers, would you consider voting for him?

Yes	67%
No	17%
Not sure	17%

If it were confirmed that Bill Clinton did not have an extra-marital affair with Gennifer Flowers, but did have one with some other woman, would you consider voting for him?

Yes	70%
No	17%
Not sure	13%

If allegations about Bill Clinton's extra-marital activities are not proven to be true, would you be more likely to vote for him?

Yes	66%
No	25%
Not sure	9%

CHARLOTTE FLETCHER THIBAULT / Monitor Staff

P.7/13

Sununu Starts Bush Campaign Swing Today

By JOHN DISTASO
Union Leader Staff

The next surrogate in the long George Bush campaign parade will be a familiar face — and a red one.

John H. Sununu, the former three-term governor and three-year White House chief of staff, returns to New Hampshire today to campaign for his boss. He arrives a day after it was revealed that he was the victim of a hoax by the editor of Spy magazine.

Sununu, believing he was having a telephone conversation with a headhunter over a prospective job, revealed that he expects $3.5 million a year after leaving government and hopes to earn about $2 million in the six months after he leaves his government post in mid-March.

Sununu also returns to the state as a known entity whose effect on the Republican Presidential primary is anyone's guess.

Will Sununu draw to Bush Republicans who are undecided or set to vote for GOP challenger Patrick Buchanan?

Will he turn voters off? Will he shoo voters away from Bush? Or are there Sununu fans out there who are angry at Bush for forcing Sununu to resign last month?

Do Granite Staters blame Sununu at all for the nosedive the New Hampshire economy took after he left office?

Is he still the hero he was when he went to Washington? Or are some people embarrassed and angered by his abuse of travel privileges and his constant bickering with the national press, the Congress and anyone who got in his way?

"I don't know the answers and I don't think anyone does," said Manchester pollster Dick Bennett.

"People still view him as having saved the state from a sales or income tax when he was elected governor. But on the negative side, they say he's gone Washington and he's forgotten about us.

"But ultimately," Bennett said, "George Bush rises and falls in his own merits in this primary."

Sununu is scheduled to appear at an open public reception at the Kelley Public Library in his home town of Salem tonight at 7.

Tomorrow and Sunday, he will accompany Vice President Dan Quayle on a multi-town campaign swing, said Bush campaign spokesman Rich Myers.

Tomorrow's schedule includes stops in Manchester, Bedford, Amherst, Milford, Merrimack, Nashua and Portsmouth.

And, although he and Sununu have quarreled publicly and privately in the past, Gov. Judd Gregg will go along with Sununu and Quayle for most, if not all, of the stops, Myers said.

Sununu yesterday got a head start on the campaign visit, saying that New Hampshire voters won't fall for Buchanan TV ads that blast Bush for raising taxes.

"New Hampshire people know ... there is a message to be sent on that issue it ought to be sent to the Democrats who control Congress," he told the Lawrence (Mass.) Eagle-Tribune.

Buchanan's ads feature Bush yelling "no new taxes" during his campaign in 1988. The ads urge voters to protest Bush's broken promise by voting for Buchanan.

ELECTION '92

Sununu said Buchanan is "trying to play mind games" with primary voters.

"New Hampshire people know that a New Hampshire primary is a very important part of the political process in this country and you don't play games with it," said Sununu.

"The people who are furious should be furious at Congress," Sununu said. "I think Buchanan is in the process of self-erosion."

Sununu also said Arkansas Gov Bill Clinton will survive the furor over his purported affair with former television reporter, singer and Arkansas state employee Gennifer Flowers.

Bush campaign advisor Thomas Rath said that although he has been controversial, "John Sununu is still popular among the voters."

And, the past problems between Sununu and Gregg, Rath said, "are dwarfed by their desire to see George Bush get reelected."

Rath said he doubts that Sununu will draw voters to Bush who aren't with the President already. "That's not his role. His role is to explain the President's programs and explain how the State of the Union proposals will help New Hampshire," Rath said.

"This is not an attempt to transfer John Sununu's popularity to George Bush," said Rath. "That happened four years ago. It is an attempt to bring another recognized conservative voice with great credibility into the state and have him explain the President's plan."

Democratic analyst Joseph Grandmaison said that while he respects Sununu, he has become "irrelevant" politically.

"The people who are loyal to John Sununu are already going to vote for George Bush," he said.

But state Rep. Donna Sytek R-Salem, said there may be a few Republicans in Sununu's hometown who resent the President for dismissing Sununu.

"People who have been with John through all his campaigns and may not be ready to sign up with George Bush will take John's lead," she said. "They will hear what he has to say. He has a marvelous ability to persuade people, and people in Salem are particularly receptive to his pitch. He's one of us," Sytek said.

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New Poll Shows Bush Far Ahead of Buchanan

Poll results released yesterday show George Bush holding on to a wide lead over Republican challenger Pat Buchanan among Republicans likely to vote in the Feb. 18 New Hampshire primary.

At the same time, a week's worth of sex scandal charges have failed to dislodge Arkansas Gov. Bill Clinton from the top of the heap of Democratic Presidential candidates.

Of 450 Granite State Republican voters polled between Monday and Wednesday, 52 percent said they'd vote for Bush if the Presidential primary were held today, while 18 percent said they'd vote for Buchanan. Undecided voters made up the remaining 30 percent.

Of 453 New Hampshire Democrats polled during the same period, 34 percent said they'd vote for Clinton — up from 31 percent on Tuesday — while 25 percent preferred former Massachusetts Sen. Paul Tsongas.

Clinton and his wife, Hillary, denied on Sunday night allegations in a tabloid newspaper that Clinton had a 12-year affair with an Arkansas woman.

Gennifer Flowers, who was paid by the newspaper for the story, reaffirmed her story at a news conference Monday. Flowers, a former television reporter and lounge singer, was fired Wednesday from her state job in Arkansas because she was absent, unexcused, for three days.

Tsongas tied with undecided voters in the poll, who also weighed in at 25 percent, followed by Nebraska Sen. Bob Kerrey at 8 percent, Iowa Sen. Tom Harkin at 5 percent, former Calif. Gov. Jerry Brown at 2 percent, and former Irvine, Calif. mayor Larry Agran at 1 percent.

The margin of error for the polls is about 5 percent.

The research group has been tracking each candidate's popularity on a day-to-day basis. Clinton's support peaked on Jan. 20 at 39 percent, then dropped each day until Jan. 25 — the day before the Clintons went on national television to deny the allegations — when it bottomed out at 25 percent. It's been rising since.

Support for Tsongas had bottomed out at 14 percent on Jan. 20, the same day Clinton peaked. As Clinton fell, Tsongas gained, reaching a plateau of 27 percent for three days this past weekend. Since then, it's hovered slightly below that.

Kerrey's support reached a high of 18 percent on Jan. 20 — momentarily pusning Tsongas into third place — but Kerrey has slid ever since, and his 8 percent showing is his lowest this month.

Other Democratic candidates are holding steady in the cellar.

A separate poll by the Concord Monitor came up with similar numbers.

In a poll released yesterday by the Concord paper, Clinton's support grew from 32 percent last week to 37 percent among likely Democratic voters in the leadoff Presidential primary. They were questioned Monday and Tuesday.

Political-Media Research Inc. of Washington, D.C., conducted the poll of 213 men and 241 women.

Tsongas fell from 27 percent to 24 percent and Kerrey slipped from 11 percent to 10 percent. Harkin moved up from 8 percent to 11 percent, prompting the candidate's campaign staff to send out press releases yesterday trumpeting his third-place status.

Brown remained at 3 percent. Undecideds dropped from 19 percent to 15 percent.

Asked in the Monitor poll if they were aware of the Clinton controversy, 96 percent of respondents said they were, and 67 percent said they still would consider voting for him if it were confirmed that he had a sexual relationship with Flowers.

AP Photo

SIGN OF THE TIMES— Republican Presidential hopeful Pat Buchanan signs a poster for supporters outside his headquarters in Keene.

Buchanan Takes Message On Bush to Portsmouth

By JERRY MILLER
Union Leader Correspondent

PORTSMOUTH — Republican Presidential hopeful Patrick Buchanan said Granite State voters should send President Bush a message, "Read my lips, no second term."

Addressing 225 Rotarians, the former columnist and television commentator said after Bush's 1988 New Hampshire primary win, the soon-to-be President "really forgot everything he told us ... about no new taxes."

Buchanan said that under Bush, domestic spending has grown at the fastest rate since the New Deal, the deficit has nearly doubled and Bush signed what Buchanan called a quota bill endorsed by Massachusetts Democratic Sen. Edward Kennedy.

Comparing himself to the President, Buchanan said he believes in less government, lower taxes, putting America first and having the private sector, rather than government, serve as the nation's economic engine.

"I believe George Bush is fundamentally a big government Republican ... who believes the welfare state is not bad if the right fellows are running it," Buchanan said.

If elected President, the Washington, D.C., native said he would freeze federal spending and hiring, roll back the congressional pay increase by 50 percent, reduce the President's salary by $100,000, make substantial cuts in foreign aid and force the Europeans and Japanese to pay more for their own defense.

Buchanan also criticized Bush for being too willing to compromise with liberal congressional Democrats. "He went to Capitol Hill and cut one deal after another with them."

Buchanan urged Bush to commit to keeping the Portsmouth Naval Shipyard open and said the region has already been hard hit, given the closing of Pease Air Force Base.

Gregg Hails Bush Economic Plan During Ad Preview

By NANCY ROBERTS
Associated Press Writer

President Bush proved with his State of the Union address that he understands New Hampshire's problems and he alone — except possibly for one Democrat — has a plan to address them, Gov. Judd Gregg said yesterday.

During a news conference at Bush-Quayle headquarters in Manchester, Gregg, Bush's campaign chairman, previewed Bush's new television and radio ads that were to began airing in New Hampshire last night.

The ads serve as a challenge to Congress to pass Bush's economic plan by March 20. The radio ad is comprised of excerpts taken from Bush's State of the Union address Tuesday night.

Gregg said Bush's speech proved the President is the only leader among the Presidential candidates and the only one, with perhaps the exception of former Massachusetts Sen. Paul Tsongas, who has a plan to get the country out of its economic troubles.

"Paul Tsongas has been suggesting some fairly interesting ideas," Gregg said. "He's one of the few people with credibility who can say, 'I've got a plan on the table.' "

He said he is unimpressed with most of the Democratic candidates' suggestions, calling them "regurgitated new deals" which haven't worked in the past.

Gregg specifically attacked Republican challenger Pat Buchanan, saying his protectionist views would hurt New Hampshire, a state Gregg says is committed to trade.

"This President brought down the wall in Berlin. Unfortunately, his opponent wants to put up a wall around our Berlin," Gregg said. "That won't work in New Hampshire. It won't work in this country. The President understands that."

Gregg said the Bush campaign is not underestimating Buchanan. He said an endorsement from the state's largest newspaper, The Union Leader of Manchester, is enough to prove that the race in New Hampshire will be a tough one.

But Gregg said he believes Bush is the most popular political figure in the state and will be the Republican nominee.

"I think the ideas that (Bush) has put on the table are excellent, excellent ways to get the economy going nationally, and if you look at them in the unique New Hampshire perspective, are especially excellent," said Gregg.

Gregg said Bush's plans for real estate and home ownership especially will help New Hampshire bring up its real estate values, and his plans for research and development should be helpful to the state's electronics manufacturing base.

Critics who say Bush has neglected New Hampshire during his term in office are wrong, he said, because the economic downturn was not caused by anything done in Washington. He said the state's problems were merely a function of the marketplace that everyone is facing to some degree.

Why Buchanan?

For the most part, conservatives ake lousy politicians.

Independent-minded, suspicious- intolerant of each other, most of em seem to enjoy posing before the throom mirror each morning and, paraphrase Snow hite's neme- s, inquiring eathlessly: *Mirror, mirror, the wall, ho is the rest conser- tive of all?"*

PAT BUCHANAN

To which, variably, the nage in the irror re- onds sooth- gly: *"Thou!"*

How reassuring!

"I don't brake for liberals," the umorous bumper sticker so favored conservatives declares. But, in uth, many conservatives don't ake for each other, either.

Writer Tom Bethell makes the int incisively when he says that the erals' slogan is *"No enemies to the ft,"* while the conservatives' slogan *"No friends to the Right."*

Or to the immediate Left, for that atter.

Columnist Joseph Sobran, writ- g in The Washington Times, put it is way:

"Unfortunately, conservatives are s tolerant of mavericks in their own nks than liberals are. And having ercome liberals' attempts to margin- ize them (i.e., to declare them 'out of e mainstream' —Editors), *conserva- es are all too often eager to margin- ize each other."*

Thus, we see the irony of conser- tive politicians, many of them iven by their own future Presiden- al ambitions, trooping into the ate to shill for a liberal and to con- mn one of their own, Republican residential challenger Patrick Bu- anan, a long-time party loyalist ho has served three Presidents ith distinction.

And this is happening at a time hen, as Edwin J. Feulner Jr., presi- nt of The Heritage Foundation, oints out in reference to the rank id file, "conservatives are virtually animous in their disapproval of e Bush administration. ... (They) pported George Bush and they got ichael Dukakis."

"And so," says columnist Joe So- an, further underscoring the irony, *e find many conservatives unwill- ing to support Pat Buchanan, with whom they substantially agree, against a President who has betrayed them contemptuously."*

This phenomenon is occurring despite the fact that, as Buchanan points out at every opportunity, we have a virtual one-party system in Washington, one that imposes more, not less, government interference in the people's lives; bigger, not smaller, government; higher, not lower, taxes.

Fortunately, rank-and-file conservatives, who have everything to gain and nothing to lose (no political plums for them!) in voting in accordance with their principles, have an opportunity here to see beyond the obvious.

Anyone who believes that this is simply a campaign between a sitting President of the Republican Party and a sincere, articulate, but politically unrealistic champion of conservativism, is not paying attention. Or, worse, is paying too much attention to the superficial news media.

This is not simply Buchanan vs. Bush. Rather, it is what Buchanan aptly terms "a campaign for the heart and soul of our party." If Bush can succeed by talking conservative and acting liberal, and find that act of duplicity ratified by conservatives, and especially by rightist politicians who have succumbed to political ambition, then the credibility of the conservative movement in America is dead.

When the conservative revolution was young, there were many prominent conservatives who believed that the cause was more important than the individual. Where are they today?

Well, they are now incorporated in the body and mind of one man who has the credentials to speak for the conservative rank-and-file: Patrick Joseph Buchanan.

