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Divider Title: Mirabella 5-13-93

THE WHITE HOUSE

OFFICE OF THE PRESS SECRETARY

For Immediate Release

REMARKS BY THE FIRST LADY
AT WOMEN'S ISSUES FORUM SPONSORED BY
MIRABELLA
May 13, 1993

Cannon Bldg. Conference Room

Thank you. Thank you very much. I am delighted to be here, I feel so at home because I look out in this audience and see people with whom I have worked and am working. I am particularly pleased to have been introduced by Tipper Gore who is a remarkable woman and doing an extraordinary job in making clear that mental health is part of health care. It is not to be marginalized, ignored and treated as though it were a second class part of our health care system and she deserves a large part of the credit for making that case, as she has all over the country. I am also pleased to be here with members of Congress, particularly women members. Three of whom we have already heard from; Senator Mikulski, Congresswomen Schroeder and Snowe both of whom chair the Women's Caucus. There are a number of the other caucus members, both Republicans and Democrats here in the audience. Ever since I was given the responsibility of working on health care I have been so supported by the extraordinary work that has gone on before by individual members of Congress. But particularly women members who have been fighting battles about health care and women and children's health concerns for a number of years. I also add my thanks to Mirabella and the other participants in this symposium.

I want to spend a few minutes talking about the future and where we go. I think that the kinds of issues that have already been touched on by the other speakers particularly the women members of the House and Senate who have already spoken about what has been accomplished in the last several years. The results of the survey as well as Tipper's comments helped set a context for where we are at this point in history when it comes to health care in general and women's health care in particular. We have a number of challenges that confront us in creating a health care system that is responsive to the issues that have already been discussed.

First and foremost, we need a health care system that emphasizes primary and preventive health care. A system that rewards the kind of action that is taken on a personal basis to seek health care at the front end of a problem, as opposed to permitting it to deteriorate to a point of acuteness. Now, the reason we have to alter our health care system to take that into account, even though it is a very common sense approach, is that historically we have built up a financing system for health care that paid for procedures, tests and the kind of acute care that comes with the back end of health. It is really a system of sickness care as opposed to health care promotion. That dates back to the very earliest insurance systems that covered surgical interventions and other kinds of hospitalization and became then the pattern which we have lived with ever since, in both the private and the public sector.

We need to reverse our priorities. Yes, we have to continue and expand coverage for acute care and hospitalization, but we have to take a different approach if we are going to have a health care system that truly promotes health. So to that end when the President comes forward with a plan, it will emphasize primary and preventive health care. That will be particularly important for women and children. We will put on a par with other kinds of medical care, well-child care, prenatal care, and the kinds of diagnostic tests that can pinpoint a problem early instead of letting a condition deteriorate. If we focus on primary and preventive health care we will need to change the mix of health care practitioners which we currently have. Because our current balance is about 70% specialist and 30% generalists. In order to have universal health care coverage for all Americans that emphasizes primary and preventive health care, we need more primary and preventive health care physicians, nurse practitioners, physician assistants and others who will be on the front lines delivering it.

One of the most significant findings of the Mirabella survey was the one which asked women what they want in their physicians. Because what they want, is someone who will listen, who will take time and will once again have a personal relationship that is really a basic doctor-patient relationship again. Because what we have done through the system we have financed and created over the years, is to rachet down the kind of reimbursement that we give for that sort of clinical time. You do not get paid adequately if you are a family practice physician, if you are OB/GYN, a pediatrician, an internist who cares about looking at your patient as a whole person. That is what not just women, but I would argue, men as well want, but the system has not promoted that kind of interaction. One gets paid better for the least personal interaction and the more tests and procedures that can be ordered, that has to be reversed. We have to change the way of thinking that has interfered with the doctor-patient

relationship and undermined the kind of feelings that really serve as the basis of trust in a health care provider. That will be a major thrust of the movement we will try to have be part of health care reform, as we move to primary and preventive health care.

Secondly, we will provide a basic package of benefits for every American, that will include mental health and substance abuse treatment. I stress this because there have been a number of articles speculating about how it seems un-economical, one might even argue frivolous, to include mental health coverage and substance abuse treatment in a basic benefit package. My response to that position, which I think is wrong on the merits, is that it overlooks the inter-relationship that mental illness and substance abuse have with other health care problems. This is all part of a package, people who have substance abuse problems often are more difficult to treat for other medical conditions and we are beginning to understand the relationship between mental illness and other kinds of medical symptoms. To try to say we will only treat these bodily symptoms and not understand what we now are finally recognizing about how health is really rooted in the whole person and must be looked at in that regard, is to ignore both common sense and the kind of increasing awareness that we are building up about how best to help heal people as whole beings. So part of what we are emphasizing with the mental health and substance abuse treatment is that yes, there are real problems out there, some of which Tipper enumerated and yet it is unfair to tell people seek treatment for alcoholism or drug addiction but have no treatment available. But in addition, we have to change our cultural understanding about what health and sickness are and realize that a much more holistic approach is going to be more effective and more cost effective if we pursue that.

Thirdly, we have to provide a health care system that includes everyone, and excludes no one based on their employment status, on a pre-existing condition or any of the other exclusions that are currently operating. I have been somewhat surprised by some of the recent writing about how our concern about the uninsured is misplaced. You may have seen some of these articles in some major publications. Who are the uninsured? Why, they are all healthy 25 year olds who don't want insurance. They are self-sufficient people who understand that they can take care of their health needs, all 37-40 million of them, I guess. It is not only a gross distortion of who the uninsured are but it totally misunderstands one of the critical reasons we have a health care crisis. That reason is because we have so much uncompensated care from the uninsured and underinsured. It is not true to say that in America there is no health care for Americans without insurance. What is true is to say there is health care usually at the last minute and the most expensive kind. That is why so many of your hospital bills,

those of you who are insured, bear kind of bizarre notations-$50 for 2 tylenols. Now, is that because the hospitals are uniformly seeking to rip you off? No, of course not. It is because, for all of those healthy uninsured that some people write about, several million everyday have something happen to them and they show up at the emergency room. Maybe it's an out-patient treatment but maybe its something more serious. Maybe they can pay a little bit, but more likely they cannot pay the whole bill. So the $50 tylenol enables the emergency room of the local hospital to keep taking the people who show up with their conditions rather than turning them away. Then you and I compensate the hospital for that care.

We can not have cost containment, which must be a critical objective of health care reform, without universal access that is reimbursed at a fair rate. If we do not stop the cost shifting that currently effects the bills of those that are insured by private 3rd party payers and in the 2 major governmental programs of medicaid and medicare, we will continue to see a never ending upward spiral of costs. So it's not merely the right thing to do to insure every American it is absolutely necessary if we expect to have both healthier Americans and a healthier economy.

The fourth point I want to make, to this group particularly is that although we will come forward with major changes in the way we finance and deliver health care there will be a significant piece of these changes that will have to rest on each individual becoming more responsible. Becoming a more responsible consumer of health care making more informed choices, taking, better care of ourselves.

As it is now, too many Americans do not understand the real costs of health care. Somebody else pays for it, somehow it gets taken care of. They don't relate to the huge programs that are paid for out of general taxes. They do see their payroll contributions to medicare but they aren't quite sure what that actually buys. They're very aware of their own insurance, if they have insurance, and how much their co-pays and deductibles are but they aren't so aware that part of the reason their cost is going up is because of choices that are made by other people. Employers who choose not to employ people and pay insurance, individuals who choose not to be responsible with their own health care and on down the line. One of our goals with health care reform is to create more of a culture of responsibility when it comes to health care. To encourage people to take responsibility for themselves and their families. To provide incentives for the kind of behavior that leads to better health and frankly to provide some disincentives for behavior that doesn't. Because ultimately each of us is responsible for our own health care.

We all read the surveys, like the one that Mirabella conducted. You know, as I sometimes do, you cringe when you get to all those things you know you are suppose to be doing, and maybe you fudge when they ask how many times a week you exercise. You say," well 3 or 4", when you know in truth it's 1 or 2 on a good week. Yet, we all know in order to be as healthy as we can be, we are going have to change how we think about the health care system and we are going to have to be willing to change our own behaviors. I am very heartened by the increasing awareness on the part of all Americans but particularly women. About the issues facing us in this health care reform debate. We have a lot at stake. We have already heard reports from our members of Congress about the changes in the research protocols that have taken a very long time to occur. But which hold finally, real promise for problems that are particularly women's health problems. We have seen a lot of struggles fought over the last years to gain respect for both women practitioners and women patients.

But we still have a lot of miles to go before we have a health care system that is able again to care more about the whole person than worrying about filling out the endless forms, hiring yet another clerk to hassle with, yet another insurance company to get reimbursed for something. And yet we know what we can do as a people, if we remain committed to basic principles of reform that enhance the individual dignity of all of us and will particularly make it possible for women to be treated on a par with men, given the kind of health care they need, the kind of time and attention their problems deserve, and the outcomes that will lead all of us to be healthier and at the risk of going out on a limb, happier. Because I think that there is a relationship not only to our individual health but to our collective health and the social well being of our people. For me, health care reform is not about just eliminating administrative hassles, not about just giving us more general practice physicians to balance our specialist, not about just organizing ourselves and taking responsibility, it is about the vision of the kind of people we can become if we once again have a ethos of caring and we really do try to give each other the kind of help that enables all of us to be healthier. Thank you very much.

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Divider Title: Wash State 5-17-93

WASHINGTON BILL SIGNING

I regret that I cannot be with all of you this evening. So many of you have worked so hard on behalf of health care reform in the state of Washington. I want to take a moment to acknowledge a few of those whose leadership on this initiative has made a critical difference: Governor Mike Lowry, former Governor Booth Gardner, State Representative Dennis Dellwo, State Senator Phil Talmadge and Dick Cooley.

For many years, states have taken the lead in reforming the health care system -- by developing innovative solutions to the health care crisis faced by their citizens.

Many of the elements of the Washington Health Services Act mirror the essential elements of the national health care reform package that we are developing here. These elements include: a uniform benefit package which will be offered through certified health plans, a dramatic increase in access to health care and health care insurance, health care cost control, and the development of a public-private partnership where employers play an important role in sharing in the responsibility of paying for health reform.

The President recognizes the innovation and leadership in health care that has occurred in the State of Washington. But finding a lasting solution to this country's health care crisis

can't be done by states alone. Controlling costs, providing security, and guaranteeing all Americans a comprehensive package of benefits are challenges for our entire nation to solve. That's why the President and this Administration have formed a partnership with you in the states to take on this challenge together.

Under the President's health care reform proposal, the federal government will provide a broad framework for providing health security and controlling health costs, and states will continue to lead the way in making those guarantees a reality for all Americans.

Many thanks to the state of Washington for leading the way. You are all to be commended. Good bye.

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Divider Title: Linda B.T. 5-17-93

LINDA BLOODWORTH-THOMASON

I'm so proud of my dear friend Linda for receiving the American Women in Radio and Television's Silver Satellite Award. But I have to tell you I'm not surprised. I would be hard pressed to find anyone who deserves this recognition more -- for her personal and professional achievements as well as her efforts to improve the image and status of women in broadcast communications.

Linda has been tremendously successful in rising above the "glass ceiling" that still exists for so many talented women.

She has brought to the sitcom a humorous way of dealing with the serious issues facing women that others were afraid to touch. Her characters are smart, strong, successful and funny.

Linda's professional talent goes well beyond the sitcom format. When we were getting ready for the Democratic National Convention, it became clear we needed some way to portray just who Bill Clinton was and why he was right for our country. Bill and I turned to Linda and asked her to perform this impossible task: take 400 pages of script and hone it down to just 14 minutes of air time.

Well, she performed this miracle and she did it beautifully. I'm sure most of you remember the "The Man From Hope" video that brought the Convention to its feet. That video was the turning point of the convention.

On a more personal level, few people know Linda's efforts off the screen on behalf of women. Few known that Linda established the Claudia Company. Named after her mother, the Claudia Company keeps 56 women in college -- providing an opportunity for a better education they otherwise would not have had.

Bill and I are lucky to count her as our friend.

We love you Linda and congratulations from both of us.

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Divider Title: Penn Commence 5-17-93

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

REMARKS BY THE FIRST LADY
AT THE UNIVERSITY OF PENNSYLVANIA COMMENCEMENT
May 17, 1993

Thank you. Thank you very much. It is indeed an honor for me to be part of this celebratory commencement at one of the premier and oldest institutions of education in our country. I want to thank President Hackney, the regents, the other honorary degree recipients, faculty, alumni, family members, citizens but most of all those of you who graduate this year from the end of your various degree programs whom I had the privilege to watch march by me just 15 minutes ago. I wish everyone in this stadium and indeed everyone in this great city could have stood there with us and watched not only the faces of individuals, many of you look like you've been celebrating already, but the diversity, the excitement, the hopefulness, the enthusiasm and the sense of moving forward into a future that none of us can predict but for which each of you has been well prepared.

Commencements are a time to stop and think about the past, to celebrate this present moment and to look forward into the future. There is no way that any commencement speaker at any campus this spring could stand before you and tell you what will happen. Not tomorrow, not next year, not for the rest of any of your lives. But part of the reason commencement speeches have a certain similarity and familiarity to them is because when one does stand in front of a group like this, impressed by your accomplishments and achievements, remembering one's own past, it is an opportunity to talk about some of the ideals and values that have withstood the test of time and which can be guiding principals in lives well lead.

I started my morning on campus here sitting on the park bench with Benjamin Franklin and I hope each of you has had that same opportunity. The way that he sits there, in this relaxed manor, the way he looks at you as you look back at him as though he were making yet again an important point that needed to be repeated, gives one a sense of the continuity of time and life and history in this institution which is very reassuring. And then when I opened the program for this commencement and saw the quotation from Benjamin Franklin that I had intended to use as well, I was struck by how at this moment what he began all those years ago before we were even a country had special meaning.

Franklin was, as the program says, an advocate of good citizenship. "We may make these times better if we bestir ourselves," he wrote. The nobelist question in the world is "What good may I do in it?" That is the question for this commencement. That will be, I hope, the question you ask yourselves as you journey through your life. That journey will not always be an easy one, it will not always have clear directions attached to it. As we are here in this magnificent stadium we can remember the many Penn Relays that have been held here and think often about the different kinds of events that take place. And although I am always impressed by everyone of them, sprints and hurdles and other track and field events, for me life is not a sprint, it is a marathon. It is something you prepare for and often you keep going through when times are tough, when you may even know where you are heading. And one of the questions to ask yourself is Franklin's. Because often by asking "what good may I do in it?" you end up giving yourself that direction and not only doing good but feeling good about that.

There are many people in this stadium today who are responsible for your being here. Who believed in their journey, who believed that as parents and family members they had responsibilities to you and worked every day, often through hard times, to try to fulfil them. Because a college degree is a collective achievement because for every person dressed in black here in front of me I know there are people in the stands who are proud and often thinking back to when their checking accounts looked more red than black as they sacrificed to make this day happen.

And speaking of sacrifice, I just need to get this out of way. A reporter asked me about my new haircut, I know its been on all of your minds it is after all, the number one issue. I had a friend call me from Japan who saw it on CNN. So I told him the truth, that when the President called for sacrifice and asked everybody at the White House to get a 25% cut I decided to go for a 50% cut to do my part.

When I graduated from college in 1969, I too had dreams for my life and I also hoped to be able as I fulfilled those dreams to think about what good I might do if I bestirred myself. I gave a speech at my commencement and I have had an occasion in the last year to go back and re-read that. I see the idealism, I see the excitement and I see some of the naivete that marked me and marked many who are at the beginning of their adulthood. I know that at twenty-one, I did not fully appreciate the political and social restraints that one faces in the world. I know that I assumed that we could overcome a lot of these obstacles that are still with us, despite the progress we have made. But I am glad that I felt idealistic at twenty-one because I think it is

important to feel that way and I have tried to maintain that feeling as I have grown older.

My father, if he were here today, would tell you that the reason I have changed from being a Goldwater Girl to a Democrat is because I went to college. Not that he didn't approve of my going to college, he always believed in education but that I came out different than what he had sent. Some of you may have had those conversations with your parents. What is it you learned and why do you feel that way now? But always during my growing up years and through college and beyond, what I loved and respected about my father is that he always took what I believed and cared about seriously, even when he disagreed very strongly. And there was always in our home an opportunity for the kind of discourse, one might say arguments, that mark people who care deeply and who have ideals. Being twenty-one is a license to be idealistic and I encourage all of us, no matter what age, to keep renewing that license because our world needs us to do that.

The sixties were a time of momentous change in our country but so are the nineties. Our world has changed dramatically from the days of assassinations, of wars, of riots. But yet, as we look around us today and we see all of the positive changes that we have lived with, we know that there is still much to be done in this, the most powerful nation on earth. Too many people work too hard without ever getting ahead. The Philadelphia Inquirer, in its Pulitzer Prize winning series of a year or so ago, in talking about what has happened to the American Dream, made that point forcefully. Many of the people in this stadium who have worked hard for a living have seen the security they thought they were working for, be endangered because the world around us is presenting new economic challenges that we have to be prepared to face. To few of our people today can meet those challenges and take advantage of our new opportunities.

They have not been prepared, they have not been prepared to negotiate this new world because in too many cases families are not offering the kind of stability and structure that builds skills and confidence in children. And other institutions including our schools are not setting high expectations and working hard to assure that children achieve those expectations. We have to learn how to make change our friend because no one can repeal the laws of change or tell you it will turn around and be the way that it once was. So today more than ever, we need to focus our attention on our children, give them the stability and structures they need and once again make education the passport to the American dream that it used to be. Because as we look around us, we see that there is a lot of work to be done.

We can look at places that are now on our front pages that we never heard of a few years ago, with names like Bosnia or Somalia. We can watch the spread of ethnic hatred, nuclear

proliferation, starvation, and the kinds of problems that come into our living rooms whether we want them or not. And here at home we watch our cities crumbling under the dual assault of drugs and guns that create a level of violence that is unacceptable. Within a few miles from this campus on this beautiful day we know that there are children whose parents are afraid to let them play outside. Who cannot faithfully walk to school. We know there are young people who are beset by hopelessness and despair. How can we claim to be civilized when our children can not even leave their homes in safety? How much longer will we permit those kinds of conditions, in which drugs and guns determine the quality of life to continue?

Now is a good time for us at this commencement to take a deep breath and decide how each of us will deal with these challenges. Because if you do not shape your life, circumstances will. Like generations of Americans, you will look for the right balance in your lives. A balance of work, and family and service. A balance between your rights as individuals and your responsibilities to yourselves, your families, your communities, your country and our world. I hope your experience here at this university will serve as a guide. Here you have met people from diverse backgrounds. You've had your ideas and beliefs tested you've had to learn what you're willing to stand for and stand against. You have been part of a microcosm of the restless and diverse country we call America. You have seen people from every kind of background, every religion, every continent on this earth. You know well that you have had an opportunity to argue about what you think should happen and you've even had the chance to argue seemingly contradictory positions. Because if your college years were anything like mine, you have probably been in a position to take different positions even more than once in an evening's discussion, to try out these new ideas and to try out what your real values and beliefs are.

What we have to do here at this university and in this country, is to find a way to celebrate our diversity and debate our differences without fracturing our communities. We must always uphold the idea of our colleges as incubators of ideas and havens for free speech and free thought. And our country and our colleges must also be communities. Communities of learning, not just book learning but people learning. Where every person's human dignity is respected. Freedom and respect are not values that should be in conflict with each other. They are basic American values that reinforce each other. But, we cannot debate our differences nor face our mutual challenges unless and until we respect each other, men and women, young and old, across the ethnic and racial lines that divide us. I know that you share, you share the general distress that any acts of hate, hateful acts, hateful words, hateful incidents that occur too frequently today in our communities and even on our college campuses. In a

nation founded on the promise of human dignity, our colleges, our communities, our country should challenge hatred where ever we find it. But we should listen as well as lecture, confront problems not people and find ways to work together to promote the common good. We must be careful not to cross the line between censoring behavior that we consider unacceptable and censuring, that's u and o. For the all the injustices in our past and our present we have to believe that in the free exchange of ideas justice will prevail over injustice, tolerance over intolerance and progress over reaction.

And we have seen that in our own history, in the struggles over civil rights, worker's rights, women's rights, human rights. We have seen how movements armed only with the power of their ideas have prevailed over ingrained prejudices and entrenched injustices. That is why is it always time for a free and open discussion in every college and every community throughout our country about how we can live together, bring out the best in each other, make our diversity a source of strength and not weakness. We are all in this together and we have to recognize that because as the President had said, we don't have a person to waste in this interdependent world in which we live.