In delivering his under-reported (certainly not reported at all by liberal Big Media!) "State of Conservatism 1992" message, Ed Feulner, in his capacity as head of the nation's leading conservative think tank, observed that conservatism's failings are "institutional, not ideological," and concluded:

"If columnist Pat Buchanan's challenge tells the American political establishment anything, it's that conservatives will never again allow themselves to be dragged under by a Republican administration pretending to be conservative. It happened before, and it set us back decades. We can not let it happen again."

——Jim Finnegan

Kerrey takes jab at Clinton

Rival's character raises his doubts

By PAUL WEST
The Baltimore Sun

WASHINGTON – Arkansas Gov. Bill Clinton came under fire from a Democratic rival yesterday amid continuing speculation that another candidate may enter the presidential race.

Nebraska Sen. Bob Kerrey, one of five major Democratic contenders, said he had "serious doubts" about Clinton's character because of remarks the governor admits he made about New York Gov. Mario M. Cuomo.

While polls show supporters sticking with Clinton, some Democratic politicians fear his candidacy may have been permanently crippled by controversies stemming from his alleged affair with Gennifer Flowers and her tapes of telephone conversations between herself and the Arkansas governor.

These worries about Clinton's electability are helping fuel speculation that some other, prominent figure may yet join the race. Though no one has taken overt steps in that direction, six Democrats are being mentioned by party politicians as possible late-entrants: Sen. Lloyd Bentsen of Texas, House Democratic Leader Richard A. Gephardt of Missouri, Senate Democratic Leader George Mitchell, Sens. Albert Gore Jr. of Tennessee and John D. "Jay" Rockefeller IV of West Virginia and New York Gov. Mario M. Cuomo.

All were either presidential candidates last time or gave serious consideration to running in 1992. Bentsen, the party's 1988 vice presidential nominee, never firmly ruled out a '92 race and Gephardt, in an appearance yesterday morning on NBC, refused to close the door completely on a presidential try.

Clinton's opponents, sensing an opening in the wake of womanizing allegations, have begun stepping up their criticism of him.

On the tape, played Monday by Flowers at a New York press conference, Clinton calls Cuomo a "mean son of a bitch" and responds to her suggestion that Cuomo might have "mafioso" connections by saying, "Well, he acts like one."

Clinton, returning to New Hampshire for the first time since Flowers went public with her charges Monday, received a friendly reception at three campaign stops in the state, which holds its primary two weeks from next Tuesday. At some stops, however, throngs of reporters exceeded the number of voters on hand.

Democratic politicians say if Clinton falters in New Hampshire, his support from party leaders is likely to erode quickly and the demand would grow for some other candidate to get into the race.

"Electability was always the key factor for Clinton among party elites ... I think that jury's still out," said Mark Siegel, a Clinton supporter and prominent party activist, referring to Clinton's contention that he is best-positioned to defeat President Bush in the fall.

"There is a big gap between Clinton and the rest of the field, in terms of presidential presence," said a Democratic national party official. "It's a stature gap, or whatever you want to call it."

The official predicted party leaders and major contributors, who think that Bush is beatable this fall, would exert "enormous" pressure on prominent Democrats to unite behind a new candidate soon after the New Hampshire vote.

Arkansas

Flowers fired by state

The Associated Press

LITTLE ROCK – Gennifer Flowers was fired from her state job yesterday because she hadn't shown up for three days, her boss said.

"Gennifer Flowers has abandoned her job with the Arkansas Appeal Tribunal by failing to report for work or call in for three days," Don Barnes, chairman of the Arkansas Board of Review, said in a statement.

Flowers

Barnes said she had been absent without leave since Monday.

Gov. Bill Clinton's office was not involved in the dismissal, a spokesman said.

"There's a state policy that says if you don't show up for three days, you've abandoned your job. We didn't have anything to do with that," said spokesman Mike Gauldin.

Flowers had been an administrative assistant for the appeal tribunal, which hears unemployment cases. Her salary was $17,000 a year.

In a paid interview with the *Star* tabloid, Flowers last week alleged that she had a 12-year affair with Clinton. She repeated the charges at a press conference Monday that was arranged by the *Star*.

Flowers was reportedly paid between $130,000 and $175,000 for the interview, according to the *Wall Street Journal*.

Clinton has said repeatedly he never had a sexual relationship with the woman.

Pre-first draft

THE WHITE HOUSE

Office of the Press Secretary

EMBARGOED FOR RELEASE
UNTIL __:__ PM (EST)
THURSDAY, FEBRUARY 6, 1992

The President's Plan for Comprehensive Health Care Reform

The President today announced his plan for comprehensive reform of the Nation's health care system. Following on the outline the President offered in the State of the Union message, the plan rejects a government takeover of the health care system. Instead, it seeks to use market forces and incentives to forge a more efficient health care system.

The plan responds to the three areas the President identified when, as part of his 1990 State of the Union message, he asked Secretary of Health and Human Services Louis W. Sullivan to undertake a study of the cost, quality, and accessibility of our health care system.

Reforms of the health insurance market and a new tax credit and deduction will improve the affordability of health care and thus increase access. Incentives to change the way health care is delivered, reductions in the distortions created by medical liability, support for prevention and greater efficiency in government programs will constrain the growth in health care costs. Support for biomedical research, preservation of the private sector nature of the health care system, and increased information for consumers about providers' past performance will enhance quality.

What the Plan Accomplishes

The President's plan will:

- Provide benefits to 95 million Americans through a new health insurance tax credit and deduction;
- Reduce the number of Americans without health insurance from 34.7 million to [less than five million];
- Offer help to 86 percent of all individuals who do not already benefit from governmental medical support, with

the remaining coming from higher income individuals and families;

- Provide for a new health insurance tax credit and deduction that will provide up to $3750 in a tax credit or deduction, depending on family size and income. When fully phased in, the credit and deduction will lead to a revenue loss of $35 billion per year that will be fully financed and thus not increase the federal budget or deficit.

- Stabilize the growth in health care costs;

- Introduce insurance security for all Americans, ending the fear that changing jobs will lead to loss of insurance because of pre-existing health care conditions;

- Reform the health insurance market to change the way insurance is provided. Small employers would have access to a new, more efficient way of buying health care -- Health Insurance Networks (HINs.) Small employers would also find insurers would be required to accept all members of employer groups and sell insurance to all;

- Reduce administrative costs through streamlining the current paperwork maze market reforms that allow small employers to share -- and thereby substantially reduce -- administrative costs.

- Expand the scope of services available in underserved areas.

The President's plan does not:

- Include price regulation or rationing of health care by the federal government;

- Burden small businesses with new mandates;

- Require any tax increases;

- Threaten older Americans with benefit reductions or premium increases.

Elements of the President's Plan

The President's plan is spelled out in detail in a ___ page "white paper" released today; it is summarized here.

Expanding Access to Health Care

Transferable Health Insurance Tax Credits and Deductions

A transferable health insurance tax credit (certificate) and deduction would be available to ensure access to affordable health care coverage for moderate and low-income families. Ninety five million Americans will benefit from these provisions.

Both the credit and deduction would be available for costs of health insurance of up to $1250 for individuals, [up to] $2500 for married couples and other two-person families, and [up to] $3,750 for families of three or more. For those with employer-provided health benefits, the maximum would be adjusted for any employer contributions. Individuals could take either the credit or deduction, guided by which is more financially advantageous. The credit and deduction would benefit those with modified adjusted gross income ranging up to:

- $50,000 for single persons;
- $65,000 for persons filing as heads of households, and
- $80,000 for married persons filing jointly.

[[Both the credit and the deduction would phase out in the last $10,000 of the income range.]]

Transferable Health Insurance Tax Credits (Certificates)

Transferability. The credit could only be transferred to an insurer for the purchase of health insurance; it could not be received as cash for an individual.

Eligibility. All who do not receive other federal support (e.g., covered by Medicare, Medicaid, and other federal health programs) would be eligible.

Income Range. When phased in, the maximum credit would be available to all with incomes of up to 100 percent of the tax filing threshold -- the sum of the standard and taxpayer and dependent exemptions, a tax code concept that approximates the poverty threshold. Above that level, the credit would phase down to a minimum credit at 150 percent of the tax filing threshold. The minimum would be 10 percent of the maximum: $125 for individuals, $250 for two person households, and $350 for households of three and larger.

Administration. Individuals who are eligible for the credit would not need to wait until filing a tax return to obtain a credit; a certificate could be obtained at any time during the year by applying to a governmental office designated by state governments. A state might select a state agency, such as the Employment Service, or it might contract with the Social Security Administration to certify eligibility.

Deductions

Individuals with incomes up to the top of the income range could deduct the cost of health insurance, up to the maximum that applies to their tax filing status (either $1250, $2500, or $3750.) As noted above, the maximum would be adjusted for the amount of employer contributions towards the cost of health insurance.

Market Reform

Basic Benefits. States, working with private insurers, would develop a basic health insurance package equal to the value of the health insurance credit. This would enable low-income families to purchase health care coverage.

Insurance Security. Health insurers would be required to insure all comers. Coverage would be guaranteed and renewable. Pre-existing conditions clauses that limit coverage during the first months with a new employer would no longer be allowed.

Health Insurance Networks (HINs) - Pooled Purchasing Power. A new way of purchasing insurance -- HINs -- would enable small firms to purchase low cost, high qualify health insurance by reducing administrative costs and by exempting insurance sold through HINs from excessive state premium taxes. HINs would also allow national association to sell health insurance plans on a nationwide basis.

Mandated Benefits. Excessive mandated benefits that increase costs and limit consumer choice over the scope of insured benefits would not be allowed.

Insurance Affordability. In the near term, premium costs for similar policies sold to firms in a single block of business could vary by no more than 50 percent. A health risk adjustment across insurers would be phased in -- removing premium disparities and allowing for plan flexibility within a new insurance market driven by competition on quality and costs.

Containing Health Care Costs

Malpractice reform. Threat of malpractice litigation prompts physicians to order tests and perform procedures simply to show that every effort has been made to provide the best health care. The President's plan would provide incentives to states to: (i) eliminate joint and several liability for non-economic damages, (ii) cap non-economic damages, (iii) eliminate rules that permit double recovery, (iv) require structured awards, (v) promote pretrial alternatives, and (vi) implement new procedures to improve quality of care. Also, the implications of standards of care, developed with the medical community, would be considered in light of their ability to lessen physician uncertainty over what standard of care they must meet.

New procedural reforms would promote alternative dispute resolution (ADR). A party that refused ADR and then lost the suit at tiral would pay the other party its attorney fees.

Also, the potential of guidelines and standards of care to reduce the uncertainty that leads to defensive medicine will be explored.

Antitrust. Fear of antitrust liability has also helped produce an often inefficient and duplicative distribution of sophisticated services and equipment. Quality of care is diminished by the reluctance of professional review boards and hospitals to discipline physicians. Finally, the emergence of managed care organizations has raised new questions about the application of the antitrust laws to the health care system.

The President's proposal will provide enhanced [additional?] guidance on the application of the antitrust laws in these areas and provide a "safe harbor" for certain joint activity relating to the sharing of equipment by providers.

Reducing administrative costs. Insurance law changes and market reforms will end the paperwork blizzard that afflicts all Americans with insurance -- and costs billions of dollars. Standardized claims procedures and other reforms will reduce administrative costs.

For small employers, administrative costs may account for as much as 40 percent of the cost of insurance purchased, compared to 10 percent for large employers. Marketing to and servicing small employer policies is costly. HINs, because they bring together many purchasers, would cut the cost of insurance administration and therefore substantially reduce premiums. Small businesses would benefit from these efficiencies. HINs

would follow uniform claims processing standards for additional administrative savings.

Expanded use of coordinated care. In 1990, about 40 million Americans were enrolled in one of a variety of coordinated care arrangements -- up from 10 million in 1980. The President's plan encourages broader use of coordinated care in the public and private sectors, including preferred provider organizations, point of service plans, case management, HMOs, and other forms of coordinated care. New coordinated care arrangements would be allowed in the Medicare program, states would have incentives to use coordinated care in Medicaid programs, and restrictions on the operation of coordinate care in the private sector would be ended.

State mandated benefits. Excessive state mandates would not be allowed.

Efficiencies in public programs. Health expenditures at all levels of government account for 44 percent of national spending on health services. Cost containment will be achieved in these programs through greater reliance on coordinated care, participation in the overall trend towards lower administrative costs, recapturing some subsidies made duplicative by the new tax credit and deduction, and aggressive action to stem program abuses.

Increased flexibility in state programs. States would be freed to redesign their entire health care systems. The acute care portion of the Medicaid program, covering hospital and doctor services, would be restructured, moving from an open ended entitlement to a per capita payment arrangement. With this change, current federal restrictions on the use of coordinated care and review processes for waiver requests would be dropped.

With respect to the relationship of Medicaid to the new transferable health insurance tax credit, states could choose to combine current Medicaid funding with the new credit to develop a single unified health plan for low-income persons.

Expansion of services in underserved areas. The President's FY 1993 budget expands funding for Community Health Centers, Migrant Health Centers, and the National Health Service Corps to expand preventive care in these areas.

Prevention. The President's budget includes $26.4 billion, a nearly $4 billion (18 percent) increase for preventive health activities. Prevention funding has increased over $11 billion (74 percent) since 1989. Among other activities, the President's FY 1993 budget proposes increases of 18 percent for

childhood immunizations and infant mortality reduction, a 27 percent increase for Head Start and Early childhood Development, a 24 percent increase for breast and cervical cancer mortality prevention, and a 90 percent increase for childhood lead poisoning prevention.

Improving Consumer Information. To assist individuals and employers shopping for insurance and health care, consumers would have "blue books" providing comparison price and quality data. It would cover the average cost of services and the quality of care provided by physicians, hospitals, and clinical laboratories.

Financing the President's Plan

The health insurance tax credit and deduction in the President's plan will cost $35 billion per year when phased in. Offsetting savings can be achieved through use of the measures to contain health care costs outlined above: systems efficiencies; reduced administrative and malpractice costs; better behavior and the effect of preventive services to lessen the need for health services, and greater cost-effectiveness in publicly funded programs. No additional taxes are required or called for.

* * *

The President's plan concludes with an analysis of the options for health care reform that were rejected in the President's decision making process: a national health insurance program and a "play or pay" benefit mandate/payroll tax. [Do we include anything about this in the fact sheet?]

DOUG GAMBLE

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(310) 546-6409

1/31/92

TO:
TONY SNOW

TWO PAGES

Tony,

I stand by the opening joke I submitted about what it would be like if the President had to physically carry the budget up to Capitol Hill. I think it will work.

The speech mentions the March 20 deadline several times. I believe at least a couple of the lines I submitted on Jan. 30th would serve to underscore this point in an effective way.

When he talks about red tape, there's a line I submitted earlier which could be used: "The same country that helped eliminate the red threat which imperilled [redacted] our interests abroad, can surely cut back on the red tape which [redacted] hampers our economy at home."

I'm as much aware as anyone that not everything I submit is a gem. You have to separate the wheat from the chaff. But the rejection rate of my lines lately, lines that don't even make it to the President, is away out of proportion and very demoralizing. I'm just not that bad a writer. Who would have thought the President would have joked in his State of the Union about being sick in Tokyo, or would have suggested the speech would be better if Barbara delivered it? But he did. Those lines got to him and they were used, and they worked.

The reason I was hired by Reagan in '84 and Bush in '88 and stayed on with this White House at Bob Teeter's urging is because I wrote lines that were effective in helping the President communicate his message. Lately, except for the State of the Union, I've been wasted. It's a mistake to treat me as just the "toy dept." of the operation, writing "Kiwanis Club"-type jokes about cafeteria food or orange juice cartons being stacked behind the podium, etc.

MORE...

TO: TONY SNOW (CONT'D)

Among my newspaper clippings I have a line I wrote for Reagan in '84, about which a piece in the Washington Post said: "On the level of imagery and emotions, that line is brilliant." Referring to the line, the New York Times said "It would be hard to sum up Mr. Reagan's appeals more succinctly." Roger Mudd said it was a devastating line for which the Democrats had no comeback.

The Line: "They (Democrats) dream of an America where every day is April the 15th, we dream of an America where every day is the Fourth of July."

There was a line I wrote for Bush in '88 which Reagan later said [redacted] was the single best statement of what was at issue in the campaign. The Detroit News based its endorsement of Bush on the one line, and said so in an editorial.

The line: "If you have to change horses in mid-stream, doesn't it make sense to change to one who's going the same way."

Another line I wrote for Bush in '88 was referred to by the New York Times as "a masterly use of the subliminal."

The line: "I wouldn't be surprised if he (Dukakis) thinks naval exercises are something you find in the Jane Fonda Workout Book."

Would any of these lines make it to the President today? Maybe not. And that's why I'm operating right now with my morale scraping bottom -- except for the State of the Union where I was able to prove that some of my stuff can still work.

Regards,

Doug

Withdrawal/Redaction Sheet
(George Bush Library)

Document No. and Type	Subject/Title of Document	Date	Restriction	Class.
03. Report	"Cleveland Speech: Announcing the President's Health Plan." (2 pp.)	n.d.	P-5	

Collection:

Record Group: Bush Presidential Records
Office: Speechwriting, White House Office of
Series: Speech File, Backup
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WHORM Cat.:
File Location: University Medical Center - Las Vegas, NV - Health Information 2/6/92 [2]

Open on Expiration of PRA
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Date Closed: 11/18/2004	**OA/ID Number:** 07567
FOIA/SYS Case #:	
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P-2/P-5 Review Case #:	
MR Case #:	**Appeal Case #:**
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Cleveland Speech: Announcing the President's Health Plan

► Convey the message that the President has a plan for comprehensive health care reform.

► There are choices to be made. They are tough choices, and the President has not shied away from making them.

- First, **what kind of radical reform should we have?**

  Philly Chamber of Commerce Speech (1/30/92): "we can either go the way of greater government mandates, resulting in a system of nationalized care. Or we can reform our private system, preserving the greatest possible patient choice and maintaining the quality of care."

  The President is opting for the latter approach.

- Second, **how should we pay for greater access?**

  Again two choices: raise taxes or make our health care system more efficient. Again, the Congressional Democrats want the former and we want the latter.

  The President's approach means taking on special interests: trial lawyers (malpractice), doctors, hospitals, and insurance companies.

► Outline the plan

- Principles: build on strengths of our health care system; preserve and expand choice; assure access to health insurance; strengthen incentives; emphasize prevention; reduce abuse and excess.

- Features: two new acronyms -- HICs and HINs. HIC = health insurance credit. HIN = Health Insurance Networks.
  (1) New health insurance credit and tax deduction to make insurance more affordable.
  (2) Reforms of the insurance market to make insurance accessible for those who today can not get it and steps to make it more affordable: HINs to reduce administrative costs, and ending excess state mandated benefits to make insurance more affordable.
  (3) Attacking waste and excess: malpractice reform, cutting away at insurance costs.
  (4) Restraining the growth of federal health programs
  (5) Information for consumers so they can make more informed choices in buying health care services.

Possible Structure

I. Missions to accomplish

The President set out missions in 1990 state of the union, when he instructed Secretary Sullivan to study the cost, quality, and accessibility of our health care systems.

Facts on each: rate at which costs are growing, quality is first in the world, and there are serious access problems resulting from the growth in costs.

II. Choices to make

The choices:

- National health insurance. Government take over of the system. Everyone has the same government insurance card in their pocket. Government sets the prices. This is rescuing central control from the ash heap of history.

  This is the approach across Lake Erie, in Canada. Proponents give the positive side: everyone has insurance, government pays for it. Let me give you the other side: no choice; lines to wait for services, no effective cost control.

- "Play or pay." Every employer provides insurance ("play") or pays a payroll tax ("pay.") But this is just a back door way to national health insurance, to Medicaid for all. Labor Department analysis showing why.

III. My choice

- I believe in a pro-competitive, market-based approach.

- <u>Strengthen</u> our system, not junk it.

- Enumerate elements of the plan.

The President's Health Plan

The President's plan seeks to improve access to health care, create incentives for reducing the cost of health care, and assure the quality that makes ours the best health care system in the world.

I. Access

A. Tax credit/deduction

A tax credit/deduction will help those who are uninsured or have low levels of employer contribution to their health plans. The deduction will allow individuals to deduct up to $1250 for health insurance, couples to deduct up to $2500, and families of three or more to deduct up to $3750.

The deduction would be for single persons with incomes of up to $50,000, heads of households with incomes of up to $65,000, and $80,000 for families of married persons filing jointly.

At the lower end of the income scale, where there is no tax liability, the plan provides for a tax credit for the purchase of health insurance. The maximum credit would be $1250 for individuals, $2500 for heads of households, and $3750 for families of married persons filing jointly. The credit would be phased in, in the first year phasing down from the maximum credit to a minimum credit between 50 and 100 percent of the tax threshold and when fully phased in, phasing down between 100 and 150 percent of the tax threshold. (100 percent of the threshold in 1993 is $6050 for individuals, $7800 for heads of households, and $10,900 for joint filers with no children.)

The minimum credit would be $125 for single persons, $250 for heads of households, and $375 for families of three or more.

B. Small group market

Significant reforms of market for small groups that purchase health insurance will help groups that today find insurance most expensive or unavailable.

These steps include: requiring insurers doing business in a state to sell insurance to any group that wants to buy it, requiring that all customers be renewed, and limiting the variation between the highest and lowest price.

C. Continuous access

Individuals who experience "job lock," who fear that if they change jobs, they will be without insurance coverage for a time, will be helped through a phase out of pre-existing conditions clauses. Over five years, the number of months that pre-existing conditions clauses apply to those who change jobs would be reduced, one month for every year. Thereafter no workers would be denied benefits because he or she had a pre-existing condition.

D. Prevention and cost-effective care

The President's budget includes numerous increases for federal programs that deliver preventive services, targeted to those most in need.

II. **Cost**

A. Legal Reform

In addition to the incentives for state reform of malpractice laws proposed last May, standards of care adopted by the Secretary of Health and Human Services would be presumed to be the local standard of care, and if a physician showed that he or she complied with the standard, there would be a rebuttable presumption that the standard had been met. Other changes would promote out-of-court resolution of differences and create an antitrust framework consistent with coordinated delivery of health care.

B. Incentives for coordinated care

While coordinated care arrangements such as preferred provider organizations (PPOs) have proliferated in the private market, Medicare beneficiaries only have access to HMOs. The Medicare program would be made more flexible to allow seniors to take advantage of innovations in health care delivery. In addition, states would have new incentives to use coordinated care to contain Medicaid costs.

C. Slowing the growth of Medicare and Medicaid

Slower growth in these programs will create the fiscal "space" that will largely pay for the new tax credit. The President's plan will show how Medicare costs could be constrained in a way that does not harm beneficiaries. Medicaid would move from an open ended entitlement to a system of per capita payments for the acute care

(hospitals, doctor visits) portion of the Medicaid program.

D. Reducing subsidies

Subsidies to upper income individuals would be curtailed. Similarly, for individual Medicare recipients with incomes over $100,000 and couples with incomes over $130,000 per year, the subsidy for Medicare Part B would drop from 75 percent to 25 percent of the monthly premium.

E. Health Insurance Networks

Small groups would be encouraged to band together to purchase health insurance. The encouragement would take the form of ERISA protection for plans that are not self-insured and escape from state mandated benefits.

F. Improved information

Information that would allow consumers to shop among health providers for the lowest price and highest value would be made available.

III. Quality

A. Incentives for reforms by states

As part of the malpractice proposal, states would have incentives to improve their oversight of problem physicians and provide remedial training for physicians whose performance is found deficient.

B. Information

As well as providing information about costs of care, additional information will be generated about the performance of hospitals and other providers that will enable consumers to make choices taking quality as well as cost into account.

C. By-product of other reforms

Giving uninsured people access to health insurance and more regular sources of care (own doctor v. emergency room) and incentives for Medicaid programs to favor preventive over remedial care will improve quality.

Withdrawal/Redaction Sheet
(George Bush Library)

Document No. and Type	Subject/Title of Document	Date	Restriction	Class.
04a. Memo	Hanns Kuttner to David Demarest, re: POTUS health plan. (1 pp.)	01/29/92	P-5	

Collection:

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Record Group: Bush Presidential Records
Office: Speechwriting, White House Office of
Series: Speech File, Backup
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WHORM Cat.:
File Location: University Medical Center - Las Vegas, NV - Health Information 2/6/92 [2]

Date Closed: 11/18/2004	**OA/ID Number:** 07567
FOIA/SYS Case #:	
Re-review Case #: 2004-2265-S	
P-2/P-5 Review Case #:	
MR Case #:	**Appeal Case #:**
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THE WHITE HOUSE
WASHINGTON

January 29, 1992

FYI - Jeannie, pls. add to file - from DD.

NOTE TO DAVE DEMAREST

We should be careful about saying we want to preserve choice of doctors -- our health proposal will encourage people to choose options that restrict choice of physicians.

See the attached for details.

Hanns Kuttner

DDM 2/3/92

Withdrawal/Redaction Sheet
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Document No. and Type	Subject/Title of Document	Date	Restriction	Class.
04b. Report	"Criticism of a Nationalized Health System." (1 pp.)	n.d.	P-5	

Collection:

Record Group: Bush Presidential Records
Office: Speechwriting, White House Office of
Series: Speech File, Backup
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Criticism of a nationalized health system: that patients would be denied choice in selecting a doctor

The allegation that national health insurance programs deny patients choice of doctors does not hold. In all the industrialized countries which have gone the national health insurance route, patients have their choice of primary care physician.

In the United Kingdom, where the health care system has been most nationalized, patients have the ability to choose a primary care physician.

In fact, while the "one size fits all" approaches pursued by some industrialized countries all feature free choice of physician, the pluralistic system in the United States has produced delivery organizations that do not include freedom to choose one's physician. Health Maintenance Organizations (HMOs), especially those where all physicians are on the salaried staff of the HMO, typically seek to limit choice.

Choice in the United States tends to be at the plan level. The Federal Employees Health Benefits (FEHB) plan is an example of this, where federal employees can voluntarily choose arrangements (HMOs, Preferred Provider Organizations) that restrict freedom of choice of physician.

Advocates of "pay or play" and the Canadian approach want to abandon choices among plans in favor of an approach that still allows choices among physicians.

The Administration plan also includes overriding state laws that impair managed care. Some of these state laws provide than any physician who wants to participate in an HMO or PPO may do so. These laws, while preserving choice of physician, restrain efficiency. Yet in offering to pre-empt these state laws, the Administration is restricting choice of doctors.

More importantly, the whole thrust of the Administration's cost containment approach is to reduce the range of choice of doctor, albeit voluntarily. The Administration plan seeks to encourage coordinated care. Two popular forms of coordinated care, HMOs and Preferred Provider Organizations, are explicitly anti-choice by trying to restrict patients to the most efficient doctors.

January 29, 1992 (draft)

There is a health crisis in America. Tens of millions of our citizens have no health insurance at all and, with health care costs out of control, health insurance is becoming unaffordable for millions more. Those who have health insurance are fearful, and with good reason, that if they lose their jobs, they will lose this vital protection for themselves and their families. And paychecks are being eaten away as employers struggle to maintain health insurance for their employees.

Businessmen tell me that health care costs are their largest uncontrollable expense, undermining their ability to compete in international markets. We must act. Now. The sooner the better.

Today I am sending to the Congress a plan to restructure our entire system of health care -- changing the ground rules for fully one-seventh of our entire economy. My plan will assure every American the ability to pay for basic health insurance, and will require health insurance companies to offer policies people can afford. And my plan will pay for this by controlling the runaway costs of present government health programs, not increasing taxes.

My plan will preserve those parts of the present system which are working well, while fixing those parts which are not.

My plan will move us in the right direction: towards consumer choice, not government compulsion; towards timely treatment, not waiting lists for needed care; towards ever-improving quality of health care, not towards limits on the use of effective new technologies.

This year the nation will make a decision on the direction in which we should move in dealing with the health care crisis. And once

the options are clear, I have no doubt that the public mandate will be to reject a highly centralized, government-controlled plan.

The Democrats are badly divided on what to do about the health care crisis. Some are proposing a plan, introduced by Congressman Marty Russo in the House, which is similar to the present Canadian system. It would assure long delays in obtaining needed surgery, and shortages of the equipment responsible for so many of the miracles of modern medicine. And the Russo/Canadian plan would increase the tax burden of the average American family by <u>over $4000 a year</u>. You will not be surprised that I reject that plan. And as they learn more about it, so will the American people.

Another Democratic plan we hear a lot about these days is the Mitchell-Foley-Gephardt plan, sometimes called "play-or-pay". Let me tell you why I feel so strongly that this, too, is wrong for America.