Now how do we strike the right balance between individual rights and responsibility? How do we create a new spirit of community given all of the problems we are so aware of? Regrettably the balance between the individual and the community, between rights and responsibilities has been thrown out of kilter over the last years. Throughout the 1980's we did hear too much about individual gain and the ethos of selfishness and greed. We did not hear enough about how to be a good member of a community, to define the common good and to repair the social contracts. And we also found that while prosperity does not trickle down from the most powerful to the rest of us, all too often indifference and even intolerance do.

One eloquent description of the inter-connection between individual identity and the individual's responsibility to society comes from Vaclav Havel, the playwright who is now the President of the Czech Republic. He went to prison during the communist regime in Czechoslovakia because he could neither be free as an individual nor responsible as a member of a community. Because the community in which he found himself suppressed thought, speech, religion and the other rights we cherish, and undermined individual responsibility and respect among citizens. Havel wrote to his wife Olga from prison, "Everything meaningful in life is distinguished by a certain transcendence of individual human existence beyond the limits of mere self-care toward other people, toward society, toward the world. Only by looking outward, by caring for things that in terms of pure survival, you needn't bother with at all, and by throwing yourself over and over again into the tumult of the world with the intention of

making your voice count only thus will you really become a person."

Each of you will be defining the meaning of your own life by your actions from this day forward just as you have, consciously or unconsciously, to this point. How you make those decisions and those turning points as to what you believe in and who you are, will at the end, sum up the life you have lead. There are many opportunities and some of you have already seized them. This campus has an extraordinary number of people who have committed themselves to public service while they are here. This country is about to be committed to national service because it is time for us to once again create opportunities for all people, but particularly young people, to be of service. Just as in my generation, with the help of people like Senator Wofford, President Kennedy challenged young people to be of service to the country and the world, today we have a new call to responsibility. A domestic peace corp that will help young people pay for college or job training by performing community service, helping children learn to read and write, working in hospitals, helping the homeless, cleaning up the environment, helping yourselves, finding meaning by helping others.

There is also a great opportunity that some of you are already seizing. Because of part of my husband's, "Summer of Service," proposal, a grant has already been awarded to a program here in Philadelphia, "Immunize Children At Early Risk, I Care". It will put 150 college age students from throughout Philadelphia to work this summer. They will immunize more than 5,000 children, they will earn money for college, they will make a contribution to the community and I would argue they will have an opportunity to find some meaning in their lives that teaches them about who they are. When they come home from this immunization effort and look into their mirrors they will see people who have been changed by that experience.

We also have a great opportunity as a country to face a problem that is not only one of finance and delivery systems and buzz words like that but which challenges really, again, who we are as a people. And that is the challenge of health care. The first medical school in our country started at the University of Pennsylvania. The issue of health care bounded onto the national agenda because of the election of Harris Wofford. And it is time now as a nation to recognize that we have a chance to provide health care to all of our people and to do so in a more economical and humane way than we have up until now. I have traveled all over this country and I can tell you, based on personal experience that antidote after antidote, that although we are the richest country in the world and we have the best of medical care available in the world we spend more money on health care and take care of fewer people than our competitors who

provide health care to all of the people and have better outcomes for the money that they spend on it. What we have instead is a patch work non-system. People who are employed but without insurance, people who have pre-existing conditions and can not get insurance, people who thought that they were part of an employment contract and would always have their health care being taken care of who are now watching that be stripped away through lay-offs and other kinds of changes. Most people in this country who are uninsured get up every day and go to work. They would be a lot better off when it comes to health care if they went on welfare. What kind of signal does it send to the 37 million uninsured Americans, 82% who work or who are in the families of workers, to be able to say that? What kind of responsibility does that imply?

Health care is an important issue also for the economy. As all of these Wharton graduates will soon discover first hand, if they have not already in their work experience, we have given away competitive advantage after competitive advantage because our major companies pay more in health care benefits every single year in a system that is out of control. The expense of that health care makes too many products more expensive than the competition. We in effect say to our manufacturers," tie both arms behind you then get out in the world and compete and make jobs for Americans." Unless we do something now, by the year 2000 almost one out of every five dollars that you will earn will be spent on health care. And that will be spent without insuring one more American, providing better health care in any rural communities or any inner city. We need to make some solemn commitments and change in the direction of insuring that every American will be secure. If you change jobs or if lose your job you will still be insured. If you get sick or if you have a pre-existing condition you will still be insured. If you are an older American and need help with prescription drugs and a start on long term care, particularly in your home, you will be insured. If you are a physician, or a nurse, or a pharmacist or a dentist, you will no longer spend 20-40% of your time and income filling out countless, meaningless forms. If you are an employer who has been struggling to maintain health insurance benefits for your employees you will see that cost stabilize and decrease over time.

This health care issues is not just an issue of economics, although it is that. It is a human issue, it is a social issue and it goes to the very root of who we are as a people. Can we take care of ourselves and be more responsible about our health, can we take better care of our families, can we have a healthier country? I'm betting that the answer to all those is, yes. Because I'm betting that in these very exciting and challenging times, as we move toward a sense of community and define the common good in terms that include us all but set standards by which to judge our progress together, that there will be

contributions from all of us that will meet the challenges we face.

And for each of you, I think you are living in very exciting times and I hope that as you go forth from this university you do so with the kind of high spirits and enthusiasm I saw today. And that you understand that this marathon we all run for, which none of us knows where the end will be, cannot only be an exhilarating experience, but it can be one that leads to meaning in a challenging time for us as individuals and for us as a people. Thank you all. And Godspeed.

END

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Divider Title: Families USA 5-25-93

THE WHITE HOUSE

OFFICE OF THE FIRST LADY

For Internal Use May 25, 1993

Remarks of the First Lady
at Families USA

Thank you. I am delighted to be here. I'd like to start by thanking Rob and Judy and all of you for really leading the way on health care reform. As Bob said and as I know so well there are many of you in this room who have been out working on behalf of health care reform for a very long time. I don't know if any of you were around in 1915 when the first national commission called for health care reform on a universal basis or were around in 1938 and '39 when the Murray Dingle Bill was introduced. Maybe some of you were around in the early 1970's when President Nixon introduced a very comprehensive national health care plan with an employer mandate. Some of you might find that hard to believe, but there were Republicans like that 20 or 30 years ago who took positions that now are considered more difficult for their party to embrace.

But I know that for at least the last decade many of you have been on the forefront of trying to educate the public about the issues confronting us as a nation both on a human scale and an economic one. And trying to do all you can to convince our fellow citizens that this is an effort whose time has come. That we can no longer deny what is happening in our health care system, pretend that it will go away, try to pay for it over or tinker with the margins. That it is indeed time for national health care reform.

I'm very grateful particularly to Ron and many of you for the work that you've provided over the last year and a half as my husband hammered out his own health care opinions and looked for ways to provide a comprehensive approach. And many of you were in rooms for very long meetings and briefings and question and answer sessions that led him to his absolute conviction that health care reform is something that he intends to tackle. Now it is no surprise that we are quickly discovering that real change is hard and that there are many arrayed against change for the own purposes. But if you believe as we do that part of what this election we held was about was accepting responsibility for the problems of this country and being willing to tackle some hard choices then I hope that you will stay with us as we travel down this road together. It will not be smooth, by any means, but I am confident that at the end of it we will feel that we've made our contribution in trying to put our country on the right

track and solve a lot of our problems, most particularly health care.

I want to say just a few things to start with and then mostly spend my time with you answering questions that you have on your minds. Because this is an audience that is very well educated and sophisticated about the nuances of health care reform. I want to share a few thoughts with you before we move to your questions and my attempts at answers.

There are a number of very difficult decisions that will confront us as a country when we unveil our health care reform proposals. All of them require that our people have a requisite level of understanding about what is at stake in this health care reform debate. I cannot emphasize too strongly how all of your grass-roots public outreach efforts are critical and need to be doubled and re-doubled again. Because, in my many travels and conversations around the country I've experienced what I'm sure many of you did, which is a kind of mixed message coming back at me. Many people are concerned, in general, about the health care situation, many are concerned, in particular, about their own situation with respect to the cost of their own insurance or their lack there of or the many other issues that come our way in this debate.

But in my conversations I often find many people don't draw relationships between how all of these things fit together into the whole that we have to address. And it is so important that we draw the connections for our fellow citizens. Let me give you just one example. As Mr. Blendon and others have argued repeatedly over the last months, we have to explain this proposal to people in a way they understand. Right now most people seem to be satisfied with their insurance coverage but scared about losing it, having it diminish, having it increase in cost. They are reluctant to pay very much more themselves, either in the form of taxes or any other contribution, to help cover people who themselves are uninsured. Because there is an enormous amount of economic and psychological insecurity out in the country. It makes a big difference to people who are worried about their own insurance if they understand that part of the reason for the underlying insecurity they feel is because there our so many of their fellow citizens who are uninsured. And to explain to people that the uninsured in our country do end up getting care, but they get care at the most expensive point of entry by going into the emergency room, often after a condition has deteriorated or become more acute and they have not sought primary or intermediary care. They then are put into the hospital in a room next to someone with insurance which is one of the reasons why the person with insurance ends up paying $19 for a tylenol on his or her bill in order to help pay for the person in the room next door. Most people don't ever think of it that way, they don't

ever see the connections between uncompensated care and their own insurance bills. That is just one example of the many examples that we have to look for to help people understand what is at stake in this debate.

And there are really five words I'm using over and over and over again. Security, Cost, Quality, Choice, and Simplicity. Each of those five words stand for a series of attitudes, expectations, feelings, proposals that we hope we'll be able to make clear when we present a comprehensive plan.

Security is obviously number one. As Rob pointed out, this debate is being driven by people who will not have that sense of security even though they may be insured. When you have 100,000 Americans a month losing insurance, when you have employers shopping around and finding it increasing difficult to provide even the same benefits at the same costs with only inflation adjustments, when you have people who see their friends and neighbors being laid off or having their retirement benefits ripped out from under them there is a great deal of insecurity. So the primary objective of this reform is to make every American regardless of their insurance status today, regardless of their health status to feel they will be secure. They will have access to the health care system, they will be guaranteed a comprehensive benefit package, their package of benefits will travel with them from job to job, from state to state, so that they then can worry about something else. That security is key and don't just think about it in the terms of the uninsured, we can not when the national debate if that is the focus. The uninsured deserve to have security so that everybody will be more secure. Security is the first primary argument that underlies our hope to have universal access as quickly as we can realistically obtain it.

Second, cost. We have to be able to demonstrate that costs will be controlled effectively. And that through the effective control of cost will come a re-allocation of resources within the health care system that will do a better job taking better care of more people. And there are many examples that illustrate what we are talking about with respect to cost. And some of those I think can drive home our point again in ways that people understand. If people understand that the paper work hospital is growing 4 times faster than the real hospital and that much of their health care dollar, therefore, is going in to providing for clerks who are checking and filling out forms and insurance underwriters who are spending their time trying to figure out who does or does not need insured. And personnel and doctors, offices and hospitals who themselves are part of the paper work hospital that if we control costs what we are talking about is eliminating from the system a lot of those features that have very little or really nothing to do with the status of anyone's health. So part of what we have to persuade people is that we

are not asking them to pay more money for our health care system we are asking them to participate in a universal health care system that provides security and controls costs because we think there is money in there that can be better utilized than it is today.

Thirdly, quality. No one wants to do anything that undermines the quality of our health care system. That has to be the first and foremost position that we take when were talking about what we hope to see at the end of all this reform. It's high quality, good doctor-patient relationships that lead to better outcomes, more opportunities for people to get information about quality so they know about outcomes so they can be better consumers of health care. And in the quality debate that will take place I will predict to you that, that will be where most of the special interest focus their opposition. Nobody is going to run an ad which says don't pass this reform it will cut our profits. That's not how this is going to be played out. It will be played out with somebody in a bright coat, probably depending upon the market, a male, a female, a black, a hispanic but somebody looking very official in a white medical coat. Who in very kind of Marcus Welby says,"Be careful we've always had the finest quality medical care in the world they, they want to take it away from you." That will be the argument because that will be where peoples desire for security will run straight up against their fear of change. As bad things are now, as expensive as it might be at least we feel somewhat comfortable in it. And so the quality issue is absolutely key. And frankly if we don't do a good job trying to enhance quality we're not going to have the kind of reform that you and I would want to see.

Fourth, is choice. That will be the second wave of commercials after the quality commercials. "They want to take your doctor away from you, they want to prevent you from seeing who you want to see." They'll probably have some older person saying,"But I've always gone to the same doctor and now there going to take my doctor away from me", and having this bad looking doctor with a clip board, you know, with his head bent over. That is what the ad is going to look like. What we have to do is to have a health care system that guarantees choice in so far as we possible can and that we intend to do.

And then the final word is simplicity. We can't explain this to people. If they can't feel comfortable they'll be able to navigate their way through it then that too will be a roadblock to reform. And so those are the kinds of hallmarks that we're attempting to achieve in effort to put together this comprehensive package.

So finally let me just say that many of you have involved in working with the task force in providing substantive and policy and political advice of all kind and I'm very grateful for that. I think though that as hard as we all have worked to try to get to this point in time it is only the beginning. It is something that we have to see as a long term commitment because after we introduce the legislation we will have the enormous task cut out for us in order to educate people and convince the Congress to vote for it. Then after we pass the legislation we will have an enormous task to make sure it works the way we want it to work. And at every step along the way and at every level in the process we will make advocates grassroots organizations, people like yourselves who are there to not only help move it along but to understand what should be done to make it successful. And it is very important for me to stress that I view all of us as having the same objective. Though there may be disagreements, there may ways your organization would have done it differently than somebody else's organization, but what I hope is that in so far as possible we will have a united front on behalf of health care. Because believe me there are people out there who don't want anything to change and who will be loaded for bear as they say in Arkansas. And if we are not as strongly united and are willing to reach across lines that divide us in order to have as strong as front as possible we will be picked off one by one. They've done it before they will do it again My good friend David Pryor form Arkansas tried to do something about prescription drugs a couple of years ago. Drug lobbies went to the grassroots organizations and convinced a lot of them to stand up against drug reform by convincing them that it would take their drugs away from them. We have to learn from our mistakes, keep open lines of communication and be ready to be united in this effort. So with that Ron I would be glad to answer questions.

Question and Answer:

Q: Greg Hafley (National Health Law Program) Which is a legal services program working for low income people throughout the nation on health issues. And we applaud your efforts to work to cover the uninsured and to make access to health care more meaningful for people with medicaid. My question is can you tell us a little bit about how you envision having low income people, who are going to be subsidized in some fashion under health care reform, have access to the full range of plans based on what in theory may be some kind of limited subsidy? To make sure that those people are either not relegated to second tier plans or that, because of the limits in their subsidy their not subject to discrimination based on their financial ability to play by the plans that may want to keep them away or deny them care.

HRC: That's a very important question and one we have obviously given an extraordinary amount of thought to. Let me answer it in two different ways. We intend for the comprehensive benefit packages to be available to every American. That is not a negotiable part of any plan. That has to be provided so every low income person on whatever sliding scale with whatever amount of subsidy will have the same set of benefits which will be comprehensive as anybody else. So, if they choose from among plans we want them to be choosing, not on the basis of benefits but on the basis of other features. It may be that, as I have been traveling around the country and seeing how providers are beginning to think about this, it may be, as I've recently heard in New Orleans that a network of minority doctors is going to be trying to form itself into a health plan. So one person may prefer those physicians than another set of physicians. They may prefer an HMO or a fee for service network. But the level of benefits accessible to every American will be the same. There will opportunities for supplementals above that. That is something that, you know, is available at every country that were aware of. So that will be available, but that's why we want the benefit package to be a good one so that everybody is available, is able to get that.

Secondly, we have to beef up our public health infrastructure and then require that health plans utilize public health facilities as part of their integrated service network. It will not do us any good if we continue to have this desperate provision of health care that is not able to serve many undeserved areas in inner cities or in rural areas which is one of the whole reasons why we want to have an integrated delivery network. So we ought to have the plans have incentives and where necessary even requirements to make sure that all the people they are required to serve can be served. Because we except to have the service delivery area defined geographically by population and any health plan that wants to bid for those patients has to be able to show that they are going to provide access to services throughout the geographic area. The only way to do that in many areas is by linking public health facilities with private

facilities in that kind of network. So, again in Louisiana I had a conversation with the medical director at Oxners, which you know is a very well known tertiary clinic. Their already negotiating with public health clinics and others to be able to have this network.

Now, once we have a system in place that looks good on paper it's going to be up to consumers, it's going to be up to the people who run the alliances, which will have a lot of consumer involvement, to make sure it really works. Because you and I know matter how well you design a system there impediments psychological, geographic, cultural that have to be overcome. And so we're going design it in a way that we think will lead to that kind of positive outcome for low income people. But I'm not going to sit here and tell you that what's on paper is going to be translated in every community in America into what will work and that's why we're going to have to rely on the combination of consumers and oversight from the state and federal government to make sure every plan delivers to their low income members as well as the others.

Q: Sarah Casson (American Heart Association) Again, I just would like to thank for all the attention your putting on prevention. So many cardiovascular diseases are preventable and as you probably know tobacco use is the number one cause of preventable death in the United States. I would like to encourage you, I know there is a lot of talk about including an excise tax on tobacco in the health care reform package as a way to reduce consumption as well revenue enhancer. But I would like to just ask what kind of considerations your giving to other prevention issues regarding tobacco? You mentioned that pharmaceutical companies and the administration has been very outspoken about concerns with them. But the tobacco industry is completely unregulated. And not necessarily within this health care reform package but I'm wondering if you could speak to what the administration might do later on prevention and regulating the tobacco industry as far as advertising and things that go into their products?

HRC: I can't really speak on that I've only focused on this one issue and that is the advisability and amount of any excise tax on cigarette themselves and what that would be used for in terms of a designated funding stream within the health care reform and I haven't really gone beyond that.

Q: Sharon (American Physiatric Association) We're very encouraged by the activities of the health care reform task force as it applies those poor folks with mental illness and addictive disorders. Can you tell us in a benefit package will it end the discrimination against persons with mental illness and addictive disorders by providing parity and coverage with other chronic illness such as diabetes or hypertensive illness?

HRC: I doubt it. I don't think we can afford to do that at this point. I think that what you will find in the comprehensive benefit package is a very important statement that mental health and substance abuse are part of a comprehensive health care reform package. They will be covered and we will looking for ways to expand that coverage over time. But I can't, I 'm not going to sit here and tell you that it will be parity. I don't want mislead you. I think we are engaged in a great battle, as you know better than I, to convince anybody outside of a very few that are already convinced that it should be in there at all. And that the costs dependant on trying to mandate a benefit package which includes mental health coverage of a significant amount plus substance abuse coverage is appropriate. And, so I think we're going to make a very good beginning, we will establish the legitimacy, we will create the opportunity for infrastructure and we will continue to build on that. But we can't, we can't I think financially or politically at this point claim we could reach parity with this first package.

Q: Judy Riggs (Alzheimer Association) And I just want to congratulate you and thank you for all the emphasis that has been put on long term care in this package. We represent probably 1/2 the people who are in nursing homes, but we still believe though the emphasis on home and community based care is absolutely right. That's where most people who need long term care are and that's where they want to be. And in fact it really is the public-private partnership we want between government and families. Can you talk at all about how you would structure that benefits so that it really provides the flexibility for families and people to get what they want and we don't end up with another medicare home health benefit that doesn't really help on long term care?

HRC: Right, I think that we are committed to providing a long term care package that makes a good start on creating a national infrastructure for long term care by emphasizing home based care, intermediary care and by doing it in partnership with the state because a number of the states are way out ahead of the federal government. They have been modeling some very effective programs that we think can serve as a model for the entire country. We also want very much to encourage intermediary care in settings like resent settings, day care settings, congregate housing. Things short of nursing homes in which families can participate in the ongoing care of their relative maybe not be able to shoulder the entire burden but to whatever extent feasible participate financially, and psychologically, emotionally, physically. So those are the kinds of values that are guiding us. And we think it is very important to make a statement now that long term care does not equal nursing home care. Long term care has to be part of our whole approach toward providing security and choice as I mentioned before. So we think that we

can actually cover more people in ways they want to be covered by eliminating the incredible preference and even requirement for nursing home care. And instead shifting resources, creating a new infrastructure, providing incentives for people to stay in their homes or into one of these intermediary steps and that's what we intend to do. And we intend to get as much as start on that by funding as much of it as we can as soon as possible. But we want to do it in a reasonable effective manner. And although there are some states that are way out ahead of the rest of the country, most states are not. Most states have largely responded to the nursing home lobby and built more nursing homes, more beds, required people to spend themselves down in order to get into that. So we have to change attitudes, and change the incentives and create infrastructure that will actually work.

The other piece of that is we have to provide more flexibility in a lot of the existing funding streams so that workers, para-professionals can go into homes to help families. You don't have to have registered nurses doing things that some one at a much less cost can do more effectively within the context of a home. So there is a lot of things, and I know Judy you know that Robinwood Johnson Foundation and others have been trying to fund programs to show us the way as to how to be more effective, reach more people, treat them with respect and give them choices and that's what our long term care program will be aimed at doing.

Q: Pat Weiss (Grey Panthers) There is a doctor in Northern Virginia who has diagnosed our society as having a terminally ill, we're a terminally ill patient due to greed. I hope that you will harness the greed of the doctors and hospitals and the pharmaceuticals but I would go further in suggest that you totally eliminate the health insurance companies. I can't see any real need for them in our, there rather superfluous and we pay there profits as well as all the paper costs, I think you see what I mean. Are you going to eliminate them?

HRC: No, but it's going to be kind of a Darwinian struggle for them for a change, and only the best and the fittest will survive instead of what we currently have. Moving from where we are to what our vision for health care in our country is, is going to require a necessary transition period. Health insurance is actually a relatively small part of the over all insurance business in this country. There are a number of insurance companies that have seen the writing on the wall and have moved more toward trying to work with large employers, for example, to help them understand the health care system and to be more effective consumers of it. So I predict that we will still have a health insurance industry, it will be a lot less than it is now, there will be far, far fewer companies and they will like everybody else go back to making money the old fashion way, a little bit of money and a lot of people. Instead of what they

have been doing which is through underwriting practices, eliminating anybody who ever might get sick. And so I think what we're looking at is a reasonable role for those insurance companies that survive this transition.

And the other side of the coin, you will also hear a lot about this depending upon what state you live in. The elimination of insurance companies means the elimination of lots of jobs of lots of people. Many women, many clerical workers, many people who I know because of these changes will be unemployed within the next several years, that is not an easy prospect to contemplate. There will also be significant unemployment in the paper work hospital, whether it's billing departments in hospitals or clerks and doctor's offices. The entire underwriter industry will be decimated in terms of health care. So when we're talking about eliminating anybody we are talking about social costs that I think we have to be very sensitive to because those people have to make a living and they have to put food on the table and they have to take care of their children when there sick.

Now the other side of the coin is that I anticipate an increase in employment in health care providers as opposed to paper pushers. And so that will occur and the net gain and the net loss we hope over the next several years will be basically a wash. And it will be good for the economy because we will be freeing up money that can be invested in other things and we hope put people to work making cars or widgets or what ever else they do. But don't over look the fact that in certain key states like Connecticut this reform will cause the shut down of insurance companies, the layoff of workers and it will have political as well as economic costs and those of you who are advocates need to be sensitive to that. It is not enough just to say eliminate the insurance companies when you go in to talk to the 2 Senators from Connecticut. You're going to have to be sensitive to what this means economically even though in the long run, I would argue in the medium term run the changes will be good for the economy of every single state. In the short term there's going to be some dislocation and some real loss that we are going to have to be willing to face up to, admit and then help deal with.

Q: Dan (National Council of Senior Citizens) For our organization thank you for your good works. I've got two brief questions. One, what is your sense of the wind, the schedule, the integration of medicare into the national system that your describing, number one? Number two, what is your sense of the level of involvement of consumers in the governance of help alliances or ? in terms of quality insurance, in terms of peoples rights and in terms of the confidence in the system?

HRC: Let me answer the second first. We anticipate a significant level of consumer involvement in the governing of these entities both in decision making roles and in evaluation and analytic roles. Part of the reason we hope this works the way we are talking about it, and that many of you have helped this thing through, is because we will make a better consumer out of people who are now in the health care market by giving them adequate information, by giving them roots to question decisions, by giving them the opportunity to really walk with their feet. They will no longer be tied to an employer's plan, they will no longer be tied to any particular plan, they will be able to vote with their feet as long as they are well informed about their choices. So consumer guidance on that is going to be key and I can see a whole new out growth coming up of newsletters and magazines, "Enter health plan", you know. Back and forth discussions about what works and what doesn't work and why does our health plan not have as good an outcome for, you know, heart disease as the health plan across the river. I mean I think there will be a great opportunity that many of your organizations will seize to help educate us. Right now American consumers are not well educated about their health choices so we have to involve them at every level of this process.

With respect to medicare, there will be, over time, a phase in of medicare we believed based on the objective reality that it will be better off for Senior Citizens. That it's not something that we are going to come out of the blocks with and say, " we're going to put all these big systems together" because we know there's going to be inevitable transitional problems that we are going to have to overcome. And we're not ready to just take medicare and try to start from the very first day try to integrate it. But we hope over time the integration becomes obvious and that we begin from the very first day to make the case for integration and move toward it but not start with it. And the time table on that I don't really know, it kind of depends on when we pass the legislation, when it gets implemented, when it starts proving itself so we can then move toward a truly integrated health care system that includes medicare.

Q: Marty (American Association of Dental Schools) I wonder if you can tell us whether the basic plan will include a least relief of pain and removal of infection when it's in the mouth? There have been lots of different reports about what your thinking is.

HRC: I hope so, I hope it includes dental care for children and acute dental care for adults. That's what we are hoping for.

Q: inaudible (President, National Association for Home Care) I to would like to join in thanking you for what you have done. I think it's historic and I'm reassured that you will be successful working together with all of us in getting your plan through. My question relates to the most devastating epidemic that's faced this country in some time. And that is the epidemic of AIDS. And I'm wondering what is the present contemplation of the task force in terms of dealing with this problem? And it's a very difficult problem, as you know, and I'm just wondering what your current thinking is with respect to it.

HRC: Our current thinking is that AIDS will be treated like any other disease and with respect to the removal of pre-existing conditions it will certainly no longer serve as a bar to health, access to health care. A lot of the difficult issues about a disease like AIDS revolves around experimental treatments and research. How much we're able to really direct our attention to that within the context of the health care reform plan I'm not sure of. But in terms of treatment that is currently available and considered medically eficatious, you know, that will be available part of the comprehensive benefits package. Just as it would be if you had Multiple Sclerosis, Diabetes or any other chronic and perhaps eventually terminal disease.

Q: Terry (Human Rights Campaign Fund) Specifically in dealing with life threatening and serious illnesses many times there is no treatment that is approved and has been proven effectuates or some times even safe. Very often it's the choice and individual has to make weighing the risks and potential benefits of a treatment in determining whether or not they are going to use it. When you are looking at a life threatening situation if we remove availability of these treatments very often what you are telling people is that have no choice except to face the uncertainty of their illness and prognosis. And as a follow up to that also I know that there is a lot of support developing on the Hill for investment in medical research as part of health care reform. And I'm hoping that we will be able to build a bi-partisan alliance between the administration and Congress in pushing that forward. Specifically there is a proposal for a medical research trust fund, I'm hoping that you can comment on that.

HRC: I'm aware of that and I think those are all very important issues that we have to look at carefully. I'm a very big supporter of medical research and how much money we're able to put into medical research and where we direct it to go, what we think the cost-benefit analysis is with respect to research dollars and outcomes, is something that we are looking at very carefully. And I just can't tell you what the position of the administration will be about that. I know the options that are out there but that is something we have not made a determination of.

Q: Carolyn (National Association of Rehabilitation Facilities) And my question to you would be similar in considering the core benefits package. Whether or not it would be including medical rehabilitation services and if so if there are any limits what they might be?

HRC: You know, I don't, I can't answer that specific question. I'll find out for you and let you know, I just don't have that off the top of my head.

Q: Sam (National Caucus and Center on Black (inaudible)) I wondered what kind of specific expeditious procedures are you going to put into effect to insure minority providers as well as minority beneficiaries that they will be properly treated, that there will be a prompt procedure for dealing with any complaints that they might have?

HRC: Well I think that we will have a grievance procedure, and (inaudible), some kind of mechanism within the help alliance and within each health plan that will be available to every citizen. And again it's going to require individuals to become well informed and to make choices that are right for them. So we'll have the mechanism there but then we're going to have to do a lot of grassroots work to make sure people know about the mechanism and are well informed advocates for their own case. So that they can make best use of that. But that will certainly be one of the built in protections that I think will be especially important for low income consumers and minority consumers in many communities.

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Divider Title: S.E.I.U. 5-26-93

THE WHITE HOUSE

Office of the Press Secretary

Internal Transcript May 26, 1993

REMARKS BY THE FIRST LADY
AT SEIU

MRS. CLINTON: This must have been some concert in here -- (inaudible). (Laughter.) I'm just probably grateful I wasn't here in the beginning. (Laughter.)

But I am very honored to be here, and honored to be introduced by President Sweeney. There is not anyone whom I have met in the months that I have worked on health care reform who is more knowledgeable, more committed, and more convincing about the needs of change than President Sweeney.

I also want to thank all of you, because in this room are health care workers and health care leaders. And many of you know from the front line why this campaign for health care reform is long overdue. (Applause.) You see it every day. And I remember so well during the Democratic Convention the sign that read "Affordable Health Care For Families." That was a good slogan then and it's a good slogan today. (Applause.)

You have kept health care reform on the national agenda, never wavering. Everywhere I went during the campaign and since, I have seen signs held up by many of you and your colleagues. The health action teams have been there everywhere we have gone. And the reason it's been so significant is because your constant presence speaks volumes about what is at stake.

If the people who are caring for our fellow citizens in hospitals and nursing homes and so many other settings understand so well why we need reform, you can lead the way for so many of our other citizens who understand what is at stake. This is a debate not just about reforming our health care system; it is a debate about setting the direction for our country. We have to change the way we provide health care not just because of an economic issue -- but it is a very big one; not just because it's an individual human issue -- but it is. You see it every day. But because at this point in our history, this country can no longer stand alone among its major competitors of industrialized countries in the world and not provide health security -- (inaudible). (Applause.)

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You know better than most the problems facing you and me and every other American. You know that one out of every four of you in this room risks losing the health insurance you now have, in the next two years. Just stop and think about that. You are in this room among the insured, by and large. And yet you can't be secure that you will have your insurance. Every year, millions of Americans are on the brink of losing their insurance and two million a year do. They may lose it for a month or two or six months or a year before they find a way back on to some insurance rolls. They may -- usually do -- pay a lot more to be able to get back to being insured. And every month, 100,000 Americans don't make it back on those health insurance rolls.

Just think of how you will feel because you have seen this in your work. All of us know personal examples of people who are in between insurance, were laid off, were let go, found the cost too high. And it was just at that moment in time that fate struck. It was then that the child got sick. It was then that the parents faced some terrible tragedy. It was then that they needed insurance, and they didn't have it anymore.

And then, when they tried to go back to get it, maybe they got a new job, maybe they were brought back to work after that layoff, that they found the employer's cost-cutting rules had changed policies on them. Not only had costs gone up, but now preexisting conditions stood in the way of being insured. That child was a problem. That spouse with the illness couldn't even be covered, or, if covered, only at a very high cost.

Think about what millions of insured Americans go through every month. And think about how many more of us are no longer secure, we can no longer take for granted that we are employed and our employer provides insurance, that it will always be there for us when we need it. We also no longer can count on insurance covering us in the event that awful accidents or unpredictable illness without grave financial cost and even the prospect of bankruptcy.

Security is what this health care debate is all about. Can your family find peace of mind? Can you, or your child, or your parents get the quality of care when you need it most? That's what we have to be focusing on every single day. We have enough insecurities in our world today. We see it all around us. Americans who work for a living, who pay the bills, take care of raising their families should not be burdened by the insecurity of now knowing whether they will have health insurance. (Applause.)

Those of you who are on the front line with health care workers have a tremendous amount at stake in health care reform. You

know that better than I. You see it every day -- your job, your livelihood, the quality of your workplace. But you know more about the problems in our system than most of your fellow Americans. And I ask you to talk about those problems with the people you see. Talk about it at the coffee shop, at the supermarket or at church or at dinner. Make sure that what you see every day in a system that is not a system any longer, in which people fall through the cracks through no fault of their own, make sure that comes alive for everyone you reach.

Talk about the hard choices you see being made. People being discharged from hospitals with prescriptions in their hand that they cannot afford to fill. (Applause.) How, when they try then to self-prescribe for themselves by saying, well, I'm supposed to take four of these, but I can only afford to take one of these, maybe that will help -- how they end up back in the hospital, which costs us all and the insured more money. (Applause.)

Talk about the time you spend filling out forms instead of taking care of people -- (applause.) You know better than any that a paperwork hospital and a paperwork nursing home and a paperwork doctor's office is growing four times faster than a hospital -- (inaudible) -- (applause.)

Make a little experiment sometimes. Collect up blank copies of all the forms you have to fill out. Okay? Take them and show them to your friends and neighbors. Hold them up and say, if you look at all these forms -- (inaudible) -- 1,500 different insurers and the government, they all ask for about the same kind of information, but you have to fill them all out individually because they won't take somebody else's form. Talk about the hours and waste and inefficiency that causes to you. I'd rather have those of you who are front-line health care workers making sure that I and my family and yours get better instead of dotting every I and crossing every T. (Applause.)

And one of the promises of health care reform is we're going to eliminate the ridiculous paperwork and administrative -- (inaudible) -- (applause.) Talk to your friends and neighbors about what you see every day in terms of price gouging, cost shifting, unconscionable profiteering. Explain how you see the system is being -- (inaudible) -- and ripped off because it has no real discipline -- (inaudible) -- (applause.)

Part of the reason we are in this spiraling cost explosion which makes it impossible for us to feel secure that we will be insured even if we currently are, because too many -- (inaudible) -- people have made too much money off of eliminating opportunities for caring for people instead of expanding them. We

need -- (applause) -- to get back to a system that values added -- (inaudible) -- the quality of care that is available to every American. And we need to have a budget for our health care system just like we budget everything else, so that people will know their primary responsibility is to take care of people, not to enhance the profits of all -- (inaudible) -- (applause.)

You are also, though, consumers of health care. And we want to make you better informed consumers. We want you to be able to choose your health plan, not to be required to choose only the health plan offered by your employer but to make real choices. We want to give you good information so that you can make good consumer choices among health plans.

Most people have health insurance that they don't understand as well as the car they drive. (Applause.) (Inaudible) -- car than you do for your health insurance. And I wouldn't want to embarrass myself or any of you, but I bet we couldn't really explain everything about our health insurance policy to each other if we tried. We don't get the information in understandable forms. We cannot comparison shop. We can't make good decisions that may be right for my family but wouldn't fit your family. So we need a system that promotes consumer awareness, information and choice.

The system that will be proposed will do all of that. Because among the absolute bedrock principles that we want to abide by is consumer choice as much as possible within the health care system. You know, the surest way to get an institution or an individual to change in business is to walk away when you are -- (inaudible.) Right now, we can't do that in most instances. In a new plan, every year you'll be able to comparison shop and join the plan that you think is best for you. And that will send a very good messages to those plans you do not choose to join that they had better change to get your business. An educated consumer in a health care field is one of the surest ways of controlling costs and maintaining quality. And we intend to have Americans be educated consumers and make good decisions for their own health -- (applause.)

We want security for every American. We want to control the costs in the system so that we can reallocate the money that is there so it could be used for taking care of people. We want to ensure quality and give you good information so that you can be judges of the quality of your health care. We want to give you choice among health care plans so that you can decide what is best for your family based on the comprehensive benefits package that will be available to every American. And then you can decide if you want fee for service like you have now, if you want an HMO like you have now. Do want a particular kind of service that may be available in

one plan but not in another? You will be able to make those kinds of choices.

Now, is this going to be easy? No. The status quo exists because there are people who benefit from it. There are interests who see the same statistics and hear the same stories that we do; who meet people who are afraid they're going to lose their insurance or who through no fault of their own already have, but they -- (inaudible) -- just the price of doing business.

We have to be willing to commit ourselves to these fundamental values about what the American health care system should be founded on. We have to be willing to take on every special interest group. We have to be willing to stand up and say we are going to put the American people and their health first. (Applause.) We have to be willing -- (inaudible) -- what will be a very hard-fought battle over changing this -- (inaudible.)

And you know as well as I do that there will be many arguments marshalled against reform. The strongest will be that if we change it could get worse. It's sort of hard to imagine the cost going up $100 billion a year, with millions of people at risk of losing their insurance and a 1.2 million every year losing it, with it costing more and more and delivering less and less; it's hard to imagine how these proponents of the status quo will be successful with that argument. But don't ever underestimate their capacity to confuse the issue, to scare people, to use tactics that will be very difficult to -- (inaudible.)

But we have a lot of arguments on our side. You know you can be the leader in getting this argument across, because we know that if we do nothing, we will not stand still, we will go backwards. We know if we do nothing, there will be people who will continue to profit from our existing system -- (inaudible) -- will go without care, have to postpone care, be bankrupt by obtaining care.

So I ask each of you to continue what you have begun. Stand up for the kind of health care system that makes sense, that will save money, will eliminate fraud and abuse, will focus on quality, will provide a choice, and will in the long run make this country and everyone in it more secure and healthier. If the debate is fought out on those terms, then by this time next year, I will be getting ready for the celebration -- (inaudible) -- President meeting and signing this. (Applause).

Thank you.

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Divider Title: B-B-Q 6-8-93

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release June 8, 1993

REMARKS BY THE PRESIDENT
DURING CONGRESSIONAL BARBECUE

The South Lawn

8:55 P.M. EDT

THE PRESIDENT: Thank you. Please sit down. Thank you very much. We just want to welcome you here. The big bonus of this evening is there are no speeches and no politics, and I just want to welcome you here and thank you for coming.

I also want you to know that this tent now has a hallowed heritage. On Saturday night I had my 25th college reunion under this tent and nobody left until 1:30 a.m.; so don't feel bashful if you want to stay awhile.

It is always a privilege to serve our country, but this is a unique time for all of us because of the point in history in which we find ourselves. And I just thought it would be great if we could get together and enjoy each other's company, get to know each other a little better.

I thank you all for coming, all of you for bringing your spouses, your staff members, your friends, and I hope you enjoy yourselves tonight. This is, after all, your place. I'm just a temporary tenant. I'm glad to be here, glad to welcome you here, and I wanted Hillary to say a word, too, because we're both so pleased to be a part of this evening. Thank you again for coming. (Applause.)

MRS. CLINTON: Thank you. Thank you very much. I just want to add my word of welcome, and it is really a summer celebration tonight. It's the first real day of the Washington summer for those of you who have never experienced it before. And one of secret weapons that Arkansas produces is being served tonight, and that's a tamale from a place called Doe's. Any of you who were in Little Rock in the last year know that, and they're back by special request and demand.

But we're just delighted to have you here. We're delighted to have a chance to visit with you. And we're going to have some great music, in addition to what we've already heard in just a minute, from a group called "Riders in the Sky," if any of you have heard them. And so enjoy yourself and I hope we get a chance to visit some more. Thank you all.

END 8:58 P.M. EDT

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Divider Title: C.H.A. 6-9-93

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release June 10, 1993

REMARKS BY THE FIRST LADY
TO CATHOLIC HEALTH ASSOCIATION
VIA SATELLITE
JUNE 9, 1993

MRS. CLINTON: (In progress) Millions of other Americans are gripped by fear that at any time they could lose their benefits. And every year, two million Americans do lose them. They may lose them for a month or two or six months or a year before they find a way back on some insurance roll. And they usually pay a lot more to be insured again. Still, every month, 100,000 Americans fall off the health insurance rolls. Others stay in jobs that they want to leave because they can't take the risk of being uninsured. And many families find they can't get coverage for the very problem they need care for, because that illness is stamped a "preexisting condition."

Americans who work for a living, who pay the bills and take care of raising their families should not be burdened by the insecurity of not knowing whether they will have health insurance. Security is what this health care debate is all about.

Once the new health care plan is up and running, everyone will get a health security card which will guarantee all Americans access to a comprehensive package of benefits, no matter where they work, where they live, and whether or not they've ever been sick before. Security, no matter what, is the first condition.

Second, we're going to work together to make sure that health care costs are brought under control. You see every day what happens when health care is priced out of the reach of many Americans. It forces you to absorb more red ink, and many other segments of the health care system to shift costs, and all of us bear the burden. Left unchecked, health care costs will continue to hurt our families, bankrupt businesses, and drive the federal deficit to ever greater heights.