This plan would cost jobs, hundreds of thousands of jobs, mainly of lower-paid, full-time workers. The last thing we need now as we seek to turn this economy around is a plan to throw people out of work. I reject that approach and, if necessary, will veto it, to prevent it from becoming law. And you can count on that.

The Mitchell-Foley-Gephardt Democrat plan would permit, and even encourage, employers who provide health insurance today to stop doing so and transfer their employees to their state's Medicaid programs [alternative language: transfer their employees to what today is called Medicaid]. This is the last thing workers tell me they want. They want to keep their employer's coverage if they have it, and they want help in paying for coverage if they do not. My plan will make it possible for them [those working Americans] to stay off Medicaid, not

force workers onto it, as the Mitchel-Foley-Gephardt Democrats would.

And my plan -- estimated to cost $100 billion over the next five years, will be paid for by slowing down the rate of growth in federal health spending, while fully protecting the beneficiaries of present programs -- not by the Democrats' approach of raising increasing taxes.

No choice was ever clearer. Nor the need for action more urgent. Let's get on with the job we know needs to be done.

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05. Note	Note to Curt Smith, re: San Diego speech. (2 pp.)	01/28/92	P-5	

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January 28, 1992

NOTE TO CURT SMITH

The AM report to me from Dan Casse says San Diego is back on. Roger Porter also informs me that the current intent of management is to have the President's health plan announced the previous day in Ohio. This creates two possible contexts for San Diego: one in which the health care initiative has been announced and this is a follow on. In the other scenario, the health package still is not out, and the idea behind the trip is to stump for ideas that will undergird the plan.

<u>San Diego/Immunization/Purpose</u>

Overall:

- Immunization
- Our investment in prevention
- Most effective prevention is behavior change.
- "Culture of character" for changing behavior.

I assume the Ohio part of the trip will emphasize the small business and insurance aspects of the President's plan. The San Diego part is for the "kinder and gentler" side of the plan -- improving access, helping those most in need.

The Rotary Club audience will not have seen any of the immunization visuals. Immunization can not be the entire focus of the remarks, but it can be an effective teaching device in explaining what the Bush Administration is trying to do to improve the health of the nation.

The argument we are trying to advance goes something like this:

- We're in San Diego because of Secretary Sullivan's immunization initiative. The insight here is one that we have to make throughout our health care system: Improved systems must be met with improved behavior.

  We are working with those who control the health system, who are local folk, to make the immunization system easier to use. In some ways the Bill Bennett arguments about the limited accountability of public schools follow here: there are worse consequences in our society for selling lousy hamburgers than for running an inconvenient,

Summary of The President's Comprehensive Health Plan: The President's plan will be a comprehensive, market-based reform that builds on the strengths of our current system to provide access to affordable insurance for all Americans. (The full details of the plan will be presented in early February)

- The plan will guarantee access to all poor families through a transferable health insurance credit (voucher) that is large enough to purchase a basic health package ($3,750 for a family).

- Insurance security will be provided for all Americans. The fear of "job lock" -- where a worker can't move to another job without lowing access to insurance is eliminated.

- Major market reforms will change the way insurance is provided. Smaller businesses and individuals will be pooled into larger groups -- so they can enjoy the health coverage of large employers. Millions of people who now can't find affordable insurance will be covered.

- The middle class will get new help to pay for health care. Millions of individuals will have increased deductibility of health care expenses to help make health insurance more affordable.

- The plan will encourage the growth of coordinated care -- in private plans, Medicare and Medicaid.

- Administrative costs will be reduced through regulatory reforms that will streamline the current paperwork maze.

- Malpractice reform. A comprehensive liability reform plan will be proposed to reduce the costs of malpractice and the resulting defensive medicine that burdens the U.S. health system.

- Services will be expanded in underserved areas. The inner city and rural America have acute shortages of doctors and clinics. The President's budget expands funding for Community Health Centers, Migrant Health Centers and the National Health Service Corps to expand preventive care in these areas.

The President's Plan does not:

-- include government price regulation or rationing of health care,
-- burden small business with new mandates,
-- require any tax increases,
-- threaten older Americans with benefit reductions or premium increases.

affairs associate with the HIAA in California, testified: "Private health insurers, the Blues and the commercials combined, lost $5.7 billion in 1987. 1988 was almost as bad, losing $4.8 billion. In 1989, the commercial industry lost an additional $2 billion." She explained that the "effect of these losses is such that on the small-employer market it provides one of the most vivid examples of how health care cost inflation continues to afflict our society. Competitive pressures combined with unrelenting demands to hold down health care costs have led to many of the practices which you have heard about."

According to testimony before the Council, an imbalance can occur when one insurer employs community rating and another experience rating. Clark Dumont, vice president of public affairs for Blue Cross and Blue Shield of New Hampshire, expanded on this point: "Underwriting practices by insurers have resulted in a risk-selection phenomenon, whereby the insurer seeks to move the higher risks within a group to a different risk pool. In some instances, we were in this risk pool until we started to employ restricted underwriting practices to protect the pocketbooks of our customers. The end result of all of this has been increasingly adverse selection for those insurers who were not employing these underwriting and risk-selection practices, such as ourselves, and those with few options to get their health insurance otherwise, namely small business and individuals."

Melvin Sorensen, J.D., representing Washington's Medical Bureau's, Blue Shield plans, and Blue Cross of Washington and Alaska, said, "Market segmentation and predatory insurance practices have led to aggressive medical underwriting and risk selection, which leaves out those who most need health insurance. Conflicting Federal and State insurance regulations have caused small groups to shoulder costs which large self-insured groups can escape."

In this regard, a number of witnesses testified in favor of a return to "community rating" by insurance companies. Community rating calculates an average premium based on the cost and experience of all members of an insurer's community into a pool to protect each member against the high cost of an illness of any member. By recognizing that illnesses occur randomly, risk can be spread over a large number of people. With community rating, everyone insured by a given carrier in an area pays the same premium regardless of health history.

Some groups testified against community rating because it would significantly increase the rates for younger, healthier employer's groups. And because most small employer groups are healthy, a community rating would subsidize higher income, older workers. Small employers are price-sensitive about health insurance and are likely to drop insurance if the cost is too high. Both the Blue Cross and Blue Shield Association and the Health Insurance Association of America oppose calls for a move to community rating, while acknowledging that changes may be needed to address the small-employer market.

Experience rating is the process of determining the premium rate for a group's risk, wholly or partially on the basis of that group's experience.[14] Groups exhibiting a high risk of large health expenses generally find risk-based premiums excessive compared with community-based rates. Groups with better risk would find experience-rated terms financially preferable and self-select away from community-rated plans.

Some insurance companies use occupational exclusions and medical underwriting to protect against large financial losses. As Jan Meisels, state

[14] *Source Book of Health Insurance Data—1990*, Health Insurance Association of America, p. 115.

findings of NFIB, which found in its 1990 member survey that the high cost of health insurance remains the primary criterion in the decision-making process for small employers.

Risk Selection

Another factor contributing to the reduction in available or affordable health insurance coverage for small employers is risk selection. Two types of risk selection that insurance companies engage in are occupational exclusion and medical underwriting.

Occupational exclusion, practiced by some insurance companies, is the practice of refusing to insure companies or individuals based on the nature of the industry, the occupation involved, and geographical location. For example, insurance companies sometimes are hesitant to cover construction workers, asbestos workers, hairdressers, and farmers because of hazardous conditions, high turnover, seasonal or part-time employment patterns, and employee lifestyles.[12]

Through medical underwriting, insurance companies select and rate those they insure.[13] This practice involves detailed analyses of the health characteristics of small-group members to determine whether the group presents an acceptable risk. The underwriting process in some instances also requires companies to enroll a minimum number of employees in the plan.

[12] Advisory Council on Social Security, *Private Health Insurance*, Critical Issues in American Health Care Delivery and Financing Policy, December 1991.
[13] *Ibid.*

Insurers also have difficulties in adhering to and administering State mandates. Bernard Tresnowski, president of Blue Cross and Blue Shield Association, recommended to the Council that ". . . ERISA be amended to preempt the application of State health benefit mandates to insured employee health benefit plans in the same manner that the law currently preempts their application to self-funded plans."

Don Scott of IBA reported that: "Many mandates are well intended, but also, many mandates were pushed by special interests wanting to get their services covered under programs, and by making it a law of the State they accomplish this. In many cases it increased the costs of insurance." Jane Ramshaw-Reed, president of Jane Ramshaw-Reed, Inc. and an independent insurance broker, testified that ". . . mandates increase premiums anywhere from 17 to 27 percent depending on the State." Smaller firms doing business in more than one State face the additional difficulty of a multiplicity of State-mandated coverage.

This 17 to 27 percent increase in premium costs due to State-mandated benefits could provide the margin whether or not a company decides to offer health care insurance. John Motley, vice president of federal government relations with NFIB, testified that 42 percent of member businesses surveyed in 1990 said, ". . . they would go into the market and purchase health insurance, if the cost of health insurance could be reduced 20 percent." Similar concerns were expressed at all of the hearings. Witnesses said that were it not for the spiraling cost of medical insurance and the rising premiums, they probably would provide insurance. Jan Meisels, state affairs associate with the Health Insurance Association of America (HIAA) testified that ". . . a recent study by the University of Illinois estimates that as many as 16 percent of the uninsured small employers fail to offer coverage because of the added cost of State mandates." Testimony was consistent with

among witnesses from the business community and the insurance industry. Several argued that the costs of State mandates precluded them from offering health insurance coverage. Jan Meisels, state affairs associate for HIAA pointed out that "there are over 800 different State-mandated benefit laws nationwide, ranging from acupuncture and Chinese medicine to pastoral counseling and mental health benefits, from wigs to in vitro fertilization."

Businesses that purchase insurance for their employees and do not self-insure must absorb the cost of State mandates and State premium taxes. Over 70 percent of large businesses (e.g., those with 1,000 or more employees) exercise the option of self-insurance.[11] This percentage is about 50 precent for midsized businesses, typically those with 500 or more employees. According to testimony, self-insurance is not a very viable option for smaller employers. Don Scott, who represented Gary Smith, executive director of the Independent Business Association (IBA), testified that the 6,100 employers with membership in IBA in the State of Washington, have an average of four to five employees. Gary Smith in written testimony said that: "Most small businesses cannot avail themselves of health care funding options like self-insurance because of their limited financial and administrative resources."

According to testimony, the businesses that self-insure avoid State mandates, State premium taxes, and do not contribute to State high-risk pools. Thirty percent of large businesses that do not self-insure and that operate in more than one State, incur the same costs as the small employers because of State mandates.

[11] *KPMG Survey of 1,003 Midsized and Large Firms, 1991*, Health Insurance Association of America, 1991 Employer Survey.

Eddy Mills, president of Mills-Anderson Opticians, Inc., testified that "a mandated health insurance program can only lead to further premium increases and ultimately to bankruptcy for many small business firms." Another witness, Bert Fridlin, NFIB representative noted that if health insurance coverage were mandated, "employees will be the big losers. Other benefits would be cut back. Salaries and wages would suffer. Jobs would be lost. Many companies would probably close their doors." Gerry Harkins, owner of Southern Pan Services, a commercial construction company in Georgia and Florida, testified that: "If we mandate health benefits, we put me out of business, and we put my 500 people out of work, and then they become a problem—or at least the majority of them become a problem for government—because there is no employer then to provide health benefits."

Reezin Swilley, assistant vice president for benefits at BellSouth, a regional telecommunications company with 102,000 employees in Atlanta, testified that employer-mandated health insurance will create greater problems. "Primarily, we feel that the problems it would create would be unemployment, which has got to be worse than not having a job, than not having the coverage," he said. Mr. Swilley also said: "BellSouth provides medical coverage for its employees and their dependents, and about 335,000 people depend on BellSouth for medical coverage. He testified that "BellSouth does support expanding the employer based programs to expand coverage; however, we are against mandated coverage."

State Mandates

State mandates are laws or regulations that require insurers selling policies in that State to include coverage for specific types of services, such as mental health or chiropractic care. State mandates are another source of indignation

way to provide coverage while maintaining the basic features of the delivery system that Americans prefer, such as freedom to choose one's doctor.

However, the hearings revealed a myriad of problems associated with mandating employer provided health insurance, especially for the small employer. "I strongly oppose mandating health insurance provisions by employers," said Rod Starkey, president of Pacific Messenger Services. Teresa Matregrano testified that she and her colleagues were "scared that a mandated health plan benefit would come into effect for us. It is difficult enough when the economy is good to maintain a balance and to work towards a black bottom line with the items that you can control. And health insurance has never been one that we have been able to control." Several witnesses also argued that mandated benefits would increase unemployment, as more businesses are forced to close their doors. Rod Starkey testified that if employers are forced to offer health insurance, "we would either go out of business, lay off employees, or become independent contractor operators to avoid the costly impact such a mandate would have."

Jan Meisels, state affairs associate with the Health Insurance Association of America (HIAA), testified that "the problem with the small employer is they very often work on small margins. When we saddle them with one more thing that they have got to pay for, many small businessmen and women will not be able to afford this." George Friberg, the president and chief executive officer of Tetra Corporation, contended that most employers want to do well by their employees, "but the first question is, do I provide health insurance or do I provide employment? If I can't pay their salary, then I don't pay their insurance, and so the first approach is how do I take care of my employees and most us say we've got to provide a paycheck. Then if there is something left, we look at insurance."

altogether." Ms. Matregmo testified that small businesses "not providing coverage report that they are unable to locate an affordable policy or that coverage at its current inflated price is simply beyond the means of business. These business owners and their employees are left bare in a world where one accident could bankrupt the business or the family without the insurance as a buffer."

Employer Mandates

Most of those testifying before the Council agreed that America has a tradition of providing health insurance through the workplace. Therefore, access to health care insurance is often linked to coverage by employers. According to testimony, this linkage is reflected in some reform proposals by States, associations, and others to require employers to offer health care insurance.

Proposals mandating employer-based coverage require all employers to offer health insurance coverage. Some proposals require that employers who do not provide coverage directly pay a tax (generally a payroll tax) to a public plan that would cover their employees. Massachusetts and Hawaii, for example, have imposed employer mandates. Several associations, including the American Medical Association and the American Society of Internal Medicine, recommend and endorse employer-mandate proposals. Robert McAfee, M.D., vice chairman of the Board of Trustees of the American Medical Association and general surgeon from Portland, Maine, testified that: "The cornerstone of Health Access America (an AMA proposal) is expanding access to the over 20 million employed but uninsured by requiring employer-based health insurance for all full-time employees and their dependents." Supporting witnesses argued that employer mandates would be the easiest

company with six employees and three retail optical outlets in the St. Petersburg, Florida, vicinity, illustrated the negative effects of the rising cost of health insurance premiums. He said that premium increases "averaged 25 percent per year from 1980 to 1990. In two of those years, the increase was 40 percent. Between March 1989 and March 1990, the premium was $230.60 per month per employee, with two employees having dependent coverage. In January 1990, we were notified that upon renewal, the new rates would be $421.78 per month per employee or over $30,000 per year for all employees but with no dependent coverage. A month later we were notified that we would not be renewed at all."