Our reforms will rein in health care costs through several measures. We will strip away the incentives from rewarding doctors who do more tests and procedures, and instead will create a system that encourages cost-effective, high quality care where a doctor and a patient can again be at the center of the relationship

MORE

and where decisions can be made not on how something will be reimbursed, but what a doctor believes is best for a patient. We will reduce the bureaucracy and micromanagement that bloats our health care system and that so many of you have complained about because it adds unnecessary costs.

Finally, we will say to all health care institutions and providers, just as you recommended in your proposal, we must live within a budget, and we must reallocate our health care resources within that budget away from paperwork, administration, insurance costs, into what matters most, caring for people. We're going to ask everybody -- workers, employers, providers, doctors, nurses, hospitals -- to chip in and do their part for health care. And to the drug companies that charge two and three times in America what they charge overseas, we're going to say, bring your prices down. It's only fair.

I can remember so well sitting in the St. Vincent's waiting area and talking with a friend of mine who's a physician there who told me that every day he discharges somebody from the hospital who needs continuing prescription medication to stabilize a condition. And every day there is at least one patient whom he knows cannot afford the drugs he prescribes. And so what often happens is that patient decides not to take those expensive drugs, or to self-medicate. Instead of the four a day required, maybe only one to stretch them a little further. And, sure enough, it's not too long before that patient ends up back in the hospital, costing all of us even more.

To the businesses who don't cover their workers today, yet take advantage of your hospitals and, therefore, drive up the costs for the businesses who do cover their workers, we're going to say it's time for everyone in America to take responsibility. It's only fair that we all pay our fair share.

To the individuals who think they can get by without coverage and have that terrible accident or that unpredicted illness and end up in the emergency room or in the ICU and, therefore, we all pay the bill, we're going to say, you, too, must do your part. If you can afford it, or whatever you can afford, you must contribute. It's only fair. We will all benefit if we all take responsibility for our health and for each other.

Third, our reform will reduce the waste that eats up our health care dollars now -- and so much of your time. Another key component of reform will be a wholesale reduction in the frustrating and wasteful paperwork that eats up the health care system. You all know very well what the load is like, and when you look at the number of rules, the volumes of regulations, the stacks upon stacks of

forms, you have to ask yourself, where did all this bureaucracy come from?

The short answer is it comes from everywhere. It comes from private insurers, it comes from government. Forms were created to make sure that the most vulnerable people were getting proper care. Then more forms were created to make sure doctors and hospitals didn't perform unnecessary tests and procedures. Then the insurance companies have their own sets of rules for doctors and nurses to follow, so they create their own forms. And as the number of health insurance companies grew -- today there are more than 1,500 -- so did the number of forms. The result: Instead of a system where forms enforce the rules, we have a system ruled by the forms.

Patients don't know how to read their bills or make sense of their insurance policies, and worry they'll be left hanging because they didn't understand the fine print. Doctors and nurses, especially nurses, spend as much time dotting Is and crossing Ts as they do taking temperatures and carrying for patients. One of the nurses I spoke with told us she entered nursing because she wanted to care for people. She said that if she had wanted to be an accountant, she would have gone to work for an accounting firm.

And for every new doctor an average hospital hires, it hires four new administrators. It's a bad case of the tail wagging the dog. And we're going to take that administrative mess we now have and clean it up for you and for everyone. We'll see a health care system that is made easy. One insurance form for everybody. A quality check form -- no hidden fine print. And we're going to reduce the paperwork and streamline the regulations. Doctors and nurses will be able finally to do what they were trained to do. At the same time, we will maintain and enhance the quality of American health care by measuring quality based on results, not based on micromanagement and forms.

Fourth, this reform will make a serious start at addressing the growing long-term care problems our country faces. Now, many will argue we should put off consideration of this issue. While it would be too costly to try to meet all of America's long-term care needs at once, it would be irresponsible for us not to make a start, to try to get ahead of the aging curve. Today there are too few options for people hoping to stay at home and out of institutions, and too little help for families doing their best to care for ailing relatives. Individuals and their families, as you know, are often bankrupted by the cost of long-term care, or at least forced to spend themselves into poverty and turn their backs on their older relatives. They can't get help until they have almost nothing left.

The system is complex and disjointed and it fragments the care people receive. If the long-term care system is left unchanged all that will only get worse.

Most of you know Monsignor Charles Fahey. Monsignor Fahey served on our working group on ethics, the group charged with making sure that the system we develop is driven by fundamental values, shared responsibilities, social justice. Monsignor Fahey has confronted the fragmentation and backward incentives of our long-term care system firsthand. He took a month off this year to care for both his parents, seriously ill, in order to keep them out of a hospital or a nursing home. As he struggled to nurse his parents back to health in ways that met their needs and maintained their dignity, he took on a system that looked at the moving parts but never at the whole person. As the Monsignor put it, "We've got a system that cares for the eye or the foot or the nose, but never for Charlie or Elizabeth."

Our reform will reverse the incentives and expand the options for care at home and improve coordination of services. Another example from my visit to St. Agnes: That hospital, as many of your does, runs an adult day care center. And what they found is that they couldn't get reimbursed on even a sliding scale to help keep their patients and their families from the neighborhood at home. And so what often happened is that, although nursing home care was so much more expensive, the $35 a day for adult day care in a hospital setting was beyond the financial reach of so many families that they went ahead, met the Medicaid requirements and, very regretfully, put their relative in a nursing home.

It wasn't the choice they wanted and it cost us more money. How much more sensible we will be if the St. Agneses and the St. Vincents and the other hospitals in your association are able to reach out and help families make this connection to be able to serve their older relatives.

We'll make a serious start on improving long-term care coverage for the elderly and disabled Americans by expanding home and community-based care. People with severe disabilities will have access to a broad array of services, coordinated by a case manager, tailored to individual needs. By expanding the availability of home and community-based care, we will give seniors and disabled citizens who can't manage on their own the opportunity to remain in their community for as long as possible.

Lastly, we will improve the availability of health care in the areas that have been traditionally underserved -- rural communities, urban centers and other parts of the country where a

health care card alone will mean little to people unless we guarantee that services will be there for them.

Americans everywhere need to know there will be a doctor and a health facility available to them. This is a problem that the Catholic Health Association knows very well because your members have helped to address the problem in many rural and urban poor areas. I am especially proud that one work of the Catholic health care providers in Arkansas was recognized this year, and I'm speaking about the wonderful work in caring for the needy by the St. Elizabeth Health Center in Gould, Arkansas, which serves a community that other health care providers have abandoned.

For the 1,500 residents of a community like Gould out in the country, the nearest doctor was out of reach. Many people didn't have transportation and couldn't reach even the facilities 18 miles away. But about three years ago St. Elizabeth's set itself up in an old police station and it's been filling the critical health void in that community ever since.

The President's plan will bolster these efforts by targeting funds for areas that are now undeserved. And the plan will strengthen the health care infrastructure in these areas by linking community based centers to other hospitals and providers and will provide incentives for the national health service corps and other programs to encourage doctors to practice in remote parts of our country.

This plan will make sure that all America is cared for, just as you've recommended, with integrated delivery networks where all of our providers, doctors and nurses and others will be connected up to give care in areas that traditionally have been overlooked. We've gotten away from that. We've watched bureaucracies and paperwork and red tape distance us from the human caring that needs to be at the root of any health care system.

We can't wave a magic wand and reverse time, but we can try to reconnect. I know that CHA members try every day to inject that extra bit of humanity and caring into the system. That's the kind of effort that can make all the difference at those moments when we find ourselves, as I have, dependent on each other.

This is what I hope: that in a few years we will not only have a streamlined more efficient system, that we will not only have a better distribution of health care professionals and have more primary and preventive health care physicians and nurse practitioners and physician's assistants, that we will not only have better access, but we'll feel better about ourselves and about each other. We won't

just be healthier, although that's a tremendous goal in itself, but we'll all be part of a community of caring again.

Thank you very much for being part of that community now, for thinking hard about how we can expand it to every American, and by standing behind the reforms that need to be made. Thank you all again.

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Divider Title: Bethune Dub 6-10-93

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release June 10, 1993

REMARKS BY THE FIRST LADY
AT THE BETHUNE DUBOIS FUND DINNER

Sheraton Washington Hotel
Washington, D.C.

MRS. CLINTON: Thank you very much, C. Delores, for that kind introduction and for the times we have spent together in the past. Thank you, also, Mr. Hill, for your chairing with C. Delores this evening and this fund. And I want to express my great honor at being here this evening with so many distinguished members of Congress, so many leaders of business and of other parts of the American economy, and especially with the honorees. As C. Delores said, this is not a big day for anybody else but the Clinton family. But when somebody graduates from 8th grade who you still think is not yet ready for kindergarten, it's a traumatic day. (Laughter.)

And we've been celebrating it, it seems, ever since about 9:00 a.m., and it's not over yet. And so I regret that I've not been able to be here for the whole evening and that I will have to excuse myself after my part of the program. But, apparently, when you're celebrating an 8th grade graduation, you just have to keep going until you drop, and that's what we're about to continue to do in my house.

This is an important occasion, in addition to honoring the honorees who are here. Their work obviously speaks for itself -- the kind of leadership that they have given over the years to the NAACP, to the UAW, to Illinois and now the United States. But it is also symbolic because these are three of the many people in this room who have stayed the course, who have remained committed to the possibility of change in this country.

It has not been an easy journey. There have been many obstacles along the way. The change that we seek now is not going to be easy. It is not going to be, as C. Delores said, always free of controversy. But if we remain committed to the vision about where we are going together, and if we recognize that there are those in this land who do not want any progress for anybody, anywhere, anytime, and that we have to understand what we are up against when we talk about

change, when we have to recognize that the kind of change we want to see that takes us far beyond where we find ourselves today, that really does provide true economic opportunity to people and not just lip service, that restores the dignity of work to workers, that gives people the opportunity again to have the kind of future that we talk about, then we know we have our work cut out for us.

But I would not be here tonight, and nor would you, and the three people we honor tonight would not be sitting on this dais -- and I see Dorothy Height, who has been at this longer than I can even dream, shaking her head up and down -- we wouldn't be here if we didn't believe change was possible and we were not committed to bringing it about together. (Applause.)

You know, for the first time in a dozen years, we have a chance to do some things together that will really touch people's lives where they live every single day. The members of Congress who are here tonight have voted courageously in the House to lift people out of poverty, not just to talk about it, but to do it. (Applause.)

The earned income tax credit is the greatest step for liberation that we have had in a generation, because it will say to people who are out there working, people who are serving us dinner in this great hall tonight, people who will clean up after we leave and go home and get up tomorrow and start again -- it will say, you are a worthy, dignified person, and we're not going to let you live in poverty in this country any longer. (Applause.) And they have voted for that.

They have also voted to end what I think is one of the disgraces of our time. That this country, of all countries in this hemisphere has the third worst rate of immunizing our children of any country. And why? Because we just haven't put our mind to it and our resources to it. We have let children die of measles in Los Angeles, in Philadelphia, in Houston, because we just haven't valued them.

The members of Congress who are here tonight in the House have voted to put an end to that kind of human waste and neglect. (Applause.) And they have also said that it's not going to be business as usual. We cannot make the kinds of investments we need to make in jobs, in education, and in changing the way this country does business if we don't change our spending priorities and get our house in order.

So there is a lot that we have already done together. We have opened the franchise, and many of you worked on that for a long time to finally pass the Motor Voter Act. Do you know how long that took us? (Applause.) I could remember years ago thinking that

if we just amended the Constitution to let 18-year-olds vote, we'd have a new world. And then I realized it didn't mean a thing on a piece of paper if you had county clerks all over the country who could figure out a million ways to prevent you from ever registering to get to vote. And so we've had to change that, and it's taken a long time.

And we have finally passed the Family and Medical Leave Act. I don't know if you've met anyone, but I have, who's been fired from their job because they chose to sit at the hospital bed of a child who was sick, or to take care of an older relative who needed some help. That won't happen in this country anymore, and it should not. And that is another tribute to the members of Congress who are here tonight. (Applause.)

So is it going to be easy? No. Is it going to be free of controversy? No. Are we always going to agree, even those in the same tent trying to move in the same direction? No. But, you know, there are hopes that bind us together, common causes that link our hearts and our hands. And I'm in it for the long haul. I want to live in a country again where I don't have to feel ashamed because anybody is left out or overlooked, or in any way rejected because of who they are by birth or status. I want to live in a country again where I can go to any park at anytime with my daughter and watch children playing without fear and watch older people sitting in the sun because they're glad to be alive. And I want to live in a country again where everybody who wants to be able to seize the American Dream has a chance to do it. There's a job there, there's opportunity, there's education. That's what I want for my daughter. That's what I think we all want. And that's where I think we're going to end up if we can stay committed to the course ahead of us. That is why I am so honored to be here to make this presentation. Because I've had the opportunity to watch and get to know and get to call a friend the next person whom we honor.

You know, when the voters of Illinois, which I have to brag is my home state, sent their new Senator to the United States Senate, they may not consciously have had in mind the prayer I want to share with you, but it was in the air.

There are a few lines from a prayer written by W.E.B. DuBois, but I think we all, who care about public life and certainly are in a position to serve, need to remember. Because, in this prayer, W.E.B. DuBois said that, "Remember, public office is not for private gain, but for the greater good of all. Give to those who choose officials equal realization of the great responsibility that rests on them, knowing that a land is, after all, what its voters make it."

And the voters in Illinois responded to that prayer. It was not just for Illinois, but it was for the greater good of this country that they voted for a talented attorney, an advocate, a coalition builder, a peacemaker, a distinguished legislator, a hell-raiser and a woman. (Laughter and applause.)

I don't know how many of you had the chance I had to campaign with this new senator of ours, because Illinois can't just claim her on its own, but I did. I watched her put on that million-watt smile and walk into any room, no matter who was in it, and just captivate the whole crowd. I watched her get up on automobile hoods, bus stop steps, podiums and daises all over the state and talk about why she wanted to be the United States Senator.

And what she talked about is what we all care about: public service, making a difference, positive change. She knows what that means because she's been a public servant for her entire adult life. She's been a prosecutor, she's been a legislator, and she used to win all the time in Illinois independent awards for being the best legislator. Not the best woman legislator, not the best black legislator, the best legislator in Illinois. (Applause.)

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Divider Title: Hopkins 6-10-93

THE WHITE HOUSE

Office of the Press Secretary

Internal Transcript June 10, 1993

REMARKS BY THE FIRST LADY
AT THE SYMPOSIUM ON HEALTH CARE REFORM

Johns Hopkins University
Baltimore, Maryland

11:30 A.M. EDT

MRS. CLINTON: Thank you very much. President Richardson and Dean Johns, thank you for those very warm words of welcome. And I am delighted, Dean Johns, that you have made it clear that my predecessor, Mrs. Harrison, was here before. and also I believe Mrs. Cleveland served on the committee that finally got the money together that enabled JohnS Hopkins to open its doors. And I'm also pleased that you reinforced the very strong admonition that both Mrs. Harrison and Mrs. Cleveland gave 100 years ago that women should be admitted to the Johns Hopkins School. I did not have time to go back and read the clippings, but I'm sure they were roundly criticized for being so aggressive and assertive in their views. (Laughter.)

I'm also very pleased to be here with Congressman Cardin and Mayor Schmoke, two leaders not just in the Congress and not just in Baltimore, but nationally on a number of issue that are very important to the well-being of our country. And I particularly enjoyed working with Congressman Cardin, whose expertise on health care and what has been accomplished in the state of Maryland with respect to the changes that have come about here and have really appreciated his counsel. And I'm always pleased to be with Mayor Schmoke in his city.

I also wish to extend my congratulations to all of you who are part of the Hopkins community -- to trustees, to the distinguished members of this faculty, to staff, to students, to friends of this institution. There really isn't any other quite like it. And I am honored to be part of its centennial anniversary.

One need not be a doctor, a nurse, a medical student or even involved with health care reform to appreciate the magnitude of Johns Hopkins' contributions to medicine and health care in the past

100 years. How many other institutions can boast of revolutionizing the standards for medical school admission or claim credit for being among the first to include women as students? How many have so ably served the poor and indigent in the inner city around them? And how many have spawned so many important discoveries in medical treatment?

Indeed, Johns Hopkins, as you know, is widely respected for excellence, progress, and vision in health care. And besides that, how many other schools of medicine are distinguished enough to be immortalized as a question on Jeopardy? (Laughter.) As we all know, when you make it in the popular culture you really make it. And so that ought to be one of the issues you discuss during this centennial conversation.

But given your history as trailblazers in medical education and research, your tradition of socially responsible medicine, your remarkable faculty and students, you have much to be proud of. And yet, there is also much to look forward to in the next 100 years. You will continue, I am sure, the tradition of research that brought you the Nobel Prizes of Doctors Daniel Nathen and Hamilton Smith, to the medical advancements and the treatment of blindness, to the innovative research that Hopkins doctors have produced on brain chemistry. And, although I cannot tell you what a P53 gene is, I do know that Dr. Vogelstein's recent revelation about genetic connections to colon cancer are a welcome breakthrough for those thousands of Americans who suffer from and die from that disease each year.

And yet I also know that no matter how distinguished your past and future in research is, and no matter how great your reputation as an academic medical center throughout the world is, you have also set and changed the agenda for medical education. Few medical schools were as quick to understand the importance of incorporating humanistic learning in the training of doctors. And few others have even yet today a curriculum that so emphasizes general practice and the role of the physician in society.

And you have done all of this while not neglecting to treat patients. You are a beacon in this region and in the nation when it comes to clinical and tertiary care, and most importantly, you are an anchor in East Baltimore, providing quality treatment for poor and needy citizens who might otherwise go without.

There are many things that I could say and that will be said during this day and in days to come about the achievements of this institution. But what I would like to do for a few minutes is look toward the future and share with you what I believe will be the impact of the President's reform effort on academic medical centers such as Hopkins. I believe you will be encouraged by our ideas and

the assumptions we are operating on. And yet, I think we also have to understand fully the context in which this reform effort is developing and moving forward.

You know better than most that although we do have much to be proud of in this country when it comes to the quality of our physicians, our nurses, our medical care, our technology, our research, we are facing a crisis. It is not a crisis that is evenly distributed throughout our population. There are many parts of our country that still wake up every day not really touched by what many of you see day in and day out here at this institution. They do not see the crowded emergency rooms. They do not see the hard choices that doctors now have to make, struggling with the competing demands of so-called managed care and their own consciences about what needs to be done.

And yet, we can't turn back the clock. We are not likely to go back to the time when health calls were made routinely, although there is some clinical work being done now which demonstrates that house calls and even telephone calls are very clinically efficacious. So it may be that a return to that would help us in other ways.

But what we now are confronting, what you confront is often a nightmarish vision of overcrowded emergency rooms, layers of paperwork, confusing insurance plans, and all too often, inadequate treatment at the end.

You have devoted your professional lives to improving the health and well-being of your fellow citizens. You're the ones who are on the front lines. And you're the ones with whom I have spent many, many hours, both personally and in my role on the health care reform task force, talking about what has happened to medicine; what has happened to the patient-doctor relationship; what has happened that has created a system that no one will take credit for, which has spun out of control, creating unintended consequences, whether it be in mountains of paperwork or in the kinds of cost-cutting practices that interfere with the quality of care. You're the ones faced with the ethical dilemmas about proper treatment for people with no health insurance. You see it all firsthand. And I have come through the last several months to see many of those same issues with you.

It is very difficult for me, and I can imagine, even more difficult for you to experience what I see happening to so many people -- doctors, nurses, other care-givers, patients, hospital administrators. When I go to a hospital, as I have in the last few months, and visit with the medical director, a man who had practiced for 30 years, who looks at me and says, "You know, there's that old

As you know so well in this hospital here associated with this institution, the more we try to cut around the edges, to jimmy people in the systems and make the people fit the systems instead of the other way around, the more problems we cause ourself. And the costs continue to go up. And this is not a problem any longer primarily for the uninsured or the poor. This is a problem now that threatens to undermine the security of every American. There is no one I know except the very richest in our country who can be sure, given what is happening in our economy, given the changes in companies as they make decisions about benefits or lay people off or go out of business, that even those among our citizens with the best insurance will have it next year or even, in some cases, next month.

Tens of thousands of Americans join the ranks of the uninsured each month. Workers and employers are grappling over who should pay the escalating price of health benefits. American corporations are often at a competitive disadvantage because their foreign competitors usually provide health care at a cheaper cost, not less health care but more effectively delivered health care. And doctors are burdened with more and more paperwork that doesn't necessarily have anything to do with quality and with the specter of lawsuits hanging over their decisions.

Hundreds of Americans have come together in this effort to find an answer. We have had the help of many people associated with Johns Hopkins and I could not name them all. But they have been there consulting with us, advising us, giving us guidance about what will be the best solutions. Those people who are members of the Johns Hopkins community have looked at an extraordinary range of issues, along with the other members of the task force. And it is clear that we cannot just attack one part of this problem.

That is part of why we are in the situation we are in today. If you try to control the rising costs in health care by controlling price, volume goes up. If you try to control the rising costs by regulations you have more micromanagement with checkers checking the checkers, which has very little to do with quality.

So what we have to do is to look comprehensively at all of the problems that impact on the overall issue that confronts us in the health care system today. Clearly, we believe that there are a number of principles that have to guide us if we expect the system we want to see created to be effective. First, it has to provide security for every American. Health care has to be available no matter who you work for, no matter what your health status. It has to be portable from job to job and across the state lines. That level of security is absolutely essential. It does have to control costs, but it needs to focus on eliminating the unnecessary costs in

the system first and be able to reallocate those resources to actually providing health care.

I do not know now, I have lost count of how many doctors have told me the huge percentage they are currently paying out of their income, those who are in private practice, to pay for the administrative side of their business; how many more people they have had to add; how many more hassles they have had to contend with. There are costs in this system that need to be eliminated. There is no excuse for the proliferation of forms that are of absolutely no use to the provider or the patient. There is no excuse for the kind of bureaucracy that has been built up in both the private insurance world and in the government in order to check people and double-check their decisions.

We also need to be committed to improving and retaining quality and by maintaining choice on behalf of patients. And we need to have a system that is simple enough for the average person to understand and feel good about.

We are looking for those kinds of solutions and believe that we are close to being able to present a proposal that will enable us to achieve a system that meets them. But there is a particular piece of this that I know is of great importance to the Johns Hopkins community, and that is the role of the Academic Medical Center. The kind of important role that has been played by Johns Hopkins and will continue to be played is one that we have spent a great deal of time working on, to be sure that we understand how best to put into place an overall reform system that will enable the Johns Hopkins of our country to continue and even enhance the important roles currently played.

There are a number of issues that come into consideration when we look at the Academic Medical Center. The first is the supply of physicians and the kinds of physicians in that supply. There is no way we can provide the kind of universal access that is required, and require a benefits package to be available to all Americans that emphasizes primary and preventative health care without a larger supply of primary physicians.

That is a simplistic statement, but one which will take a great deal of effort to meet. How do we move from our current imbalance of the number of specialists for primary care physicians and get to a point where we can promise there will be primary care physicians, not just in the suburbs, but in the inner city and in rural areas so there will be a true network of care that will fulfill the promise we are attempting to make to Americans.

If we can get everybody into the system with a rather limited new amount of money that comes primarily from the private sector, which is the primary funder now, but which for the first time expects everyone to participate, then we will actually begin to see the kinds of costs savings that can come from administrative savings and from better utilization of the existing system.

It will be a great accomplishment for our economy if we in the first years freeze our GDP percentage at its current rate, because right now we are looking at moving to 19 percent by the end of this decade. So if we can freeze and then move down, that would be the most likely and least disruptive way of getting this situation under control.

Q I'm with an organization called Georgia Health -- (inaudible) -- in a community-based effort in understanding some of the problems in our state. One of my fears and one that we hear over and over again is the lack of infrastructure in much of the rural areas of our country. It's true in Georgia, and it's true across the nation. There's also a major infrastructure problem in some of our inner urban areas also. It would seem that even though I certainly understand that we all do the deed for fiscal restraint, there's going to need to be some infusion of capital from somewhere to provide the bricks, the mortar, the buildings to people to go out and deliver the care where it just simply isn't right now. I wonder if you have any comment on that.

MRS. CLINTON: Yes, sir. We absolutely agree with that -- that the underserved urban and rural areas have got to be given a health care infrastructure and personnel in order for universal coverage and cost containment to work. And we have several approaches to that. We do think that the federal government will have to raise some funds in order to beef up the public health infrastructure.

We also believe that the accountable health plans will have to utilize those existing structures in order to serve the population that they're going to be bidding on to serve. And they will an incentive to do that, which they don't currently have, which is a reimbursement stream, so that the level of uncompensated care that often burdens inner city and rural providers, will be dramatically lifted. I'm not going to say it will be eliminated, because we won't know how this all works until we get into it. But I do know it will be dramatically reduced; so that there will be for the first time in many years a much fairer return for those people who are actually willing to deliver the care in those underserved areas.

Additionally, we have to look for ways to make it attractive for physicians, nurses and other medical personnel to provide care in those areas. And our plans there range from everything from providing a much broader loan forgiveness and loan program for people who are willing to serve in those areas, to a higher reimbursement rate by encouraging plans to be able to provide services in those areas and looking at some of the models that have worked, to better use of technology, because it's not just a question of pay, it's also a question of professional isolation and the like.

And we are very encouraged by how these kinds of networks of cooperation in which rural and inner city practitioners would become a part would help to create a climate in which they were much better supported, could provide better care, in which reimbursements would flow to them. So we've thought very carefully about that and think we've got to wade through the system to fund it and to continue to provide it.

Q I appreciate very much the logic and care which you've laid out the problem and principles. I'd like to ask a question about process. And that is, by what process do you anticipating in determining the coverage contained in the comprehensive package, including deductibles, copayments and so forth, since I would assume and I believe that that will strongly influence the cost, even I hope the calculated budget premiums and so forth in such matters as deductibles, copayments, even if the federal government takes care of them or reduces them for poor people -- actually have been shown I think by tests to have a substantial effect on the cost of the program.

MRS. CLINTON: You're absolutely right about the benefits package and its cost being the key to all of this. And it has been probably the most complicated task we have faced among many. Just as an aside, which I told several of the senators -- Senator Lieberman and others here probably heard me say this before -- but one of the first tasks that we did was to get into one room all the federal government actuaries who dealt with the cost projected on health care programs that were run by or funded by the federal government. They had never been at a meeting before ever.

And if you wonder why we have problems in America and in our government, just think about how driving a factor health care costs have been in the last 10 years in every budget that has ever been put together; and the actuaries have never met before I got together in a room. And they've been meeting continually since then.

And they, along with an outside panel of actuaries whom we've convened, have worked very hard to cost out the benefits package. It will include copays, and it will include deductibles,

because most of the actuarial matters and as a matter of personal responsibilities, we think that the important part of the whole approach to reforming health care. We are trying to keep the costs as low as possible. So we are looking very hard at the benefits and in the costs of them.

But we have a problem, which I never knew was a problem until I came to Washington, and that's called something called scorability. And when one presents a budget to the federal government, we end up with these kinds of arcane or -- maybe they're not arcane, they're just rules of budgeting I've never encountered in my prior life before -- in which issues like competition and the savings from competition are not giving any weight whatsoever.

And so we have tried very hard to come up with a benefits package that is a reasonable package that most Americans who are insured will feel good about, and which is affordable on actuarial tables and which in a market-driven system will generate savings that are real that can be filed back, to go back to Dr. Roland's point, even if they can't be scored in the federal budget.

So that's the key to trying to keep -- this is the centerpiece of making all this happen, as Dr. Brown clearly put his finger on. And we think we're going to come up with a benefits package that is comparable to what a federally qualified HMO would offer, an average Blue Cross-Blue Shield policy, which we think is pretty good to be available to the entire country. It won't make everybody happy, because some people, as you know, have first dollar coverage and a lot more benefits. But we think as a national guarantee package is certainly one that should be supported.

Q You mentioned personal responsibility, and a lot of the health problems and a lot of -- (inaudible) -- responsibility. Is there some way of incorporating in this formulation a disincentive for -- (inaudible) -- or an incentive for living -- (inaudible.)

MRS. CLINTON: I joked the other day that if there were a way to do that, it would probably be a disadvantage, because the actuaries would then claim people would live longer and it would cost more. So, I mean, it's like -- this is like a never-ending set of issues. But we do want to discourage unhealthy behavior. And one of the reasons we are looking at funding the public health infrastructure through some of the research improvements that we're thinking of, through a combination of tobacco and liquor is because we do think that's sends a disincentive.

Now, I'm also hopeful that once we get this system up and running, we will begin to look at some of the other ways we could provide incentives for healthy kinds of behavior. It is not easy to

build those into the benefits package or to really monitor them carefully. But I'm hopeful that once we are running, the accountable health plan, we'll be able better to compete on the basis of what kinds of additional services they're able to afford because they get the costs of the benefits package down, which will keep those people who enroll in them cheaper, which will have the benefit that you're talking about. But we do think that cigarettes and alcohol are key to preventable health care, and that we need to take a look at those for sources of funds.

Q Just following up a question, I wonder if I could suggest -- (inaudible) --

MRS. CLINTON: What you ask -- and I had a meeting yesterday with 25 physicians and other health care providers from Houston with Congressman Andrews. And Red Duke, the TV doctor, was there, and he said that he believes that we could have a massive public education campaign on accident prevention and other community public health problems, it would be one of the quickest ways to cut our costs. And he has some proposal that we're going to try to implement through this kind of process of creating models and then distributing them to states through their alliances and their health plans so that we can actually do exactly what you're saying, because that is where there are huge savings available if we can change community activities as well as individual behavior.

Q Hillary, you haven't said anything about the drug industry yet. Do you envisage it being part of the basic package? And secondly, do you envisage interim price controls for that industry?

MRS. CLINTON: Well, we do envisage their being a prescription drug benefit that would be part of the basic package as well as part of Medicare. Again, it would have a cost attached to it, but we think a reasonable cost. That would provide a significant increase in the funding available for prescription drugs, if we're able to get this actuarially squared with what we think our affordable costs are.

On the issue of price controls, this is one of the more emotional and thorny issues that confront us, because there are many who, frankly, believe that in the absence of some kind of price restraint -- whether it be freezes, controls, rate settings -- that the competitive system alone is inadequate, at least in the short run, to deal with the kinds of costs that are built into the system.

And there others -- and you know the arguments very well -- that it distorts the market, it leaks, it doesn't work -- I mean,

there are arguments on both sides and I don't think it will ever be fully resolved to anybody's total satisfaction.

But I do think that it would be very helpful for us to try to create an environment in which voluntary action on the part of providers was part of our initial presentation of this package. That would include the drug manufacturers and everyone else. I've had conversations with some of the manufacturers, I've had conversations with other entities who represent major parts of the health care system who seem to be moving towards a willingness to talk about voluntary restraint, some kind of freeze, however it could be structured.

There might also, though, need to be in the legislation some kind of trigger for this transition period that would help enforce that in the event that we were unable to achieve the kinds of initial savings that we think will help fund the whole system. There's been no final decision on that. This is something we welcome everybody to weigh in on. It is highly emotional. It's hard to kind of cut through the emotion to get to what actually would or would not work. But in any event, we would only be looking at either a voluntary system or a system with a trigger for a very short transition period. We want to stabilize the system.

And one of the big problems we've got is the huge differential in practice patterns and costs around the country. I mean, if you can pick an average and try to say this is the average hospital cost, the is the average physician cost for this kind of procedure, you literally have a 100 percent variation on both sides of that average at work right now. And it is something that you cannot overnight change those practice patterns and eliminate the excess costs in those systems in many parts of this country. But without some discipline, it will take longer than we might have in order to get ahead of the curve. So those are the kinds of issues we're struggling with.

Q The question I have is to administrative costs. Currently, in some states, my hospitals will in a year undergo a Medicare inspection, joint -- (inaudible) -- inspection a Department of Health inspection, a Department of Mental Health inspection and a CHAMPUS inspection. And a lot of times, being inspected, we'll spend hundreds of thousands of dollars and hours dealing with those and when we should be delivering care. My question to you is what are the certification for provider empowerments you envision from the alliances and the health plans, or is this going to be another layer of life insurance certification that providers have to deal with and adds administration costs?

MRS. CLINTON: Well, the answer better be no. Otherwise, we won't have done our job. What we think is that much of what you now are subjected to in terms of monitoring and checkers checking checkers and utilization review and the like, derives from a regulatory model that attempted to micromanage the delivery of health care. With a capitated model -- with some kind of budget backup, so that people know when they're running up against the limits of what we as a country or Georgia as a state is willing to pay for health care, we think better decisions will be made and we also believe, frankly, quality will be enhanced. Because for every doctor that a hospital has been able to hire in the last two years, they've had to hire four administrators in order to do exactly what you just described. So cut the difference -- give us two doctors and another trained nurse and you'll get better care at less cost and less hassle probably.

So, yes, we think that this capitated, market approach will eliminate much of what you are now putting up with. You will still have to report -- (inaudible) -- compile the kind of report card mechanism that will enable the health plan and then the consumer to make good decisions. But that we think is a minor burden that will be much more easily borne compared to what you're having to do now.

Q I'm very intrigued with the proposals that are being made because tough competition reduces costs. And I also understand the necessity to allow the states to make individual decisions about their own health care programs. Having spent quite a bit of time in Canada, I'm very familiar with the single payor system. And I wonder about the compatibility of single payor system with the notion of competition amongst the kind of health plans. And I was just wondering if there's any way -- or if you've thought about that problem and what your views on it are.

MRS. CLINTON: I think that the single payor system can be viewed as either a single payor financing system or a single payor government-driven delivery system. And what a number of governors have said to us, particularly of smaller states with very rural populations, is they don't have any idea how they can generate the kind of competition among accountable health plans that I presume will be available in Atlanta or Chicago or most of the larger areas.

So they are asking for the option of being able to provide a system within this plan that is close to a delivery system that integrates all of their existing providers. So that, for example, Montana, with a Republican governor, has just passed a piece of legislation setting up a commission to determine whether my payor should be a multi-payor or a single payor system. They have 800,000 people in that huge land mass. Their primary medical center is

Billings. They believe that they create a system that creates collaboration in Billings among their tertiary and secondary care facilities, they will then be able to contract out, those facilities will, out into the areas that are very rural with lots of need.

I don't know that they would consider that a single payor system under the Canadian model, but I think they would consider it, given their circumstances, the best they could probably put together in one, maybe two, accountable health plans. But that's something we want to let them have a choice in making. It will not change the amount of money that goes into the system. They will still have to provide the same benefits package and consumers will still have some choice in determining what the outcome is. But we don't believe from the federal government we're in a position to say to Montana, you've got to do exactly what Chicago does, and if you don't have competition, get out there and create it somehow. We just don't think that will work.

So we're going to try to provide enough flexibility so that states can make some of those decisions on their own.

Q We promised to get Mrs. Clinton out at 3:00 p.m., and she's been very gracious with her time. Let me get two more questions. And then I think if you have more time, we will respect your schedule, and let that be the end of the questions.

Q The question I'd like to ask gets back to your speech before Johns Hopkins about a week or so -- two weeks ago, and after that -- (inaudible) -- also a major source of progress and -- (inaudible) -- In a world that is largely composed of accountable health plans with this competition, there's some question as to whether or not academic health centers can survive. As we now note, there's also some question as to whether they should survive -- (inaudible).

Are you contemplating -- is the task force contemplating a separate mechanism for financing academic health centers to some sort of a pooled fund or will they be subject to the prices as computed -- (inaudible.)

MRS. CLINTON: No. We believe that academic health centers and the comprehensive cancer centers and some of the other freestanding tertiary care facilities that are at the high end of the system should be supported by the entire population so that there will be a pooling of funds to be able to support those. Now, as you well know, academic health centers have a variety of missions. They have a research -- important research mission which will have to have continued help from the federal government, and I would argue, increasing our research capacity and commitment will be a very good

investment that will save us money in the long run if we're able to do that. So we want to have a funding strain that supports that.

Secondly, they have an obligation to train medical students, and we do have to make some changes there. The current imbalance between specialists and generalists cannot continue if we expect to have a health care system that puts an emphasis on primary and preventive health care. So we have to change some of the incentives that go into medical education.

And then, thirdly, most academic health centers take care of patients. They run emergency rooms often and they certainly take care of physician-referred patients as well as, in Johns Hopkins case, serving as the primary care giver for low income areas.

So in our conversations with them, they have taken their respective mission and looked at them as independents to some extent because it very well could be that you might have a Johns Hopkins accountable health plan, just as Mayo's is now doing in Minnesota. So that Johns Hopkins would be the tertiary care center and might even, through medical students and others, help to staff clinics, but also might contract with local physicians and even contract with some independent hospitals. I mean, that is an option that many other medical centers are looking at.

Or they might be part of an integrated network that somebody else runs, but they would be the referral place. So there are a number of available ways for the independent functions of the academic health centers to be funded and to be delivered. And I'm delighted at the result of the conversations we've been having with them because I think they're beginning to understand their opportunities and not just the changes that they're facing.

Q You mentioned the term -- (inaudible) -- and market-oriented health care on a number of occasions. Have you thought about what would happen -- (inaudible) -- but have Medicare, which is clearly not either capitated or market-oriented, going on for the over 65? I don't know whether you or members of the task force have given thought about what if anything to do with Medicare, how soon it would even need to be done, and finally, whether the types of changes you envision in the under 65 population would occur -- (inaudible) --

MRS. CLINTON: We've given lots of thought to that because it's one of the key phase-in issues. I personally favor the eventual phase-in of Medicare into the entire system. And I think that that will happen. But in the short-run, while we're trying to get the alliance -- (inaudible) -- running, while we're trying to deal with the problems of the insured and the uninsured, our

perspective has been we need to get this system running. Because as much as people complain about the Medicare system -- and I always get two reactions when I speak to groups of senior citizens. I ask if they think it could be done better, and of course, they all yell and clap and say it can. And then I ask if they want to give it up immediately and try something different, there's a reluctance there. Because they've got it and the rest of us don't, as we all know.

But I think that in the transition to an alliance-based system that delivers care to the under 65 -- and one thing we're considering is making the alliances available to Medicare recipients who could choose to go in and purchase an accountable health plan with some transfer of funds from Medicare into the alliance; and depending upon where the benefits package ends up, with perhaps a supplemental, it would go into the alliance in order to pay for any additional benefits that would be otherwise unavailable in Medicare -- we think we can prove over the course of several years that this system will work. And we strongly believe that Medicare ought to be a part of it.

We don't think we can bite that all off at once, which is why it's very important to continue to do all we can to control expenditures within the Medicare system and stop the cost shifting so that we can get to a phasing-in of Medicare eventually as well.

(Lunch break. End of tape.)

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THE WHITE HOUSE

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REMARKS BY THE FIRST LADY
IN SPEECH TO CSIS CONFERENCE

Capitol Hill

MRS. CLINTON: Senator Nunn and Senator Domenici and ladies and gentlemen, thank you for this opportunity. And, Senator, because I know you're committed to responsible deficit reduction -- you just go right back to that -- (laughter) -- you're going to try to move this agenda forward so that we can continue to get the country back on the right track that will lead to the strengthening of America, which is a commitment that all of us share and which Senator Nunn and all of you have been leading spokespeople for and for which I am very grateful.

I welcome this opportunity to visit with you about health care. And what I would like to do is to speak for a few minutes, but mostly to have time to answer any of your questions or, as Senator Domenici suggested, to take advantage of your suggestions about how we proceed with this extraordinarily important and very complex matter.

I don't think that I need to remind this group what is at stake in health care reform, because you have been looking at what needs to be done to reverse the kind of economic stagnation and undermining of our future that has gone on because of decisions that we have failed to make over the last several decades. But it is clear that, in the absence of serious health care reform that controls costs and puts, finally, some discipline into the health care market, we are unlikely to be able to deal with the federal budget, the deficit, the debt, and we are going to continue to be undermined in the private sector with respect to our competitiveness. So there could not be a more timely issue for this group to address.

There are a number of competing proposals that have been analyzed and worked on for several years as to how we best go about reforming our health care system to assure security to every American so that we reach universal coverage that will enable us to provide a comprehensive benefits package at affordable cost, and will control costs, therefore, within both the public and the private sectors.

MORE

There has been an enormous amount of good and thoughtful work that has gone on. And I was pleased to receive a draft copy of the "Vision and Principles" paper that CSIS is working on, and add that to the list of organizations that are taking a responsible approach to this complex issue.