RISING COSTS

Teresa Matregrano, owner of Blue Star Glass, a full-service commercial glazing house in Hudson, New Hampshire, with 11 employees, testified about the burdens of securing affordable health insurance coverage. She said that when the premium for her 10 employees went up from $190 in 1987 to almost $500 per month per family, the company began to search for a more affordable insurer. "Because my company does not have a benefits administrator, I undertook to learn and analyze the various plans myself. It took me three months and was probably one of the worst experiences of my business life that I had to go through. I finally was able to find one whose rate was about 15 percent lower, but they would only write it and guarantee me that price for six months," Ms. Matregrano said. She added that her health insurance premium rates were increased even though no one in her company became sick during this timeframe and no claims were made against the policy.

new testimony

Ms. Matregrano reported that in September 1990, "we were forced to tell our employees that they would have to pick up half of the cost of that insurance because of the high percent increase in premium costs. I hope that the time does not come that the cost of those premiums forces me to drop coverage

testified that "I suspect that many of my workers, particularly those who are young and healthy, would prefer to have the money in their pockets rather than health insurance."

John Motley, vice president of Federal government relations for the National Federation of Independent Business, testified that according to an NFIB 1990 survey, " . . . 65 percent of our membership provides health insurance for their employees. Two-thirds of the one-third that do not provide health insurance would like to purchase it in the market place and can't . . . I think the number one reason for that is cost . . . . "

High Health Care Premiums

At the hearings, several witnesses from small businesses expressed the view that the high cost of premiums either prevents them from purchasing health care insurance for their employees or has the potential to affect their ability to remain competitive. For example, Rod Starkey, president of a parcel delivery service firm with 65 full-time workers, testified that his company offered and paid 100 percent of the cost of health insurance for the employees' personal coverage until a few years ago. "Because of premium increases averaging 20 to 25 percent every year, we have revised our policy and will pay the first $100 per month in premium costs . . . I cannot raise my rates 20 to 25 percent each year to cover health insurance increases. If I did, I would lose my customers to the big companies and eventually go out of business. Our employees may not be able to or want to continue to shoulder the increased premium costs."

On the issue of high health care premiums and the ability to offer insurance to employees, Eddy Mills, president of Mills-Anderson Opticians, Inc., a

AVAILABILITY AND AFFORDABILITY OF PRIVATE HEALTH CARE INSURANCE FOR SMALL BUSINESSES

At the regional hearings, the Council heard testimony from a number of witnesses that the majority of Americans have access to health insurance. For example, Robert McAfee, M.D., vice chairman of the Board of Trustees of the American Medical Association and general surgeon from Portland, Maine, testified that "our system serves the vast majority of Americans and approximately 215 million (or 87 percent) of all Americans enjoy access to health services through public or private insurance. Over two-thirds of these Americans are covered by employer-sponsored health plans." Nonetheless, as Dr. McAfee said: "Our system is imperfect . . . as physicians we find the most serious flaw in our health care system to be inaccessibility of health care coverage for some 33 million Americans." More than half the uninsured are employed persons and/or their dependents.

Employed, uninsured persons have been the focus of great discussion. The profile of this group is complex. They often work for businesses with fewer than 25 employees that offer no health insurance.[9] Or, they may work for employers who offer health insurance whose premiums are so high that employees choose not to purchase the coverage.[10] Some employees don't purchase insurance even if they could afford it (i.e., young, single males in their twenties). Rod Starkey, the president of Pacific Messenger Service, a Southern California family-owned and operated parcel delivery service,

[9] Employee Benefits Research Institute, *Uninsured in the United States: The Nonelderly Population Without Health Insurance*, Washington, DC, April 1991.

[10] John Motley of National Federation of Independent Business, testimony before the Advisory Council on Social Security regional hearings, Washington, DC, June 12, 1990.

El Greco Leather Products, a small to medium sized shoe company (60-100 employees) in suburban Long Island, New York, had an employee who, unknown to company management, developed AIDS. Before her death, the employee incurred over $100,000 in medical expenses. Because of her illness, the insurance company cancelled the company's policy elsewhere and the company had to seek alternative coverage for its employees. This occurred about three years ago, and the company has since gone out of business.

An above story is from Susan McNally of the Company she once worked at in New York.

Bill Silverstein, President, Gulf Aluminium.
tel: 813-531-0411.

The story as I recall it that he found out through a News Program about a couple giving birth to Siamese twins and the large amount of Dollars that it was going to cost the insurance company. When Silverstein went to work the next day, he found out the couple worked for his company & as a result his insurance company either cancelled or increased his premium beyond his ability to pay.

In a telephone poll of 1,005 adults nationwide last December, more than 15 percent of those contacted said they or a family member had changed jobs or remained in a job because of health benefits. (The poll, conducted by International Communications Research for The Associated Press, had a margin of sampling error of plus or minus three percentage points.)

Workers with a history of cancer, diabetes or heart disease, or those whose spouses or children need expensive longterm treatment, often find themselves locked into job and insurance they had when the medical condition began because any new insurer will reject coverage for a preexisting condition, either for several years or indefinitely.

Counselors at cancer support groups tell of a Hollywood executive who turned down a tantalizing job at another studio without telling his wife, who had cancer, after he realized that the insurance at the new job would not cover her treatment.

Similarly, a New York social worker recounts the story of an unhappy corporate vice president who raised capital for a new venture of his own, but gave it up after realizing that he could not get insurance to cover his 4-year-old son's treatment for a heart defect.

And Dr. Work, the California researcher afraid to leave her job at the City of Hope, originally thought she could get around the insurance issue by getting coverage under the policy covering her husband, a cardiologist who joined a private group practice after her cancer treatment. When he joined the practice, the group policy covered cancer recurrence costs two years after the original cancer treatment ended. But when the two years was up, and they applied, Dr. Work and her husband found that it had been extended to five years.

"I did everything right, I found the lump early, I had it taken care of, but I'm still being penalized," Dr. Work said. "Insurance is supposed to about sharing the risk, but nobody wants to share with the people who need sharing with."

The Job-Seeking

When Past Ills Get in the Way

Others with a history of medical problems find that insurance concerns make it difficult to find employment.

Betty Moore, 60, of Alpharetta, Ga., said she was unable to find a job in 1970 after her first round of heart surgery to replace a valve weakened years earlier by rheumatic fever.

"Everybody said they couldn't put me on their insurance because of my [illegible]d and they said I couldn't work without insurance. so I finally got a [illegible]all business loan and bought a florist shop," she said.

At the time, Mrs. Moore was still covered under the insurance policy provided by her husband's job at the Lockheed Corporation, which paid for a second round of heart surgery in 1979.

But when Mr. Moore left the job because of a disability, Mrs. Moore was left without insurance and the medical debts began to pile up.

"We have $1,000 on the credit card from when I had to go to the hospital for a kidney problem for 11 days, and we're paying that off by the month," Mrs. Moore said. "We owe our doctor $1,600, and I still owe $400 from when I fell off a ladder in November. And then my husband owes some, too. We've gotten so far behind on the doctor bills, it's going to be a while to get caught up."

After calling 10 insurance companies, Mrs. Moore finally found a $179-a-month policy for herself last November, but it will not pay for any heart-related problems for the first year.

So Mrs. Moore is hoping with a quiet desperation that she will not need further heart surgery any time soon.

"It can happen any time that a hole in the valve gets too big and it has to be fixed," she said. "I'm just hoping that it doesn't get bad soon. I don't know what would happen if it does. You can't be sure there will be a surgeon who will take you if you can't pay."

Mrs. Moore said she would not really rest easy until she reached 65 and the safe harbor of Medicare.

The Family

Juggling Ailments And the Bills

But it does not take the threat of heart surgery to worry the uninsured. Even minor illnesses or injuries can pose huge problems.

Last month, when William Price hurt his ankle playing basketball, he and his wife, Paula, went through the informal process of family triage that is becoming all too common in their Mebane, N.C., household.

The Prices have no health insurance for themselves and their two sons because Mr. Price is self-employed and they have decided they cannot afford the available policies. So with each new medical problem, they juggle their priorities and their budget. Over the winter, they spent $35 or $40 every two weeks for their son Ben, 7, to see a doctor about his allergies.

More recently, the Prices had to decide whether it was more pressing to take Ben to the dentist to get a cavity filled, to get Mrs. Price an ultrasound scan that might help diagnose her abdominal pains and fertility problems, or, as they decided after overnight ice packs left Mr. Price still unable to walk, to get an X-ray of the hurt ankle.

"My wife said I had to see a doctor, so we tried to figure out whether it would be cheaper to go to the doctor, and pay $50 right away, and then probably get sent to the hospital for an X-ray, and have to pay another bill, or just to go to the emergency room and do it all in one visit," Mr. Price said. "That's what I did, and I think it was the cheapest alternative, but the bill was $140."

The Prices already have more than $1,000 in medical debt to pay off, but their real worry is how they could afford treatment for an emergency. Indeed, concern about being uninsured caused a good part of Mr. Price's hesitation earlier this year, when he left the job he had held for five years and went out on his own selling satellite dishes.

"I really wanted insurance in case something major happened," Mr. Price said. "I looked into buying my own insurance a while ago, but it was $350 a month for a family, and that's more than we can manage. I'm hoping that the place where my wife works will get a group policy, which they're trying to do. Until then, we just have to hope the family stays healthy."

tens of millions more have scant ...
ited policies that they are at risk of financial devastation.

Even those numbers underestimate how many people are at risk and the scale of public insecurity. In a recent 28-month period, a Census Bu-au study found that more than one our Americans went at least a nth without coverage. The proporion was higher still among black and Hispanic Americans.

Dr. Blendon said several polls have shown that most Americans worry about their insurance coverage, especially in the future.

"If you ask people about their coverage, 30 percent say they're not sure their current insurance would cover a major bill, but if you ask about the future, 60 percent say they're not confident about their insurance," Dr. Blendon said. "Insurance costs are doubling every seven years, and what employers are doing to contain costs, principally, is cutting back benefits. Working people are already paying more for less coverage, and they know that in the next negotiation, the company will take back more benefits."

The American health insurance system is based primarily on group coverage provided by employers. But as the costs of insurance policies have risen, to keep pace with medical bills, employers have tried to shift more of the burden to employees, forcing them to pay larger deductibles, higher co-payments and in many cases an ever-larger portion of their own premiums.

And an increasing number of work-g families work for companies that ffer no health insurance at all. Small businesses and service businesses are especially likely to not provide insurance, and even large companies are hiring more part-time and per-day workers who are not eligible for benefits like insurance.

"Our health insurance system is based on the idea that employers provide insurance, but more than three out of four uninsured Americans are either workers or dependents of workers," said Nancy Barrand, a senior program officer at the Robert Wood Johnson Foundation of Princeton, N.J.

Insurers, faced with the ever-higher costs of medical technology, are trying to limit their risks by seeking to exclude people most likely to need expensive care. In the process they are undermining the very notion of insurance as a strategy for spreading risk.

Insurance fears press especially hard on those who have already suffered a serious health problem like cancer or a heart attack and find themselves unable to get any insurance to cover the condition. Cancer patients, even those who have long been free of the disease, may face waiting periods as long as 20 years after applying before their insurance will cover a recurrence. Other people who are deemed health risks may be forced to consider policies with deductibles as high as $20,000.

The Part-Time Worker

Staying Healthy Is a Daily Worry

Maintaining adequate health insurance has become a worry even for many workers who have never spent a day in a hospital and have always taken for granted that health insurance would be there, free, as a fringe benefit of their employment.

Hope Chasin, 44, says she never thought twice about insurance in all the years it came with her job, but now that she works on a per-day basis at a New York record company and has no employer-paid benefits, she is obsessed with the topic.

"Not a day goes by that I don't worry about insurance," Ms. Chasin said. "When I start thinking about it in any way, shape or form, I get too scared. It seems very bleak. I'm saving my money for a mammogram, and this sounds ridiculous, but I'm praying, please, let me not need root canal work right now.'"

Ms. Chasin, who earns less than $25,000 a year, said she researched every possible insurance policy for which she was eligible when her former job at Time-Life Inc. was moved to Cincinnati.

But the comprehensive coverage she wanted cost about $2,500 a year, more than she could afford, so she bought only a Blue Cross-Blue Shield hospitalization plan, for which she pays $250 a quarter and which does not pay her regular doctor bills.

That was the approach most families used to take, until the advent of employer-paid health insurance in the 1950's.

But the hospitalization insurance that used to provide genuine protection to so many families is not much of a buffer against the price of medical care these days, when bills for one visit to a specialist's office, together with fees for tests and procedures, can be many hundreds of dollars.

Even as the insurance system's gaps widen, medical prices all but assume that an insurer is paying bills. And Ms. Chasin, who says she cannot afford to see a specialist about a pain in her arm that has bothered her for months, knows it.

"As you get older, you realize all the things that can happen, that tomorrow morning you could wake up with some serious illness and enormous medical bills," she said. "I never thought I'd be in this situation, and now that I am, I'm noticing how many of the people around me have no insurance at all. I'm also noticing that whenever I talk about it, people get all heated up."

The Single Mother

No Coverage For the Children

Dr. Blendon and most other experts believe that the number of uninsured workers is likely to continue rising.

"The small businesses that are the fastest growing part of the economy universally don't offer fringe benefits," he said. "So you leave your job at Apple and go work for Apple Lookalike, and you lose your insurance."

Medicaid provides insurance for the poorest families, but covers less than half of those below the poverty line nationwide. In all but a handful of states, a family of three must have a yearly income less than $7,000 to qualify for the state-Federal program. (Pregnant women, infants and those with special medical needs can often qualify for Medicaid with a somewhat higher income.)

Children are especially likely to be uninsured. Indeed, about half of all uninsured Americans are under 25, and about a third are under 18.

"In the same period that the number of uninsured over all rose 24 percent, it was 40 percent for kids, almost all among working families," Dr. Blendon said.