In the work that we have been doing in conjunction with many groups in both the public and the private and the nonprofit arenas, we have attempted to analyze every single proposal from a variety of perspectives, and to how well it reaches the principles that we think are essential -- principles that you, too, have adopted in your approach in this draft paper.

It became quickly apparent that there were strengths and weaknesses to every one of these independent approaches that had to be taken into account, and that what we would have to do to come up with a system that we thought met the underlying principles in a timely and affordable manner, was to create an American solution to this American problem. There was no model anywhere that could be adopted wholesale. And that we needed to build on the strengths of our health care system while we tended to shoring up and eliminating where possible its weaknesses.

And what I would like quickly to do is to run through your "Visions" paper so that we can put the discussion into the terms that you have already been working on and point out the similarities and the approach we're taking and discuss areas where we need, perhaps, to continue consultations.

We believe, along with you, that we need a market-based approach to the financing and delivery of health care that will create sound and effective consumer decision-making. This is an area that individuals like in which information that is readily usable is rare. I wouldn't embarrass anyone, including myself -- if I wanted to, I could, though -- by asking each of you to tell me exactly what your insurance coverage is and all of the rest that goes into it, and how you shop to make your choices, and if you didn't, who made the choices for you and on what basis they did.

It would be a relatively short conversation, because I've done this in many groups with many well-educated people, and there's been embarrassed silence and then a scrambling to say something. If I'm contract, I would ask you why did you buy the car you most recently bought, we could have a very well informed conversation and a good debate back and forth, as Sam Nunn argued with Jim Cooper, who argued with somebody else about why they chose whatever car they bought and what kind of deal they got for it and how they negotiated the best price.

There is nothing like that in our current system. The kind of system we envision relies fundamentally on empowering and informing consumers to make those kinds of decisions. In order to do that, we need to create options among the choices that are available to consumers, and we agreed with your approach of providing what we call "accountable health plans," and you do as well, that will provide a basic benefit package that will be required by the federal government and the basic option available to every consumer.

Now, accountable health plans can deliver those benefits in a variety of ways -- through an HMO, a PPO, a fee-for-service network, some as yet undiscovered ways of delivering services the market will help to generate. And we will encourage that kind of competition and choice because we think there should be that availability of options within the delivery of health care.

In order for that system to work effectively, we will have to have adequate information, the use of report cards -- a term that you use in your draft is one that we have also used. We will go, in addition to reporting what is currently available in the market, we will have to create new sources of information better than what we have currently been able to produce. And we will have to start comparing apples to apples instead of apples to oranges. Because, as has been pointed out in many of the discussions I've had, the primitive use of information can be contrary to the outcome's quality measurements that we are looking for. So there will have to be some real thought given to creating an effectively functioning data collection system that can be easily accessed and reported to consumers and providers.

We certainly believe that there has to be the integration of providers in the delivery of services. It has been very interesting and encouraging to me to watch other organizations reach the same conclusions. Catholic Health Association, for example, studying health care reform for two years, issued its report before the President was inaugurated. It is very much along the same lines as what we are proposing, what is in the CSIS draft paper. Because if you look at our system, one of the clearest needs is for increased coordination and better integrated delivery systems, which we believe will be created by the kind of emphasis on incentive for cooperation through the creation of these accountable health plans.

Preventive health care will be a major part of the benefits package. This is a change in direction from where we have come from. And if one goes back and looks at the history of how we got into the rather anomalous situation of insuring against the disease or the chronic condition and not insuring against the preventive measure, the well child care, the other kind of diagnostic tests that lead to discovery of illness, it is a national outgrowth

of the early decisions to insure against catastrophic instances which, of course, all of us would agree with.

But the result of that, going back to the 1930s with the very first private health insurance plan is that we worked our way out of a market for primary preventive health care. We have to create that market, we have to mandate it as part of the benefits package. We strongly agree with you that we must look at ways of providing organized, coordinated care within a budget.

There are a number of laws at both the state and federal level that interfere with competition. But, more importantly, interfere with coordination. We have to think about the kind of arrangement of care we need and the best and highest use of providers within those arrangements. And so, looking at changing anticompetitive practices or laws is very important. Looking at the federal antitrust laws so that collaboration will be permitted instead of prohibited is key.

We also think, along with you, that once we establish a comprehensive benefits package -- and we are looking at a package that is approximately what one would expect from the good federally qualified HMO, the Blue Cross-Blue Shield package with the primary and preventive care in it -- then we have to be willing to remove tax deductibility for benefits above that level. So that we will continue tax deduction treatment for what is in the comprehensive benefits package. But after-tax dollars will then be used for any benefits or ancillary services beyond that package.

This is a key part of making it possible to extend such a benefits package to the underinsured and the uninsured and give those who are currently insured the security that even though they are currently insured, none of us can predict whether they will even be employed next year, let alone what their benefits level will be, and that they will always have the security that this level of benefits will be available to them. And that it will be affordable, it will remain with them whether they are employed or unemployed, because we think what we need to do is to enhance the existing employer-employee system by bringing Medicaid recipients into the same purchasing pools so that there will be both federal and private money, as well as whatever state contributions are required to cover the entire population.

We, too, agree that there need to be purchasing arrangements created to empower the consumer and to negotiate with the accountable health plan. We are referring to the entity that's health alliances, because they bring together in one entity consumers and providers, businesses, labor -- all will be available through

that alliance to negotiate for the best possible health plans which will then be open for enrollment by any citizen.

Even if one continues to finance health care through an employer-based system, consumers will be free to enroll in any accountable health plan -- not the only one that is selected by the employer.

Clearly, one of the hopes behind our reform is to reduce the costs and redundancy of health care administration, and there are a number of reforms that we believe will bring that about. Community rating is a key which will eliminate the expensive underwriting and experience rating procedures currently driving much of the costs.

If we are able to bring about these health care reforms in the administrative areas we will be able to stabilize the costs. -- it's a chicken and egg issue, how do we get to universal coverage with affordable benefits package while sweeping out the administrative costs so that those costs can be recycled through the economy and even through the health care system. We have to proceed, in our view, on both fronts at once.

We also believe we have to create a framework, as you have suggested, to eliminate excessive expenses associated with malpractice litigation and with defensive medicine that is driven by fears of such litigation. We are also concerned, as you are, about creating some kind of consensus about the appropriate treatment that is available in the last months and days of life. And Senator Domenici has already left, but he took a step toward this with the Patient Self-Determination Act, in the last Congress I believe, and we think it is appropriate to move as you do on encouraging consumers when they sign up for health plans to complete a living will, or at the very least, to have the kinds of issues that they may face in an emergency situation explained to them so we have better informed decisions being made.

An absolute red-line, bottom-line principle for us is that all Americans have to be secure. There should be no prohibition of health insurance or access to health care to anyone. And the kind of benefits package and the delivery of it will be key to that.

I could not say better than what is said in your paper that the perfect is the enemy of the good. There is no way we will create a system either that is perfect or that will satisfy everybody. I have thought for quite some time now, perhaps necessity being the mother of invention, that if everybody is a little bit put out we're probably doing the right thing. But we have to look for the best possible system in order to deliver that security which is the key to whether or not we will have a successful reform.

We agree that biomedical innovation and the appropriate use of technology and the continued role of medical research is essential, because, we think, it is one of the few ways open to us to actually improve productivity in the delivery of health care. And so the suggestions that you include in your paper about innovation and research are ones that we take very seriously and have had a number of conversations with medical research groups, academic medical centers and others who are at the forefront of assuring that the American health care system stays on the cutting edge of the development of treatments that will enable us to deliver care more efficiently.

It is also absolutely essential that we control the growth of federal spending for health care. But it is also essential that we control the growth of private spending for health care because one of the net effects of reducing federal spending, as many of you who are providers around this table know, is that it knows up in the bills that you and I pay because we carry insurance. And it particularly becomes an additional burden on the large employers, those who are providing the bulk of the private money that is funding our health insurance system. So, yes, we need to weigh in and budget the federal contribution, but we also need to be sure we have some discipline that is imposed through the market on the private sector.

And let me say a word about this because there has been a great deal of conversation about budget in this situation and how budgets do or do not correspond with competition. It is our view that we need to start with the idea of a budgeted system that is based on the average weighted premium cost that will be paid through comprehensive benefits package. That budget, we believe, should become redundant. It is a backstop, if the market works as we expect it to work. But in the absence of budget targets, of some kind of discipline as states and accountable health plans and providers adapt to this new system, we are afraid that the controlling of the costs in the federal system without some kind of discipline in the private system will further discourage the kind of steps toward more efficient delivery than we have seen in the last years and put more pressure in turn on the federal system.

Every time you cap a federal entitlement program in health care, in the absence of reforming the market in the private sector, you shift cost to the private sector, which has a result of eliminating people from coverage either because their employers no longer can provide it, or the co-pay and deductible become so high they no longer participate in it, or they get laid off, or something else happens to them. They then join the 100,000 people a month who lose their insurance. They then find their way on the public rolls

for some period of time, which then busts the cap on the public system.

This is a total system that feeds on each part of it. So from our perspective we have to define the costs within the federal system according to a formula that is paid to what we believe should be the budget for the entire system, and that we then have to do everything we can, as I said before, to make that budget with respect to the private sector largely redundant. It would only apply to the comprehensive benefits package premium costs. Anything that is bought with after tax dollars would obviously be available for any of us to do whatever we chose to do with. But with respect to how we try to get the whole system operating under some kind of discipline until we think these reforms can kick in this one of those areas that we have thought about very hard.

And one of the people working with us said, you know, the traditional way of trying to restrain health care costs has been to put a leash around every cow and try to keep it in one spot and not let them move. What we're trying to do is just put a fence around the whole system and let people decide within it how they can allocate the federally mandated part of the expenditures and the accountable health plans marketing of and delivering of the comprehensive benefits package.

Now, finally, I think it is absolutely essential that we do everything we can to come up with a system that is understandable and workable and in the eyes of the vast majority of Americans, a positive change from what they have now.

And what we hope to be able to do is to come up with such a plan that will be as inexpensive as our entire economy can manage to make it in terms of both new private sector contributions and any new revenue. We believe that an employer-based system, which is what we have now, that has a very wide range of contributions within it from zero, as you all know, to a high -- employer high of 25 percent of payroll for health benefits, but most start at the eight to 15 range with the costs going up at 10 or 11 percent a year and they're trying to keep cost increases down to eight percent.

Most of us are working off the premise that we are not going to replace our existing system, we are not going to look for public past monies to replace the existing kind of contribution to the health care system. So therefore, how do we create a system with the least amount of disruption and the least amount of new revenues required. And what we are attempting to do is to create a premium that is paid to this benefits package that will enable most employers who currently provide the comparable benefits to realize considerable savings over the next years and those employers who do not make any

contribution now or whose contribution is inadequate to fund that comprehensive benefits package --

(End Side 1)

(Begin Side 2, in progress)

-- in any way pay their fair share now, but who in many ways burden the system that the rest of us pay for.

So, finally, this system is not going to be changed by any wave of a magic wand or any silver bullet. It is, however, a system that we're convinced we need to take a comprehensive approach to initially even if we choose to phase in that approach; rather than taking an incremental step now and then hoping for an incremental step later. Because there are too many interactions among the systems not to try to lay out an approach that will affect the very pieces of it so that we can watch it being phased in, largely by the states, through a market-driven approach.

Q Let's open the floor to questions, so why don't we start around and whoever has a question --

Q Thank you so very much for being here today. The statement that we should not put anymore into the system than we absolutely have to that is already there, I think is what we really need to do. So how, when we consider the fact that 14 percent of our gross domestic product now goes to health care, more than any other industrialized nation, something that we -- (inaudible) -- how can we justify putting additional money in, which will make that percentage even greater?

MRS. CLINTON: Well, Congressman, this is one of those dilemmas that we are stuck with because of our current system. In order to control costs, you have to have everybody in the system. In order to get everybody in the system, everybody has to bear their fair share of the responsibility. At this moment in time, you have 40 million Americans who do get health care -- they show up at our emergency rooms, as you well know. They get taken care of, usually at the highest cost at the last possible moment.

We are unable, therefore, to control their access and usage of that system. In addition, we have a public system that goes up and down based on political decisions as opposed to being incorporated within the broader market system. And we see it going up and down depending upon decisions that are made that often impact adversely on the costs then in the private system. So we think it's a chicken-and-egg kind of a problem.

As Dean Johns and others have suggested, the success of our health care reform effort depends in part on our ability to put doctors and health care resources where they are most needed, not simply where they are most profitable. But that will happen only if incentives that have traditionally gone into medical education to promote specialists now go into medical education to promote generalists.

The bold curricular changes undertaken at Hopkins reflect exactly the sort of creativity and vision we need across the board. Ultimately we have to recognize that there are values in our health care system that we need to promote and reassert and even to introduce. And this curricular change that will lead to the possibility of more primary care physicians is one of those values.

I commend Hopkins and I suggest to you that our national health care reform effort will in many ways have to follow the model that Hopkins has set. Through the government provision of resources for medical education we will have to alter the incentives that are currently there if we are to have an adequate supply of primary care physicians.

We will then have to look for ways of actually providing real loan repayment options and forgiveness of loans for students who are willing to go into those area that our country most dramatically needs in primary care. We will also have to be sure that we have the kind of linkages between primary care physicians and secondary and tertiary care practitioners and facilities that will enable the primary care physician to be part of a network of care.

Technology will help us in that regard. I'm sure many of you, as I have, have watched now the kind of technological linkage that exists in rural areas with academic medical centers in some parts of our country. Where we are getting to the point where a doctor in a rural area can hold an X-ray up and it can actually be read 400 or 500 miles away.

We need the kind of communication and cooperation between our academic medical centers and these primary care physicians once their supply is increased to ensure that we have the quality of care that they will expect to be able to delivery to their patients. We also will have to be sure that the academic medical centers do not in any way fall down on their responsibility to train specialists and subspecialists, but at least for the immediate future, the balance has to be altered.

I am particularly grateful to Dean Johns and to Dr. Jim Block for the time that they have spent with us talking through the problems of the academic medical centers, how to keep the missions of

these centers alive. And let me just run through some additional issues that we think will be particularly helpful to these centers.

In addition to your obligation to help us meet our supply problem, we anticipate being able to help centers such as this deal with their financial problems. You currently bear a disproportionate burden of treating patients who cannot afford to pay. Under a new health care system, however, all patients will be entitled to health care coverage and all providers will be fairly compensated for their services. This is particularly important for the uncompensated care that is delivered by a hospital such as the one here and many others like it around the country.

I have often explained, or tried to explain to audiences of citizens what that $20 bill for the Tylenol means on the hospital bill they receive in trying to explain to them how uncompensated care is paid for. Because one of the sad, and perhaps unfair, facts that we confront in the health care reform debate is that most American believe there is a very simple answer: Don't charge as much for what you do. That, to them, is the answer. All the rest of these issues that we have looked at and worried about over the last five months pale into insignificance against the overwhelming public perception that the real problem in health care is that doctors charge too much, hospitals charge too much, insurance companies charge too much, everybody charges too much so we just cut everybody's prices and everything will be fine.

You know that is not the case, and I know it. But it will be one of our challenges to educate the public and the more that you can talk about what it means for an institution like Hopkins Hospital to try to care for the people of East Baltimore, and to try to fund that care when so many patients are either uninsured or underinsured will enable us to have a much better educated audience when we come forward with health care reform.

So there will be great opportunities because there will be so little uncompensated care left when we are able to reform the system. There will also be incentives for hospitals, such as the one at Hopkins, to be part of networks that remove care away from the emergency and the tertiary care facility out into the community.

I have visited other hospitals, much as what you're trying to do here, where you begin to have a screening system so that when people walk in the door of the emergency it is not assumed that they will sit there and wait for several hours until their minor problem can be dealt with while you deal with emergencies, but instead they are immediately deflected off into a different system, maybe down the block, maybe across the street, maybe into a van where

they are taken to a family clinic where the problem that they have can be effectively and cost effectively dealt with.

We also will continue to do what we can to support the traditional research role of the academic medical center. We know how important that is. I ticked off earlier some of the many advances that have been and will continue to be made in medical research here at this institution.

We will look for ways to support that research. We believe that medical research is a cost effective investment, and we will be looking for ways to spread the burden more fairly and to increase the resources available to academic medical centers so that you can look forward to a steady stream of revenue, maybe even increasing in some areas a particular need so that we can continue the kind of breakthrough research that has been the hallmark of Hopkins and other academic medical centers.

We will also look for ways to be sure that that wonderful phrase that comes from one of your leaders, managed cooperation, is the reality. That is what we are really looking for. We are not looking for an environment in which the academic medical center competes with any other institution at the lowest common denominator. We are looking for ways to enhance the special roles of all kinds of institutions within our health care delivery system. That can only come about through cooperation.

And I had no idea before I got into this how difficult cooperation was. (Laughter.) You know how difficult it is. But it's going to require new attitudes on the part of lots of people. Specialists are going to have to cooperate with non-specialists; doctors are going to have to cooperate with nurses; hospitals are going to have to cooperate with clinics. All kinds of cooperative, collaborative arrangement should be seeded and nurtured in a reformed environment.

There will be so many opportunities for you as physicians or nurses or other staff members to have your roles enhanced and to be given back authority for making decisions again. But that will then put the burden on you of cooperating.

We have, inadvertently over the years, created a system in which cooperation was not necessarily valued. And it has not gotten us what we want. It has instead gotten us a system in which people are pitted against one another; in which reimbursement is based often on diagnosis or tests rather than quality and outcome; where teamwork is valued because it has to be there when you're actually on the floor doing what needs to be done; but is not valued within the larger system.

So we will look to you to help us create those new relationships of cooperation. And we will look to those who are not professionals to be more responsible for their own health care; to take that primary or preventive health care option that we will now require to be given to them; to be responsible for their own well-being; to give you a little help in your efforts to try to be the healers. But you will also have to perhaps go beyond the traditional medical school orientation, to talk more about things like nutrition, diet, exercise, stress reduction, the kinds of issues that until recently have not been considered part of the mainstream medical school curriculum but which many of us in this room practice ourselves, whether you talk to your patients about them or not.

And so we will have to look to you to give new leadership of a different kind, new meaning to the words health care. Because of President Richardson said, we often have a system that is a sickness system, not a health system. And we have to participate in changing the attitudes of ourselves and our fellow citizens if this reform is really to do what we hope it will do.

The kind of opportunities available for an Academic Medical Center are really only limited by the scope of imagination and vision. I anticipate that as we move forward in the next weeks we will engage in a vigorous and, I hope, constructive debate about what direction we need to go and how the President's policies will be received. That's what should take place as we embark on a great effort to reform this system to benefit everyone.

But I hope that it will not be a debate just about narrow issues and that each of us from whatever perspective we bring will be able to step outside our own view and our own experience to think as broadly as possible. There is no better place to get that kind of vision than a place like this one. We will need your continuing guidance as so many of you have already given to us. We will need your voices.

And for every question you ask, suggest a possible answer, because there isn't any doubt, I don't think, that we can do better. We can do better as a nation because when one stops and thinks a minute about what is a stake, it is not just about how we finance health care, although certainly it is that. It is not just about insuring that we rid ourselves of the unnecessary bureaucracy and paperwork, and how we deal with the threat of malpractice that hangs over your heads, It is not just about increasing and enhancing our research agenda so that we get better results more quickly delivered to the maximum number of people. It is not even just about how we cooperate with one another among professionals. It is not

even just about how much responsibility individuals finally are willing to take for themselves.

It is all of that, but it is more. It is about the quality of our community together. It is about what kind of people we are and intend to be. It is about how we treat one another, how we care for all of us, but particularly those who are least fortunate among us. This health care reform will certainly say a lot about Johns Hopkins, about hospitals, about medicine, but it will ultimately say a lot more about what kind of social contract we have with one another, what kind of country we are, and what kind of country we want to be. Thank you all very much. (Applause.)

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THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

REMARKS BY THE FIRST LADY
TO THE AMERICAN MEDICAL ASSOCIATION
June 13, 1993
Chicago, Illinois

MRS. CLINTON: Thank you very much, Mr. Speaker; all of the members of the House of Delegates, the officers and trustees of the AMA, and all whom you represent. It is an honor for me to be with you at this meeting and to have the opportunity to participate with you in an ongoing conversation about our health care system and the kinds of constructive changes that we all wish to see brought to it.