Dana Van Putten, a New York theatrical wardrobe worker, is insured through her union. But her month-old son, David, and her 5-year-old daughter, Dina, have no coverage at all because Ms. Van Putten, a single mother, cannot afford the extra $400 a month it would cost to convert to a family policy.

Ms. Van Putten, 30, who is diabetic and had a difficult pregnancy, has been living on a $280-a-week unemployment check since January. She says she has been worried about insurance ever since she found out in November that her union coverage would not pay for the baby's hospital costs.

David's bills turned out to be particularly steep, because he was in intensive care for five days.

"I just got the bill, which was $16,195, and I clutched my hand on my heart when I saw it," Ms. Van Putten said. "I'll never get that paid off, and I'll never be able to save money to buy a house. What are you supposed to do, go bankrupt?"

The Job-Locked

Insurance Governs Career Choices

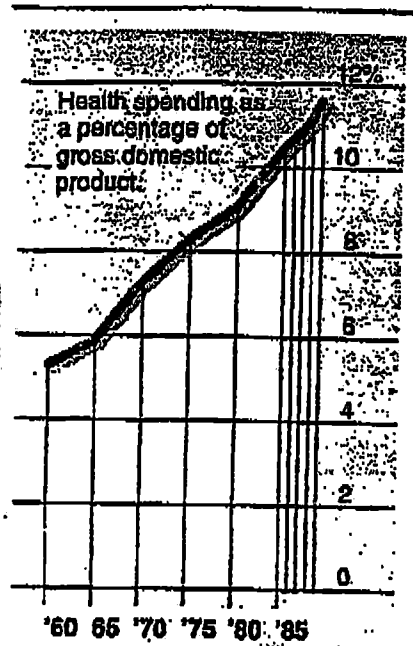
The rising number of uninsured families sends ripples through the health-care system.

"As the number of uninsured people goes up," Ms. Barrand said, "it affects everybody else because people without coverage still need health care, so they go to the hospital and end up getting uncompensated care, which forces the hospital to shift those costs onto those who have coverage."

High Medical Costs Affect Broad Areas of Daily Life

...ne Price of Health

First of five articles.



A Bigger Drain ... Income

...e: Health Care Financing ...inistration

The New York Times

Questions of access and cost: a portrait of the ailing health system, pages 28 and 29.

NYTimes 4/28/91

By TAMAR LEWIN

Long a gnawing worry of the poor, medical expenses and health insurance are now a source of mounting anxiety for millions of middle-class Americans -- healthy or sick, insured or not.

For a growing number of people, insurance status has become the pivotal factor in important personal decisions, trapping some people in jobs they do not want and forcing others to forgo needed medical care.

One spreading phenomenon is known as "job-lock" — fear of changing jobs because of a medical history that, in today's more stringent insurance market, would probably prevent a worker's acceptance by a new health plan. Cancer patients or those with chronic diseases are most vulnerable.

Anna Wu Work, a 36-year-old molecular biologist, says it is only her health coverage that keeps her working full time as a researcher at the City of Hope National Medical Center in Duarte, Calif., when she would rather spend more time with her daughters, Elizabeth, 4, and Kelsey, almost 1. She is afraid to leave her job or ask for part-time work, because she was treated for an early stage of breast cancer three years ago, and needs health insurance in the unlikely event of a recurrence.

Shaping the Health System

"It's a special time," Dr. Work said, "and I want to be with my children, especially since I know I might not be there forever. But the one thing I can't do now is quit, because I have insurance here and I'm uninsurable if I leave."

Most Americans still have health insurance. But as the nation's medical costs soar, more and more people are being squeezed financially or abandoned altogether by insurers. Their fears, and the vaguer disquiet of many well-insured people who see awesomely high bills for common medical procedures, are becoming important new forces for change in the nation's health system.

"We've gotten to the point where everybody is scared," said Robert J. Blendon, a professor at the Harvard School of Public Health who is an expert on public opinion and health policy. "Everyone has heard these terrible stories about some middle-class working person they can identify with who had no insurance and got into an awful situation."

One Nightmarish Story

If concerns about health insurance are an emerging obsession for America's middle class, it is stories like Brent McRae's that shape the worst nightmares.

Mr. McRae was 27 years old and only two months into the new sales job that made him move to California from Texas in 1988 when he began to lose weight and feel ill. After five weeks of testing and finally surgery, he was found to have colon cancer.

The bills were more than $100,000. But after his release from the hospital, he found out that the insurance he was still paying for through his former employer in Texas had been canceled because the employer had not sent his premiums to the insurer.

"To this day, I have no idea who kept the premiums," Mr. McRae said, "but that was just the beginning."

During his time in the hospital, Mr. McRae passed his new employer's 90-day waiting period and became eligible under the company's insurance for coverage of the six months of chemotherapy that he faced, at $700 a week — or so he thought.

"Five weeks into the chemotherapy, Mr. McRae said, with a catheter imbedded in my chest, I walk into my oncologist's office, and he sits me down, puts his hand on my knee and tells me there's been no payment because John Hancock is denying coverage, saying the cancer was a pre-existing condition, even though it hadn't been diagnosed when the coverage began. Then he said he could no longer bankroll my treatment."

Mr. McRae went without chemotherapy until he got new insurance, and last year had further surgery because the cancer had spread to a new part of the colon.

"At one point in the middle of the whole thing, I hit bottom, between having cancer and being told I had no insurance, and I tried to commit suicide," he said.

But his story has a happy ending: for the last year he has been cancer-free, and last month, in an out-of-court settlement, the former employer and the two insurance companies paid his medical debts and legal fees.

The Uninsured: Overview

33 Million Lack Basic Protection

Most Americans still have health insurance coverage, either through their jobs or, if they are elderly or poor, through Medicare or Medicaid.

But some 33 million Americans, 13 percent of the population, most of them lower-income workers or their families, live without this basic necessity of modern American life. And

Fill in the blocks exactly as you wish your brick or tile to be engraved. It is not necessary to use all of the lines available. Remember to leave a space between words.

Again, thank you for your support and for helping 23,000 Southern Nevadans with mental retardation. A receipt will be mailed to you.

Name _____

Address _____

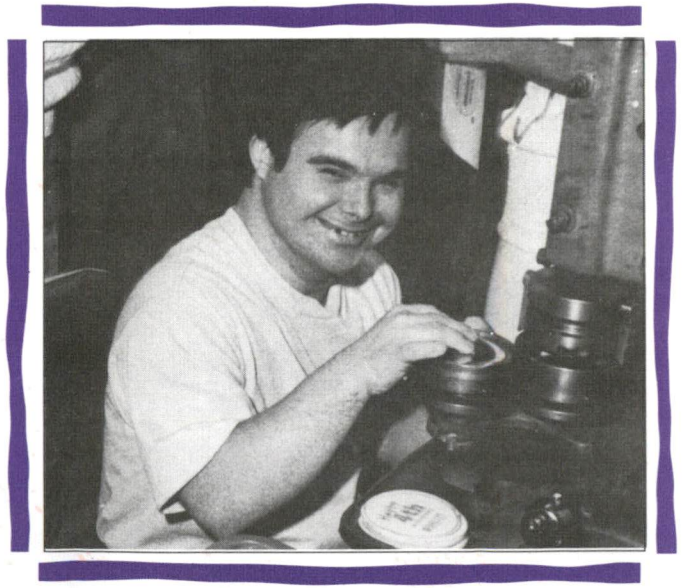
City/State _____ Zip _____

Phone _____

Bricks

Small Tiles

Large Tiles

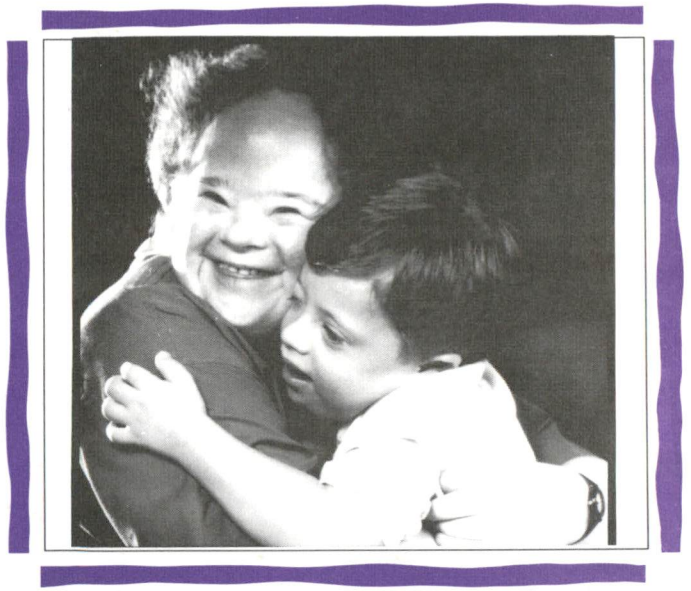


Send form to:

Opportunity Village

917 South First Street •Las Vegas, Nevada 89101

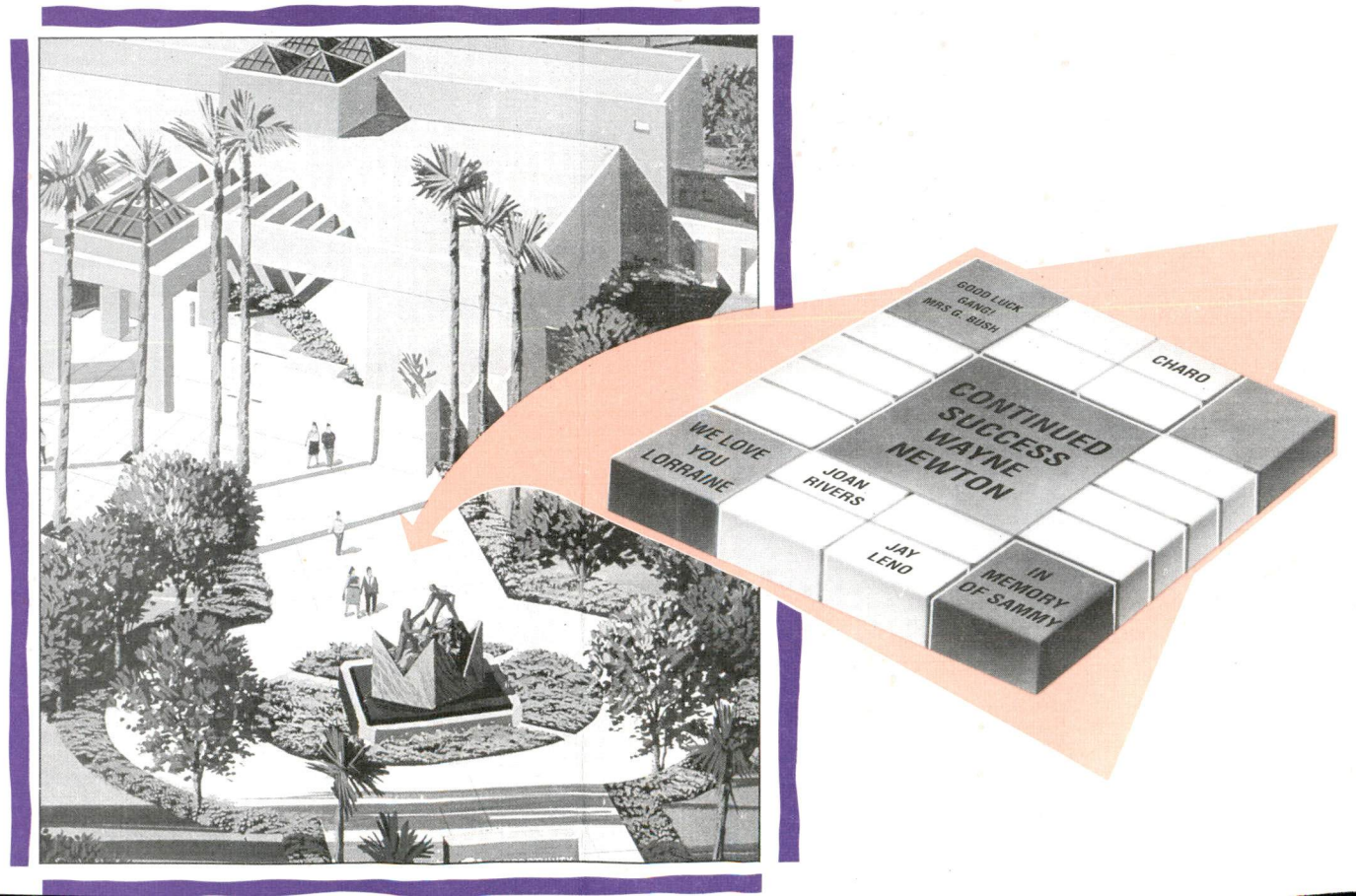
THE WALK OF FAME



OPPORTUNITY VILLAGE

Working Together We Can Build A Better Future Today.

The new Opportunity Village will be the finest facility for people with mental retardation in the United States. In order to recognize the contributions of our parents, members, volunteers and individual supporters, a special campus walkway has been designed. By buying a personalized tile on our Walk of Fame, you can show your support of Opportunity Village's continued success.



All of the walkways on the new Opportunity Village campus will be engraved with the names of individual contributors. To buy a sand-colored brick or peach granite tile, simply fill out the reverse side of this form and mail it with your payment. For more information, call 384-8170, Ext 5.