I know that you have, through Health Access America, and through other activities and programs of the AMA been deeply involved in this conversation already, and all of us are grateful for your contribution. I'm also pleased that you invited students from the Nathan Davis Elementary School to join us here this afternoon. (Applause.) I know that the AMA has a special relationship with this school, named as it is for the founder of the AMA, and that the AMA participates in its corporate capacity in the Adopt a School program here in Chicago. You have made a real contribution to these young men and women. And not only have you provided free immunizations and physicals and lectures and help about health and related matters, but you have served as role models and mentors. It is very important that all of us as adults do what we can to give young people the skills they will need to become responsible and successful adults. And I congratulate you for your efforts and welcome the students here today.

All of us respond to children. We want to nurture them so they can dream the dreams that free and healthy children should have. This is our primary responsibility as adults. And it is our primary responsibility as a government. We should stand behind families, teachers and others who work with the young, so that we can enable them to meet their own needs by becoming self-sufficient and responsible so that they, in turn, will be able to meet their families and their own children's needs.

When I was growing up, not far from where we are today, this seemed an easier task. There seemed to be more strong families. There seemed to be safer neighborhoods. There seemed to be an outlook of caring and cooperation among adults that stood for and behind children. I remember so well my father saying to me that if

MORE

you get in trouble at school, you get in trouble at home -- no questions asked -- because there was this sense among the adult community that all of them, from my child's perspective, were involved in helping their own and others' children.

Much has changed since those days. We have lost some of the hope and optimism of that earlier time. Today, we too often meet our greatest challenges, whether it is the raising of children or reforming the health care system, with a sense that our problems have grown too large and unmanageable. And I don't need to tell you that kind of attitude begins to undermine one's sense of hope, optimism, and even competence.

We know now -- and you know better than I -- that over the last decade our health care system has been under extraordinary stress. It is one of the many institutions in our society that has experienced such stress. That stress has begun to break down many of the relationships that should stand at the core of the health care system. That breakdown has, in turn, undermined your profession in many ways, changing the nature of and the rewards of practicing medicine.

Most doctors and other health care professionals choose careers in health and medicine because they want to help people. But too often because our system isn't working and we haven't taken full responsibility for fixing it, that motive is clouded by perceptions that doctors aren't the same as they used to be. They're not really doing what they used to do. They don't really care like they once did.

You know and I know that we have to work harder to renew a trust in who doctors are and what doctors do. That is also not unique to the medical community. Just as our institutions across society are under attack and stress, all elements of those institutions are finding that they no longer can command the trust and respect, whether we talk of parents or government officials or other professionals -- police officers, teachers -- that should come with giving of themselves and doing a job well that needs to be done.

But focusing this afternoon on those concerns that are yours -- what has happened with medicine, what is likely to happen -- we need to start with a fundamental commitment to making the practice of medicine again a visible, honored link in our efforts to promote the common good. And the way to do that is to improve the entire system of which you are a part. We cannot create the atmosphere of trust and respect and professionalism that you deserve to have, and that many of you who are in this room remember from earlier years, without changing the incentives and the way the entire system operates. That has to be our primary commitment. If we do not put

medicine and those who operate within medicine in the forefront of the respect they deserve to have, no matter what we do to the system on the margins will not make the differences that it should. (Applause.)

As you know, the President is in the process of finalizing his proposal for health care reform, and I am grateful to speak with you about that process and where it is today and where it is going. I had originally hoped to join you at your meeting in March in Washington, D.C. And I, again, want to apologize for my absence. I very much appreciated Vice President Gore attending for me, and I also appreciated the kind words from your executive officials on behalf of the entire association because of my absence.

My father was ill and I spent several weeks with him in the hospital before he died. During his hospitalization at St. Vincent's Hospital in Little Rock, Arkansas, I witnessed firsthand the courage and commitment of health care professionals, both directly and indirectly. I will always appreciate the sensitivity and the skills they showed, not just in caring for my father, not just in caring for his family -- which, as you know, often needs as much care as the patient, but in caring for the many others whose names I will never know. I know that some of you worry about what the impact of health care reform will be on your profession and on your practice. Let me say from the start, if I read only what the newspapers have said about what we are doing in our plan, I'd probably be a little afraid myself, too, because it is very difficult to get out what is going on in such a complex process.

But the simple fact is this: The President has asked all of us, representatives of the AMA, of every other element of the health care system, as well as the administration, to work on making changes where they are needed, to keeping and improving those things that work, and to preserving and conserving the best parts of our system as we try to improve and change those that are not.

This system is not working as well as it did, or as well as it could -- for you, for the private sector, for the public or for the nation. The one area that is so important to be understood on a macronational level is how our failure to deal with the health care system and its financial demands is at the center of our problems financially in Washington. Because we cannot control health care costs and become further and further behind in our efforts to do so, we find our economy, and particularly the federal budget, under increasing pressure.

Just as it would be irresponsible, therefore, to change what is working in the health care system, it is equally irresponsible for us not to fix what we know is no longer working.

So let us start with some basic principles that are remarkably like the ones that you have adopted in your statements, and in particularly in Health Access America. We must guarantee all Americans access to a comprehensive package of benefits, no matter where they work, where they live, or whether they have ever been sick before. If we do not reach universal access, we cannot deal with our other problems.

And that is a point that you understand that you have to help the rest of the country understand -- that until we do provide security for every American when it comes to health care, we cannot fix what is wrong with the health care system. Secondly, we do have to control costs. How we do that is one of the great challenges in this system, but one thing we can all agree on is that we have to cut down on the paperwork and reduce the bureaucracy in both the public and private sectors. (Applause.)

We also have to be sure that when we look at costs, we look at it not just from a financial perspective, but also from a human perspective. I remember sitting in the family waiting area of St. Vincent's, talking to a number of my physician friends to stop by to see how we were doing. And one day, one of my friends told me that, every day, he discharges patients who need medication to stabilize a condition. And at least once a day, he knows there is a patient who will not be able to afford the prescription drugs he has prescribed, with the result that that patient may decide not to fill the prescription when the hospital supply runs out. Or that patient may decide that even though the doctor told him to take three pills a day, he'll just take one a day so it can be stretched further.

And even though St. Vincent's has created a fund to try to help support the needs of patients who cannot afford prescriptions, there's not enough to go around, and so every day there is someone who my friend knows and you know will be back in the hospital because of their inability either to afford the care that is required after they leave, or because they try to cut the corners on it, with the net result that then you and I will pay more for that person who is back in the hospital than we would have if we had taken a sensible approach toward what the real costs in the medical system are. That is why we will try, for example, to include prescription drugs in the comprehensive benefit package for all Americans, including those over 65, through Medicare. (Applause.)

We believe that if we help control costs up front, we will save costs on the back end. That is a principle that runs through our proposal and which each of you knows from firsthand experience is more likely to be efficient in both human and financial terms. We will also preserve what is best in the American health care system today.

We have looked at every other system in the world. We have tried to talk to every expert whom we can find to describe how any other country tries to provide health care. And we have concluded that what is needed is an American solution for an American problem by creating an American health care system that works for America. (Applause.) And two of the principles that underlie that American solution are quality and choice. (Applause.)

We want to ensure and enhance quality. And in order to do that, we're going to have to make some changes, and you know that. We cannot, for example, promise to really achieve universal access if we do not expand our supply of primary care physicians, and we must do that. (Applause.) And you will have to help us determine the best way to go about achieving that goal.

I've spoken with representatives of our medical schools, and we have talked about how the funding of graduate medical education will have to be changed to provide incentives for the training of more primary care physicians. (Applause.) I have talked with representatives of many of the associations, such as this one, about how continuing educational opportunities could help even mid-career physicians, once we have a real supply of primary care physicians who are adequately reimbursed and adequately supported, how they might even go back into primary care. (Applause.)

We have also very much put choice in the center of our system so that we will have not just choice for patients as to which plan they choose to join, but choice for physicians as to which plan they choose to practice with, including the option of being part of more than one plan at the same time. (Applause.)

Now, as we work out all of the details in the many proposals and its parts that must come together, I am not suggesting that you will agree with every recommendation the President makes. I don't expect any group to do that. In fact, I suppose that if everybody's not a little put out that means we probably haven't done it right. But I do hope and expect that this group, as with other groups representing physicians and nurses and other health care professionals will find in this plan much to be applauded and supported. And I also believe that given the complexities of the problem we face, it would be difficult to arrive at a solution that was universally accepted.

But the reason I have confidence that this house, the AMA, and others will be supportive of the President's proposal is because we have benefited so much from what you have already done and from the involvement of many of you and others around the country.

Again, contrary to what you may have heard scores of practicing physicians served on the working groups that were studying health care reform. I am deeply grateful on a personal level that members of the AMA's leadership spent invaluable time coming to meeting after meeting, day after day sharing their ideas, reacting to ideas at the White House. And, of course, in the course of that we learned we had many common goals and objectives.

We will not only stand for universal coverage, but in addition the following: community rating so that we can assure all Americans they will be taken care of -- (applause); eliminating restrictions based on preexisting conditions so that every American will be eligible -- (applause); a nationally guaranteed comprehensive benefits package that will emphasize primary and preventive health care as well as hospitalization and other care -- (applause); the kind of choice and quality assurances that we will need to have to make sure this new system not only operates well during the transition but gets a firm footing as it moves into the future and we will therefore be emphasizing more on practice parameters and outcomes research so that you, too, can know better what works.

One of the great interesting experiences I have had during the past months is as I've traveled around from state to state is having doctors coming up to me and telling me that they need more information; that all too often the information they receive doesn't come to them in forms that they believe are practical in their particular context. And what we want to do is by working with organizations like yours is be sure that the quality outcomes and the kind of research that will done will be readily available to every practicing physician in the country.

We also believe that it will be essential to continue medical research and to use the breakthroughs in medical research, again, not just to alleviate human suffering but to save money, because you know better than I that often times a breakthrough in research, a new drug, a new procedure is the quickest way to take care of the most people in a cost-effective manner. So we will continue to support medical research. (Applause.)

All of these principles arise from the same common assumption -- that the status quo is unacceptable. And it is not really even any longer a status quo because we do not stand still, we drift backwards. Every month people lose their insurance; every month you have more micromanagement and regulation to put up with; every month our health care system becomes more expensive to fix.

I know that many of you feel that as doctors you are under siege in the current system. And I think there is cause for

you to believe that, because we are witnessing a disturbing assault on the doctor/patient relationship. More and more employers are buying into managed care plans that force employees to choose from a specific pool of doctors. And too often, even when a doctor is willing to join a new plan to maintain his relationship with patients, he, or she I should say, is frozen out.

What we want to see is a system in which the employer does not make the choice as to what plan is available for the employee, the employee makes that choice for him or herself. (Applause.) But if we do not change and if the present pattern continues, as it will if we do not act quickly, the art of practicing medicine will be forever transformed. Gone will be the patients treasured privilege to choose his or her doctor. Gone will be the close trusting bonds built up between physicians and patients over the years. Gone will be the security of knowing you can switch jobs and still visit your longtime internist or pediatrician or OB/GYN.

We cannot afford to let that happen. But the erosion of the doctor/patient relationship is only one piece of the problem. Another piece is the role that insurance companies have come to play and the role that the government has come to play along with them in second-guessing medical decisions.

I can understand how many of you must feel. When instead of being trusted for your expertise, you're expected to call an 800 number and get approval for even basic medical procedures from a total stranger. (Applause.)

Frankly, despite my best efforts of the last month to understand every aspect of the health care system, it is and remains a mystery to me how a person sitting at a computer in some air-conditioned office thousands of miles away can make a judgment about what should or shouldn't happen at a patient's bedside in Illinois or Georgia or California. The result of this excessive oversight, this peering over all of your shoulder's is a system of backward incentives. It rewards providers for over prescribing, overtesting, and generally overdoing. And worse, it punishes doctors who show proper restraint and exercise their professional judgment in ways that those sitting at the computers disagree with. (Applause.)

Dr. Bob Barrinson, one of the practicing physicians who spent hours and hours working with us while also maintaining his practice, told us recently of an experience that he had as one of many. He admitted an emergency room patient named Jeff. Jeff suffered from cirrhosis of the liver and --. Dr. Barrinson put him in the hospital and within 24 hours received a call from Jeff's insurance company. The insurance company wanted to know exactly how many days Jeff would be in the hospital and why. Dr. Barrinson

replied that he couldn't predict the precise length of stay. A few days later the insurance company called back and questioned whether Jeff would need surgery. Again, Dr. Barrinson said he wasn't yet sure.

And what was Dr. Barrinson's reward for his honesty and his professionalism? He was placed on the insurance company's "special exceptions" list. You know, that's a list of troublesome doctors who make the insurance company wait a few days or a few weeks to determine the bottom line on a particular patient.

From that point on, the insurance company called Dr. Barrinson six times in two weeks. Each time he had to be summoned away from the patient to take the call. Each time he spoke to a different insurance company representative. Each time he repeated the same story. Each time his role as the physician was subverted. And each time the treatment of the patient was impeded.

Dr. Barrinson and you know that medicine, the art of healing, doesn't work like that. There is no master checklist that can be administered by some faceless bureaucrat that can tell you what you need to do on an hourly basis to take care of your patients; and, frankly, I wouldn't want to be one of your patients if there were. (Applause.)

Now, adding to these difficulties doctors and hospitals and nurses, particularly, are being buried under an avalanche of paperwork. There are mountains of forms, mountains of rules, mountains of hours spent on administrative minutiae instead of caring for the sick. Where, you might ask yourself, did all this bureaucracy come from? And the short answer is, basically, everywhere.

There are forms to ensure appropriate care for the sick and the dying; forms to guard against unnecessary tests and procedures. And from each insurance company and government agency there are forms to record the decisions of doctors and nurses. I remember going to Boston and having a physician bring into a hearing I held there the stack of forms his office is required to fill out. And he held up a Medicare form and next to it he held up an insurance company form. And he said that they are the same forms that ask the same questions, but the insurance company form will not be accepted by the government, and the government form will not be accepted by the insurance company. And the insurance company basically took the government form, changed the title to call it by its own name and requires them to have it filled out. That was the tip of the iceberg.

One nurse told me that she entered the profession because she wanted to care for people. She said that if she had wanted to be an accountant, she would have gone to work for an accounting company instead. (Laughter.) But she, like many other nurses, and as you know so well, many of the people in your offices now, are required to be bookkeepers and accountants, not clinicians, not caregivers. (Applause.)

The latest statistic I have seen is that for every doctor a hospital hires, four new administrative staff are hired. (Applause.) And that in the average doctor's office 80 hours a month is now spent on administration. That is not time spent with a patient recovering from bypass surgery or with a child or teenager who needs a checkup and maybe a little extra TLC time of listening and counseling, and certainly not spent with a patient who has to run in quickly for some kind of an emergency.

Blanketing an entire profession with rules aimed at catching those who are not living up to their professional standards does not improve quality. What we need is a new bargain. We need to remove from the vast majority of physicians these unnecessary, repetitive, often uneven read forms and instead substitute for what they were attempting to do -- more discipline, more peer review, more careful scrutiny of your colleagues. You are the ones who can tell better than I or better than some bureaucrat whether the quality of medicine that is being practiced in your clinic, in your hospital, is what you would want for yourself and your family. (Applause.)

Let us remove the kind of micromanagement and regulation that has not improved quality and has wasted billions of dollars, but then you have to help us substitute for it, a system that the patients of this country, the public of this country, the decision-makers of this country can have confidence in. Now, I know there are legal obstacles for your being able to do that, and we are looking very closely at how we can remove those so that you can be part -- (applause) -- of creating a new solution in which everyone, including yourself, can believe in.

In every private conversation I've had with a physician, whether it's someone I knew from St. Vincent's or someone I had just met, I have asked: Tell me, have you ever practiced with or around someone you did not think was living up to your standards? And, invariably, the answer is, well, yes, I remember in my training; well, yes, I remember this emergency room work I used to do; yes, I remember in the hospital when so-and-so had that problem. And I've said, do you believe enough was done by the profession to deal with that problem and to eliminate it? And, invariably, no matter who the doctor is, I've been told, no, I don't.

We want you to have the chance so that in the future you can say, yes, I do believe we've been dealing with our problems. It is not something we should leave for the government, and, certainly, we cannot leave it to the patient. That is the new kind of relationship I think that we need to have.

Finally, if we do not, as I said earlier, provide universal coverage, we cannot do any of what I have just been speaking about because we cannot fulfill our basic commitment you as physicians, us as a society, that we will care for one another. It should no longer be left to the individual doctor to decide to probe his conscience before determining whether to treat a needy patient. I cannot tell you what it is like for me to travel around to hear stories from doctors and patients that are right on point.

But the most poignant that I tell because it struck me so personally was of the woman with no insurance; working for a company in New Orleans; had worked there for a number of years; tried to take good care of herself; went for the annual physical every year; and I sat with her on a folding chair in the loading dock of her company along with others -- all of whom were uninsured; all of whom had worked numbers of years -- while she told me at her last physical her doctor had found a lump in her breast and referred her to a surgeon. And the surgeon told her that if she had insurance, he would have biopsied it but because she did not he would watch it.

I don't think you have to be a woman to feel what I felt when that woman told me that story. And I don't think you have to be a physician to feel what you felt when you heard that story. We need to create a system in which no one ever has to say that for good cause or bad, and no one has to hear it ever again. (Applause.)

If we move toward universal coverage, so therefore everyone has a payment stream behind them to be able to come into your office, to be able to come into the hospital, you will again be able to make decisions that should be made with clinical autonomy, with professional judgment. And we intend to try to give you the time and free you up from other conditions to be able to do that.

One specific issue I want to mention, because I feel strongly about it -- if my husband had not asked me to do this, I would have felt strongly about it because of the impact in my state of Arkansas -- we have to simplify and eliminate the burdensome regulations created under *CLEA -- (applause) -- a well-intentioned law with many unintended consequences that have affected not only those of you in private practice but public health departments like ours in Arkansas around the country.

But again we need that new bargain. You have to help us know what should be eliminated so that we then can just focus in on a very small part of this whole situation and eliminate the rest of the regulations that were thrown on top.

So those are the kinds of issues in which we think we can make it more possible for you to practice in a more efficient, humane, better manner. We also believe strongly that we have to emphasize preventive care. And we have to provide a basic policy of preventive care. And we have to be sure that all of you and those who come after you into medicine are trained well in medical school to appreciate the importance of preventive care. (Applause.)

Much of what is now considered outside the scope of mainstream medicine is crowding in. Many of us in this room I know exercise, try to watch our diets, do things to try to remain healthier. And yet often medical education and medicine as it's practiced does not include those new kind of common-sense approaches to health. We need to be a system that does not take care of the sick but instead promotes health wherever we can in whatever way we possibly can do it. (Applause.)

And finally, let me say that we will offer a serious proposal to curb malpractice problems for all of you. (Applause.) But let me add that it, too, must be part of this new contract. In order to do that and to do it in a way that engenders the confidence of the average American, we must have organized medicine standing ready to say we will do a better job of taking care of the problems within us. (Applause.)

I have read or tried to read everything I can find about all of this. And you know as well as I do there are studies all over the field. It depends upon who writes it and who it's written for and the like. But we know there's a problem. We know we're going to deal with it. But one of the stark statistics from these studies is that all too often the largest number of malpractice suits is brought against the same physicians on a repetitive basis.

Now, it may be that for some that is an unfair accusation, and we need to deal with that through reform. But for others, you need to weed them out of your profession if they cannot practice to the quality that you expect your fellow colleagues to practice to. So we will propose serious malpractice reform, and we will have to look to you to help us make sure that the problems that will still flow from people who should not be making decisions will be eliminated. That way we can give confidence back to you as a profession, that you will not be second-guessed or unfairly called into court. And we will give confidence to the public that they will

be protected insofar as humanly possible. So that is what we will have to look for when we come forward with that. (Applause.)

Now, reaching consensus on all that should be done and putting it into a piece of legislation and moving it through the Congress is not going to be easy. There will be many groups that will nibble at the edges of it, not like the whole idea of it, want to continue to the status quo. But if we do not have the courage to change now, if we do not move toward a system that once again gives you back your professionalism to practice prudent, practical, intelligent medicine again; if we do not move toward restoring the dignity again to the doctor-patient relationship, and that encourages young people to become physicians because they want to participate in that wonderful process of healing and caring, then the entire society, but most particularly medicine, will suffer.

The reason we are doing any of this is because of children like those who are here from Nathan Davis. Most of us in this room are at least halfway through. (Laughter.) And most of us in this room have sat in dozens and dozens of meetings just like this. We've sat and listened to people tell us what was wrong with health care or what medicine or with whatever, and we've talked about the problems at least seriously since the 1970s. And we've produced proposals like yours for Health Access America.