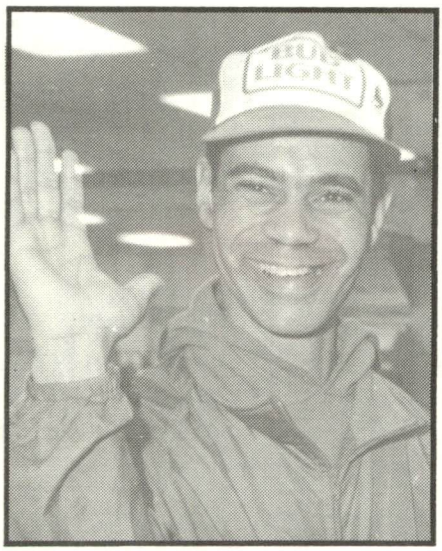
Bricks - $50 each
4"x 8"
12 letters per line
2 lines per brick

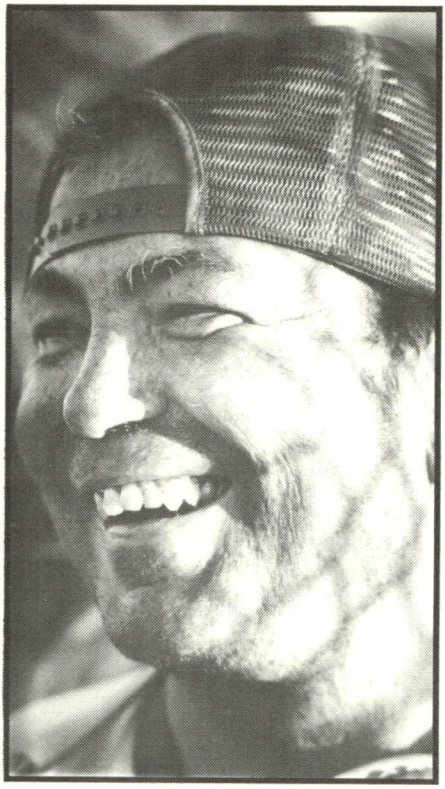
Small Tiles - $125 each
8"x 8"
12 letters per line
3 lines per tile

Large Tiles - $1,000 each
16"x 16"
14 letters per line
5 lines per tile

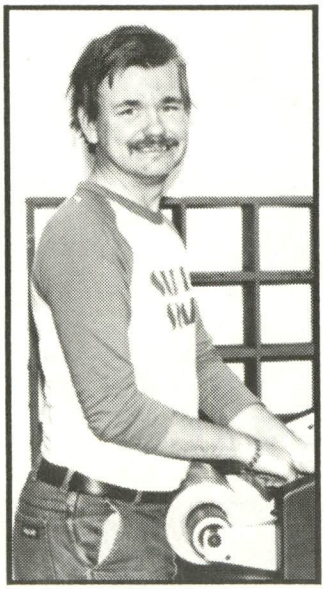
Opportunity Village

Opportunity Village





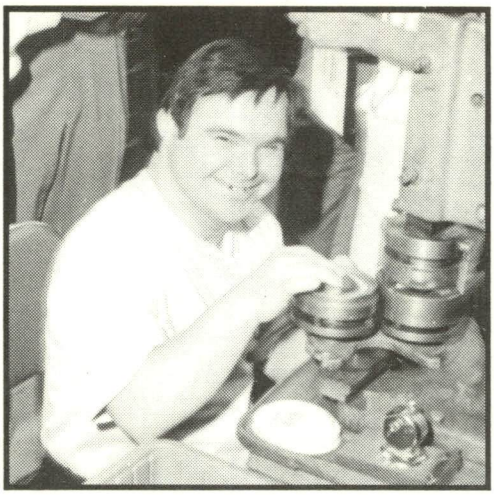
We're Build



Opportunity Village provides job training, job placement, education and advocacy to people with mental retardation. It serves more disabled people than any other organization in Nevada.

In 1989, Opportunity Village was named the best work training center for the disabled in the United States. A local organization, Opportunity Village has earned a national reputation for excellence.

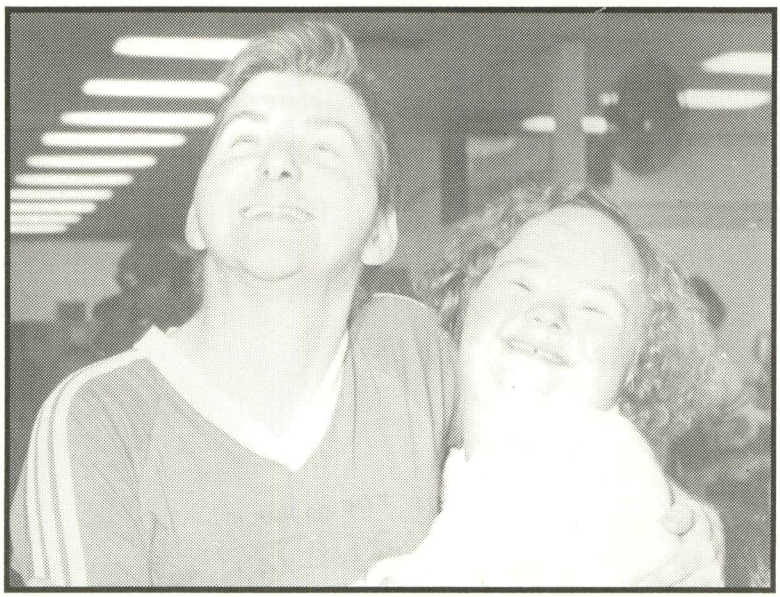
Opportunity Village is unique because it generates 79 percent of its operating revenues itself. This self-sufficiency saves Nevada taxpayers $20 million each year.



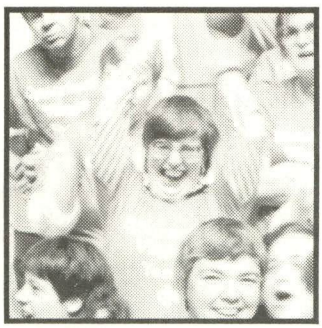
All I want
is just a chance.

A chance to
show people that
I can do what
they can do.

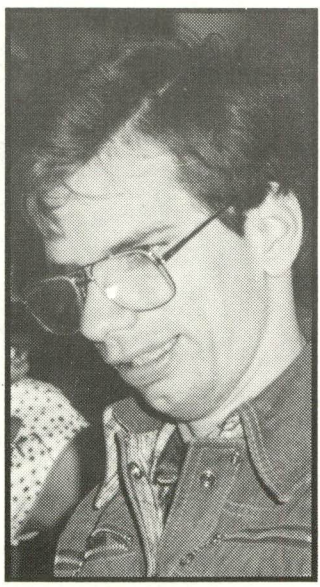
ture Today



Opportunity Village is successful because of the support it receives from this community. Schoolchildren, business leaders, club members and concerned citizens have joined together to make our programs work.



There are more than 22,000 people with mental retardation in Southern Nevada. One in every 10 families has a mentally retarded member.



Opportunity Village is committed to integrating people with disabilities into our community. Opportunity Village seeks to place every adult in a productive job, and to encourage all people to strive for their fullest potential.

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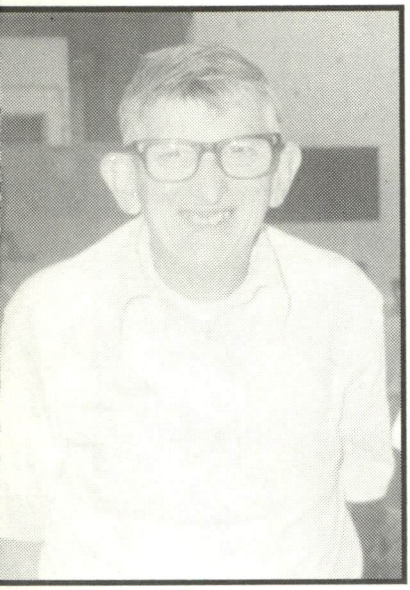
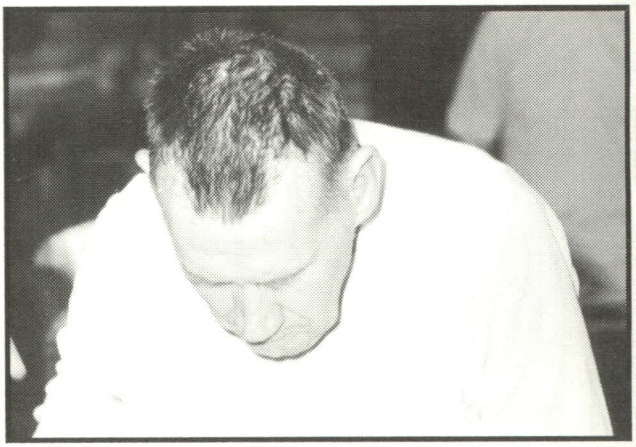
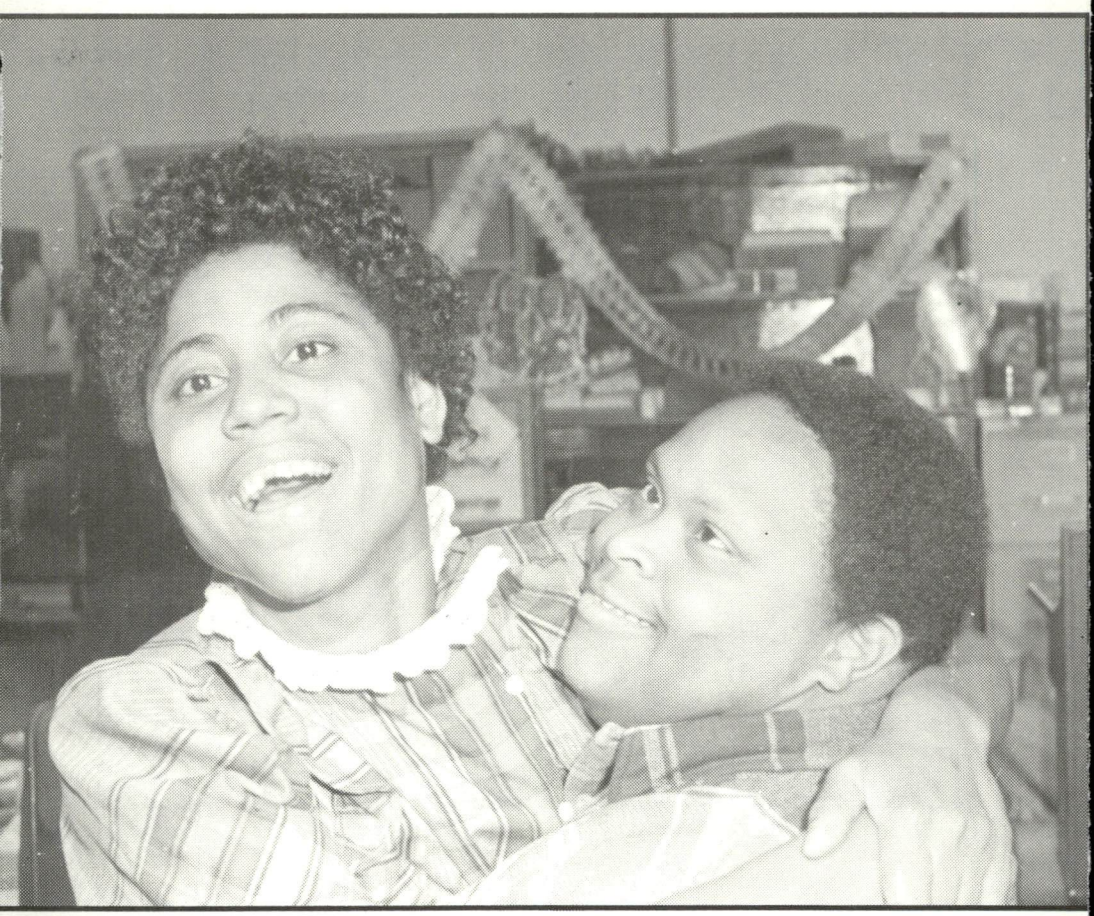






Opportunity Village Association for Retarded Citizens
917 South First Street Las Vegas Nevada 89101 (702) 384-8170

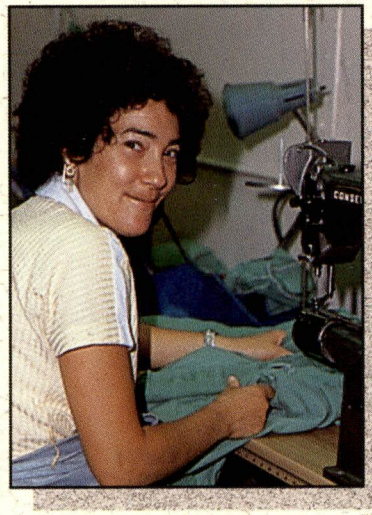
OPPORTUNITY VILLAGE

New Facilities Campaign

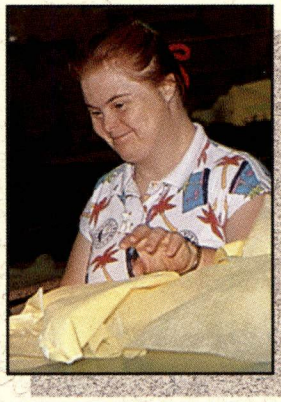
Working toget

Opportunity Village has launched a $6 million capital campaign to build the Las Vegas Valley Campus for the Intellectually Handicapped. The Campus will be among the finest facilities of its kind in the world, and will dramatically improve services to Clark County's largest disabled population, people with mental retardation.

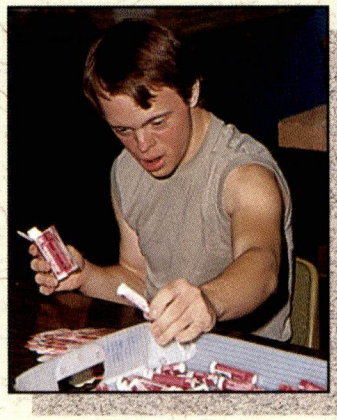
Mental retardation affects 3% of Nevadans, more than 20,000 Clark County residents, and one in 10 Southern Nevada families. Explosive population growth has pushed Opportunity Village to the bursting point. It is impossible to continue to provide effective services in Opportunity Village's current dilapidated and inadequate facilities. For this reason, the Opportunity Village Board of Directors has established the construction of new facilities as the number one priority of the organization.



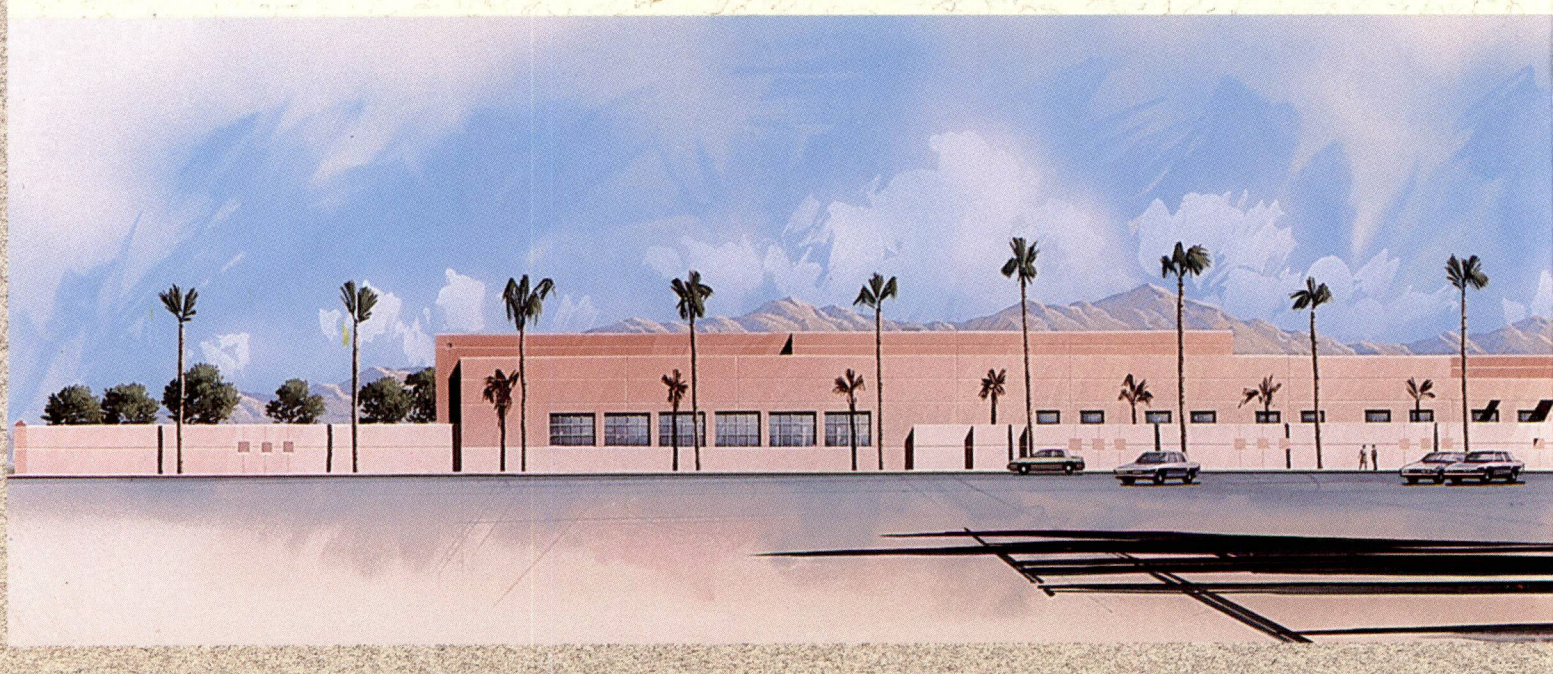
ADULT DEVELOPMENT CENTER ($1.9 million)



The Adult Development Center will offer self-help training and enrichment to people with profound disabilities. The facility is designed to promote independent living skills; small training areas will include bedrooms, bathrooms, and a kitchen. Most clients of the Adult Development Center live in the state institution; their training at Opportunity Village is their primary contact with the community.



Instituted in 1986, Adult Development Training is Opportunity Village's fastest-growing program, and the Adult Development Center its most pressing facility need.



"Opportunity Village is the largest private organization serving the disabled in Nevada. More than 300 people participate in full-time training daily, and more than 3,000 Southern Nevada families receive technical assistance, information and/or referrals yearly. That's a tremendous record of accomplishment."

Senator **Richard Bryan**

"Opportunity Village was one of the first non-profit organizations in the world to contract with the United States Air Force for commissary jobs. Today, the cooperative agreement with Nellis Air Force Base is used as a model nationwide. That's a great tribute to the people of Clark County."

County Commissioner
Thalia Dondero

"I'm just proud to lend our whole-hearted support in law enforcement to the wonderful people at Opportunity Village."

Sheriff **John Moran**

"Opportunity Village potentially saves the state of Nevada taxpayers millions of dollars a year. I can't say enough good things about the people at Opportunity Village."

Governor **Bob Miller**

"Client supported businesses generate an unprecedented 72% of Opportunity Village's total operating budget. That speaks for itself. We're proud to be part of it all."

Donald D. Snyder
Chief Executive Officer/ Chairman of the Board
First Interstate Bank

"There are 20,000 intellectually handicapped citizens in Clark County. I'd hate to think what would have happened all these years without Opportunity Village."

Grant Sawyer
Former Governor State of Nevada

"I can't think of a greater group of people that I'd rather work with. We teach people to care for themselves."

Sig Rogich
Chairman of Opportunity Village Building Campaign
Lifetime member of Opportunity Village
Chairman of Advisory Board

"In 1989 Opportunity Village won the National Community Awareness Award from the Association for Retarded Citizens of the United States. It was a great honor for our state, but most of all a great honor for the people at Opportunity Village."

Mike O'Callaghan
Former Governor State of Nevada

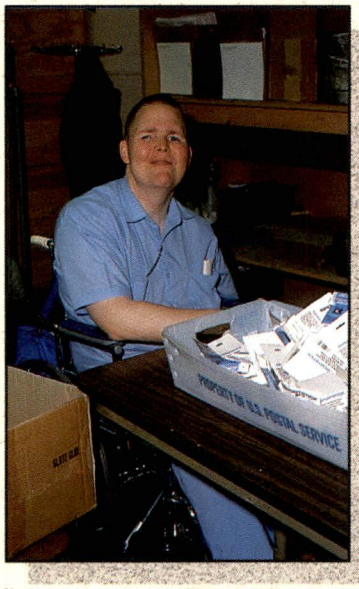
"Every dollar donated to Opportunity Village stays right here in Southern Nevada. Knowing where the money goes makes a big difference to me. Nevada Beverage Company has pledged $250,000 to Opportunity Village's building campaign; we give Opportunity Village a nickel for every case of Bud Light sold."

John Wasserburger
Chief Executive Officer
Nevada Beverage Company

r future today.

RENOVATION OF MAIN STREET THRIFT STORE ($0.7 million)

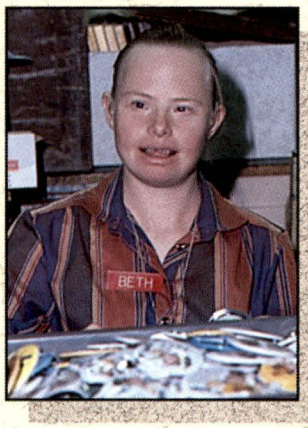
The Main Street Thrift Store is Opportunity Village's largest single source of income. Its renovation will increase sales space, eliminate current safety hazards, and improve profitability.

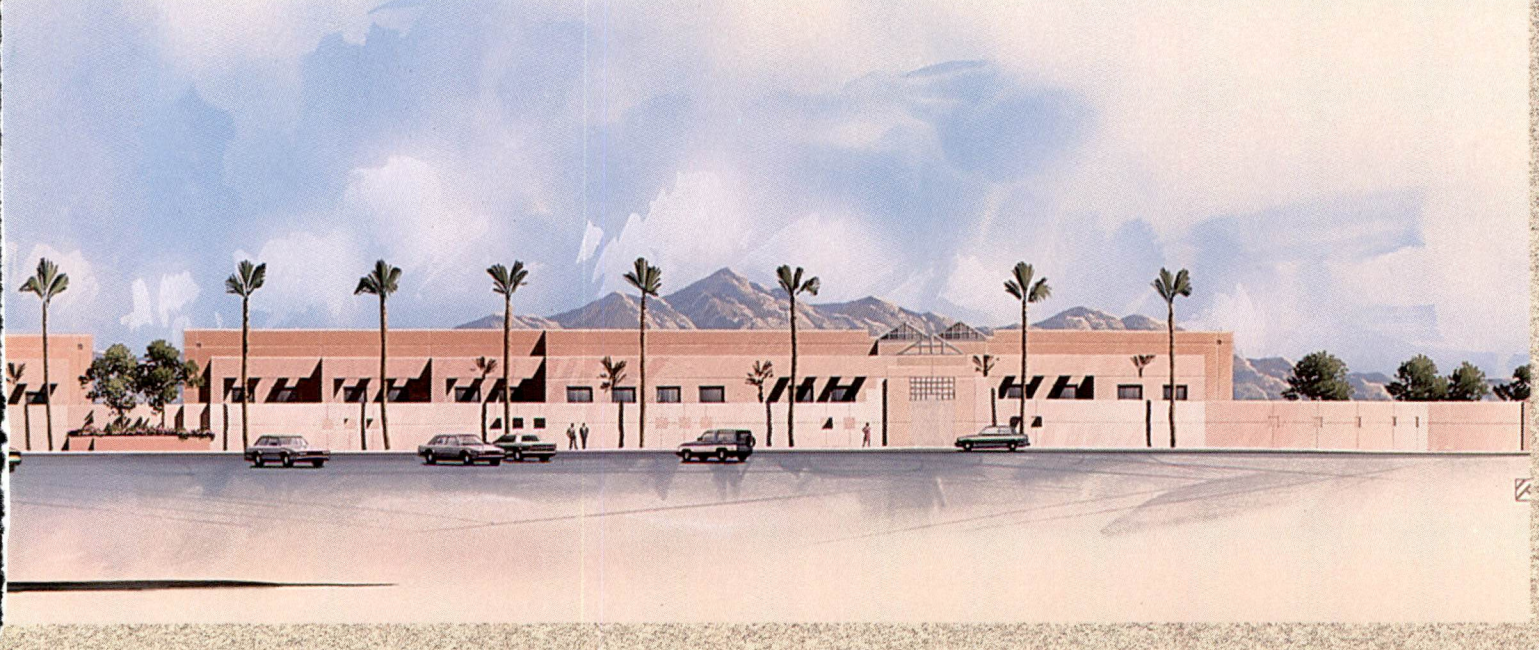


Opportunity Village is the largest private organization for the disabled in Nevada. Since 1954, it has built a national reputation for its financial self-sufficiency, for its commitment to community awareness and education, and for its innovative work programs.

A local organization, Opportunity Village has long been a boon to our community. A 1988 economic impact study demonstrates that Opportunity Village saves Southern Nevada taxpayers more than $20 million per year. This savings is projected to exceed $32 million annually by 2005.

The Las Vegas Valley Campus for the Intellectually Handicapped will be a beautiful, clean, productive place. No longer will any of us have to look at dilapidated, run-down, and fenced-in buildings, and say that this is what Southern Nevada is willing to do for its intellectually handicapped citizens. Instead, the new Opportunity Village will showcase the best of Nevada, and set national standards for programs of its kind.





her we can build a bette

WORK TRAINING CENTER ($2 million)

The Work Training Center will house all of Opportunity Village's sheltered workshop activities, as well as some independent businesses, like the print and button-making shops. The facility will be designed for light industrial use, and will vastly improve the nature of contracts Opportunity Village will be able to accept. Light industrial work pays higher wages and provides more marketable training to people with mental retardation.

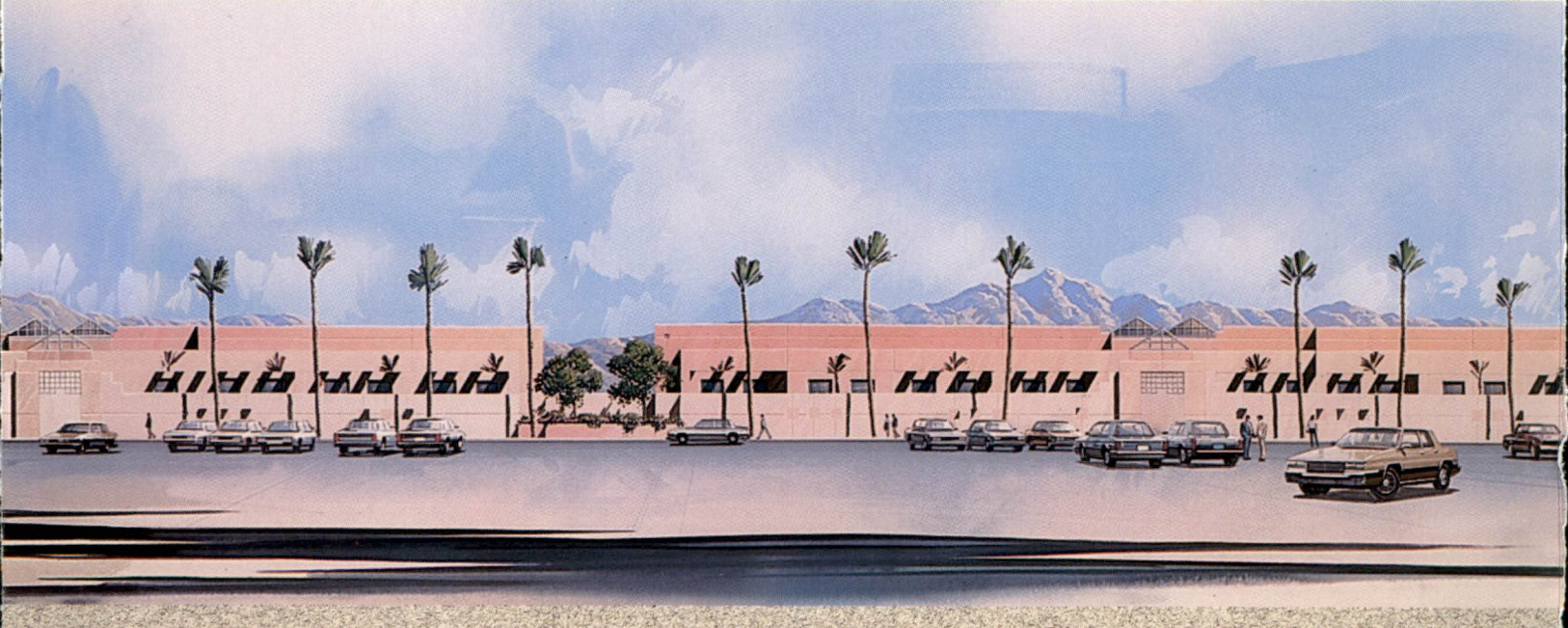
Client-supported businesses now generate an unprecedented 72% of Opportunity Village's total operating budget. It is estimated that the new Work Training Center will increase Opportunity Village's financial self-sufficiency by 5% in five years.

CULINARY/LEISURE FACILITY ($1 million)

Primarily for culinary training and recreation, this facility will consist of a large multi-purpose room, an industrial kitchen, and administrative offices. Meals will be offered to staff and clients as part of the culinary program; the dining area will convert to an indoor gymnasium.

Much of the community employment available to Opportunity Village clients is in the restaurant business, and this program will mean jobs for hundreds.

Currently Opportunity Village has no recreational facilities. This indoor facility, and the availability of nearby outdoor recreation at the new campus, will dramatically improve the quality of life for Opportunity Village clients.



OPPORTUNITY VILLAGE

917 South First Street • Las Vegas, Nevada 89101

A lot of people say they want money. They want a mansion. I don't want any of those things. All I want is just a chance. A chance to show people that I can do what they can do.