But while we have talked, our problems have gotten worse, and the frustration on the part of all of you and others has increased. Time and again, groups, individuals, and particularly the government, has walked up to trying to reform health care and then walked away.

There's enough blame to go around, every kind of political stripes can be included, but the point now is that we could have done something about health care reform 20 years ago and solved our problems for millions of dollars, and we walked away. Later we could have done something and solved our problems for hundreds of millions, and we walked away.

After 20 years with rate of medical inflation going up and with all of the problems you know so well, it is a harder and more difficult solution that confronts us. But I believe that if one looks at what is at stake, we are not talking just about reforming the way we finance health care, we are not talking just about the particulars of how we deliver health care, we are talking about creating a new sense of community and caring in this country in which we once again value your contribution, value the dignity of all people.

How many more meetings do we need? How many alerts? How many more plans? How many more brochures? The time has come for all of us, not just with respect to health care, but with respect to all of the difficulties our country faces to stop walking away and to start stepping up and taking responsibility. We are supposed to be the ones to lead for our children and our grandchildren. And the way we have behaved in the last years, we have run away and abdicated that responsibility. And at the core of the human experience is responsibility for children to leave them a better world than the one we found.

We can do that with health care. We can make a difference now that will be a legacy for all of you. We can once again give you the confidence to say to your grandsons and granddaughters, yes, do go into medicine; yes, it is the most rewarding profession there is.

So let's celebrate your profession by improving health care. Let's celebrate our children by reforming this system. Let's come together not as liberals or conservatives or Republicans or Democrats, but as Americans who want the best for their country and know we can no longer wait to get about the business of providing it.

Thank you all very much. (Applause.)

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THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release June 18, 1993

REMARKS BY THE FIRST LADY

Woodstock, Vermont

MRS. CLINTON: Thank you. (Applause.) Thank you very much. Thank you for that kind introduction and thank you for holding this meeting in Woodstock, Vermont. It is a great pleasure for me to be back in Vermont and to have a chance to see some of you. And I hope later in the afternoon to have a chance to visit with some of the citizens here in this community.

I also want to thank Governor Walters, as the chair of the Democratic Governors Association, for inviting me to speak with you and with the governors today. And it is particularly fitting that this meeting would be held in Vermont, because it is a state that has done more than just talk about the importance of health care reform. It has been out front on this issue, and has put forward some of the most forward-thinking proposals that we have been able to review and analyze, that would move our country toward expanding coverage for all citizens and lowering costs. And it is no surprise that Vermont is in this position.

For years, Senator Leahy has been fighting to improve health care, and has particularly argued strongly about the role of states in improving health care and how imperative it is to move on reforming health care now. And I personally have benefitted a great deal from my relationship with Senator Leahy and the work that he has been willing to do with me. And I am very grateful for that.

And at the same time, it is always a pleasure to have a governor like your governor, Governor Dean, who fights hard from the perspective not only of a governor and someone who has to make these hard decisions, but for him, health care reform hits very close to home. As a physician, he has lived with the problems of today's patchwork system. He has seen the people who have been left out. He has dealt with the problems of a practitioner. He and his wife, Judy, stand out as examples of what the medical profession should be about -- people doing their best to care for those in need. And I've learned a great deal about this issue from Governor Dean, and I am very grateful for that.

MORE

Before I go any further on health care reform, however, I want to announce something of great importance to the state of Vermont. I was informed late last night by the Department of Labor that two emergency applications to assist dislocated workers here in Vermont have been approved. And I wanted to come and announce that today because there are hundreds of workers at IBM and at St. Johnsbury who would otherwise not know today that they were going to get some assistance when they have been laid off. (Applause.)

The two grants total $1,225,000 and they will assist approximately 800 dislocated workers. And I told Senator Leahy and Senator Jeffords and Congressman Sanders, all of whom I flew up with today from Washington, that the administration was very committed to continue the kind of economic efforts that it has started in Washington so that we could in the future see fewer of these kinds of abrupt changes that throw people out of work who have been working hard all of their lives. And what we hope to do is to have the kind of partnership with the states and local communities, with new leadership on the economic front in Washington that enables us not just to help dislocated workers, but to locate more and more people in jobs that will not be dislocated in the global economy that we are confronting. So I am delighted to be of assistance in announcing this grant to make it clear to Vermont that Washington does know where you are, Governor, and Washington cares about the people of Vermont. (Applause.)

Because, you know, our nation's competitiveness ultimately rests on the skills and talents of our people. And if we do not have a work force that is well-equipped and ready to go to work, to be competitive, then all the rest that we talk about cannot come to pass. And it is clear that health care reform is an economic issue as well as a human one. We have to be able to provide the kind of security with a good job and good health care benefits that people deserve to have. It is with that kind of security on a personal level that will enable people to make the kind of commitments to the future that we need them to make.

So this is an issue linking economic security and health care security that we have to talk about now and into the future as many times as we have the opportunity to do so, because we cannot separate the health care reform debate from the economic competitiveness position of our country, and we cannot let people live with the kind of insecurity that comes when they can show up at work one day and told that their company is shutting down that afternoon, and that whatever benefits they once took for granted will no longer be there. That has to end in America, and this is one of the ways we can do that. (Applause.)

Which is why it is so important that governors like those whom you see before you stay intimately involved in the health care reform debate. Because I know, from the 12 years of experience that my husband had as the governor of a state, that often that is where we find out what is really meant by national economic policy or health care policy, because bills can be passed in the Congress, but they have to be implemented at the state and local level. And so it is imperative that people with the kind of experience you see before you stand ready to advise, to experiment, to come up with the kinds of ideas that will enable us to have a national health care reform system.

Because imagine, if you will, seeing the health care reform issue from the eyes of one of these governors who is sitting here, just as my husband was for 12 years. He remembers what it was like to see the number of uninsured and underinsured people. He remembers what it was like, despite the best efforts of the states to try to control costs, to watch them continue to accelerate it. He remembers what it was like to try to deal with the budgetary pressures that were pushed upon the states by the human need underlying the expaNsion of Medicaid. He remembers what it was like to have businesses coming in to see him who were saying, we want to keep providing benefits because it's the right thing to do, But it becomes harder and harder every year. And he remembers what it was like, being on the receiving end of a bureaucracy in both the public and the private sector that second-guessed decisions, that peered over shoulders, that employed people not to deliver care but to check up on those who were. He remembers and he wants, therefore, to take that experience and put it to work along with these governors to make the changes he knows need to be made.

Because the problems are felt most clearly at the local level, we need a national partnership in reforming health care. It will require national solutions, but it will absolutely require states to be involved in implementing those solutions. States cannot solve the health care crisis on their own. No matter how innovative -- and we have before us today, the most innovative among our governors -- But they cannot on their own deal with what is a national problem.

So I'd like to take a few minutes to talk about the process we have undertaken to improve the country's health care system and to talk about the fundamental goals of our reform. First, as Governor Dean has already said, we tried to pull together from across our country people from every walk of life, every kind of experience, who knew what the problem was and had experienced it firsthand. We felt strongly that state government had to be represented in that process. Many of these governors and many others sent staff members to work with us, came in themselves to attend

meetings, gave us the benefit of their deliberations as they drafted legislation, worked with legislatures and with groups in their own states.

We have been meeting on a regular basis, and we have found, as you might guess, that our process has been improved because of the contributions from the state and local level. We've held more than 1,000 meetings with people who have a particular point of view on health care reform; because just about everyone in this country does have a stake in making sure we do it right.

And it's been interesting to me to see how willing people have been to put aside their own particular point of view to try to look at the whole; because it is unlikely we will or anyone could come up with a proposal that would satisfy everybody. Everybody will have to move a little bit in order to get to a point where the whole will be bigger than the sum of its parts. And many people have been willing to do just that in our efforts to craft this proposal.

We have also been working hard to educate ourselves, the American people, about what is at stake. When people understand how the health care crisis impacts on them personally, not just in terms of whether or not they have insurance, or whether their insurance this year costs the same as it did last year, or whether they fear losing insurance because of something beyond their control like a preexisting condition or their inability to change jobs, or even whether they stand scared on the precipice of the next health care disaster because they don't have insurance, but when they begin to see their personal situation in context with what is going on in the broader community, then we make real progress so that everyone understands how the pieces of this fit together. That's the kind of educational process that we are engaged in now that each of you is a part of.

It's important, as I walk down later this afternoon this beautiful street I rode up to come to this meeting, to know that as I will pass store after store after store, some of the people working in those stores will have insurance; down the block some will not. If a medical emergency happens later this afternoon, the person will be taken to the nearest hospital without regard to that. The person will then be given the care that is needed for that emergency, because it is not fair to say that people go completely without care in our country. They get care, but often only in an emergency, only when it's become more expensive than it should have.

And regardless of whether that person had the insurance to take care of that emergency, it will be paid for by those of us who do -- those of us who carry private insurance; those of us who

have employers who pay for it; those of us who have government assistance. That is one of the reasons why when one looks at a hospital bill you're sometimes struck by the fact that aspirin was charged to you for $20. It's not because it's worth $20, it's to take care of those people who were taken of who didn't have compensation.

Or when we think about what it's like for people who are trying to make job decisions, and they can't make them to use their best talents to be competitive because they can't leave a job where they have benefits.

And when people begin to understand how we are all in this together, how today is not at all secure with respect to what we will have tomorrow, then the education process really takes hold -- because the most important thing that I have found as I traveled around the country, no matter whom I have talked with, is security. That's what people want. Whether they think they have it now or whether they never have, they want the security to know that their primary and preventive health care needs will be taken care of and that their acute and chronic needs will be taken care of.

This is the key to what kind of health care reform we have to offer to the American people, because what we have to be able to say at the end of this process is that if we enact the President's proposal, those millions of Americans, nearly 40 million now, who do not have any insurance will have health security. Those millions more who have some insurance but not enough if the real emergency comes, will have security. And most importantly, the majority of us who do have some insurance, who feel that we have taken care of ourselves, through our own efforts or that of our employers, we can rest assured we will have it next year and the year after and the year after that. No matter who we work for, no matter how sick we might become, no matter who we marry or the state of the health of the child we bear, we will all be secure.

We have to make it possible for every American who works for a living, who pays the bills, who takes care of raising their families, who pay the taxes, that they do not have to fear going without insurance and health security. (Applause.)

You have before you governors who have taken impressive steps on their own in the absence of federal action, who have tried to meet the needs as they saw them in their own states. Governor Chiles from Florida has a health care reform act that will bring the promise of care to many Floridians who have never had insurance. You know here that Governor Dean's Vermont Health Care Authority is working hard to provide universal access in a way that makes the most sense. Governor Jones and Governor McWherter have been fighting for

better health care in their states and have come forward with comprehensive legislative proposals.

The national reform effort will bolster these efforts, will support them, will enable them because we will have a national framework within which the responsibilities of the federal government will be spelled out and the responsibilities of the state government. That is an issue that Senator Leahy has been working on for a number of years with my good friend, Senator Pryor from Arkansas -- to build up this kind of partnership between the national and state governments.

Once the new health care system is up and running, every American citizen and those who are permanent residents in this country will get a health security card. That card will guarantee all Americans a comprehensive package of benefits, no matter where they work, were they live, how old they are, or whether they have ever been sick.

The benefits package will emphasize primary and preventive health care because we have to begin to redress the imbalance that has been allowed to develop in our health care system where we had the most highly sophisticated health care available anywhere in the world; so that you could with great ease and comfort of mind know that you could get a heart bypass, but you could not be sure that you would be able to get your child adequately immunized. We need to reverse that. To not do anything that endangers the quality of the very top of our health care system, but to build up the base so that we can provide more services and save more money because we will allocate our resources better. (Applause.)

Second, we are going to make sure that with that health card that guarantees those benefits packages, we will be bringing costs under control. You see, every day what happens is that health care is priced out of reach of many Americans. Many of you have seen your own personal costs, your business's costs, your state's costs get driven out of sight. I know that Florida's health care costs, for example, have quadrupled in the last 12 years, and that is happening all over the country.

This forces us as individuals, as businesses, as states, and as the federal government to absorb more and more red ink. And it forces many segments of the health care system to shift costs wherever they can find those dollars. That's what leads to the $20 aspirin. All of us bear the burden and if left unchecked, health care costs will continue to hurt our families, bankrupt our businesses, and our state budgets, and drive the federal deficit ever and ever higher.

But there has been some innovative efforts at the state level to try to get a hold of costs. Governor Romer's program, Colorado Care, for example, confronts the cost problem head on, something the federal government for the last 12 years has never been able to do. We will learn from the efforts of Colorado and other states how best to control prices within the health care system, but it will be absolutely necessary as we move to a reform system to realize that if we do not control the costs, we cannot reach universal coverage and we cannot provide the kind of broad-based benefits packages that Americans deserve to have.

So we will have the rein in health care costs in several ways. We will have to get rid of incentives for doctors who do more tests and procedures. Instead, we will create a system that encourages cost-effective, high quality care where doctors and patients can again be at the center of the relationship, and where decisions can be made not on how something will be reimbursed, but on whether a doctor believes it is best for a patient.

We will have to reduce the bureaucracy and micro-management that absorbs billions of dollars out of our health care system, and that so many of you have complained about because it adds unnecessary costs. And we will have to tell health care institutions and providers that we all must learn to live within a budget. We can no longer write a blank check for health care in this country. (Applause.)

We will have to ask everyone -- workers, employers, doctors, nurses, other health care providers, hospitals -- to do their part. We'll have to tell every other aspect of the health care industry that it can no longer expect to be raising its prices and profits growing at two to three to four to five to eight times the rate of inflation. We're going to tell workers that if they do not do their part to be responsible users of health care, then we will never be able adequately to rein in costs. But we will also have to tell companies that do not cover their workers today and, therefore, drive up the costs for all those other companies that do, it is time, finally, for everybody in America to take responsibility. That has to be one of the keys to our future. (Applause.)

There can't be any more free lunch. There can't be any more free health care to which people feel they are entitled. There cannot be any more people who take advantage of the system and basically take a free ride. It is only fair that we all pay our share.

Now, Governor Roberts from Oregon knows that this is no easy task. But Oregon took this issue on anyway by asking employers to contribute for their workers' health care. And it means that

everyone will share the burden. It will be, therefore, spread more evenly across more people, which will enable all of us to have more security, a better functioning health care system, and lower costs.

And we're going to tell individuals who think they can get by without coverage because they're 25 and believe they're immortal, that when they have that terrible accident or unpredicted illness and end up in the emergency room or in the ICU and stick us with the bill, that we're not going to let that go on any longer. Everybody will have to contribute to the health care system, just like in many states they have to have auto insurance -- because nobody can predict when you're going to have that accident or you're going to have that illness, and it's time that everybody bears their fair share of the responsibility for taking care of those accidents and illnesses when they occur. (Applause.)

It is an absolutely critical part of this plan that people become responsible. Many of the problems that we are dealing with in Washington today have been made all the much harder because of years of irresponsibility at the federal level. It is time for us to go beyond partisan politics, to go beyond ideology and to say, responsibility is not a Republican or a Democratic or a liberal or a conservative concept. It is at the root of what it means to be an American, and we're going to start insisting upon it being present once again in this country. (Applause.)

Thirdly, we are proposing a wholesale reduction of the frustrating and wasteful paperwork that eats up the health care system. When you look, as Ira and I have, at the volumes of regulations that have been put into effect over the years, the stacks and stacks of forms, you ask yourself: Where did all this bureaucracy come from? And the short answer is, it came from everywhere. It comes from private insurers, it comes from the government. Forms were created to make sure forms were filled out properly. And it makes it impossible, often, for the most vulnerable people to get the care that they need. And it also has undercut the delivery of care. Because as the number of health insurance companies grew -- and today there are more than 1500 -- so did the number of forms. And the result is that, instead of a system in which patient care and doctor decision-making and nurse caring drive the system, paperwork does.

Most nurses now spend nearly half of their time filling out forms. Most physicians now spend an extraordinary percentage of their income contributing to the bookkeeping and accounting necessary to fill out forms. Patients don't know how to read these bills. They don't understand these forms. Those of us who have gone to school longer than we'd like to admit can't understand these forms.

And, yet, we are continued to be deluged by them because that is the excuse for not getting to the heart of the problem.

We now need to make it clear that what is going to count is quality outcomes, not paperwork processing. And if we do that -- (applause) -- if we do that, then consumers will see a health care system made understandable and easy. One insurance form for everybody; a report card for quality that is understandable so that choices can be made; no hidden fine print. And doctors and nurses will finally be able to do what they were trained and educated to do: keeping people healthy, not filling out forms.

And again, the states are paving the way. Governor Sundlund's "Right Track" program holds out the promise of coverage for all Rhode Island's children by streamlining so many of the programs that affect children. Governor Carnahan recognizes that providing responsive primary and preventive care can mean more than bringing children to health care providers, it means bringing the health care providers to the children. And Missouri's initiative to provide health care to children in schools will focus on making the state a primary care-giver for many children and eliminate a lot of the unnecessary bureaucratic maneuvering and cataloging of kids that goes on now.

Let's take a child as a whole person, figure out how to take care of that child. Don't divide them up into little pieces that fit into the welfare bureaucracy, the health bureaucracy, the child support bureaucracy, the education bureaucracy. That's what Missouri is trying to do. That's what this country needs to do. Because if we focus on preventive care and eliminate the administrative hassles that now exist, our reform efforts will work, and more children will be healthier.

Fourthly, this reform will focus on addressing long-term care. This is a problem that we need to get ahead of the aging curve on as soon as we can. States have a large stake in providing and paying for this country's growing need for long-term care.

Now, many will tell us to put off consideration of this issue and not to do anything. That's the way we got into all of these problems. Don't take on any hard issues. Don't expend any political capital. Don't make -- (gap in tape) -- and maybe the voters will just think you're doing a good job. We've got to put those days behind us. If we don't begin to address long-term care now, in four or eight years we will be so much further behind it will be an extraordinary financial and human drain for us to begin then. We have to make a start. And we need to do that by building up the infrastructure in the states so that people who wish to stay in their homes and out of institutions will have that option. And people who

need intermediary care, whether it is adult day care or congregate housing, will have that option.

As you know, individuals and families are too often bankrupt by long-term care. And it is not fair to make them make that choice between money or dignity. We need a system in which we give real choices to the elderly and the disabled. And if we have an administration and we have states that are willing to embark on this partnership together, we will create more options for community-based care, which is not only what people tell us they want, but is less expensive and will enable us to cover more people. So we will expand home and community-based care in this reform proposal so that people with severe disabilities will have access to a broad array of services, coordinated by a case manager, tailored to individual needs. And by expanding this availability of care, seniors and disabled citizens who can't manage on their own will remain in their own home or their own community as long as possible. (Applause.)

Finally, we will improve the availability of health care in underserved urban and underserved rural areas. It will not do us any good to have a health care reform system that holds out the promise of health security if it does not deliver. There are many parts of our country that have traditionally not had adequate access to health care. I don't need to tell Governor Walters or Governor King that a health security card alone will mean little to people unless we guarantee that the services they need will be available for them in even the most remote parts of America.

The President's plan will bolster these efforts by targeting funds for areas that are now underserved. It will strengthen the health care infrastructure in these areas by linking community-based centers to other hospitals and providers, and will offer incentives for the National Health Service Corps and other programs to encourage doctors to practice in remote parts of our country. That is one of the most cost-effective things we can do to encourage doctors and nurses and others to pay off their loans, to be forgiven for their loans, if they will go into areas that need their help. There is hardly a program that is more worthy of consideration than that, and it will be reinvigorated after being allowed basically to die on the vine over the last 12 years.

If we make sure that all of our people are covered by integrated delivery networks, like Governor Dean and others are talking about, then nobody, no matter where they live, will be without access to decent care.

For 12 years, these governors and those who served with them and before them have taken the lead in keeping health care on the agenda. Before my husband was elected President he worked with

the National Governors Association to craft a bipartisan approach toward health care reform. It is that kind of attitude we need to encourage not just at the state level, but in Washington as well.

We need to end the partisanship. We need to recognize the federal government does not have all the answers, that it needs to work with the states to solve the health care crisis. In order to do that, we need real leadership from the top. And that's what this President is willing to offer.

The federal government will establish the framework and set the standards, but it will be us to the states to tailor the program to meet those standards and offer the guaranteed benefits in ways that each state thinks will work best for that state. We cannot do this without that kind of partnership. And we need that partnership to continue that has already started so that we have the benefit of your advice and counsel.

There is no way that we can wave a magic wand or even pass a piece of legislation that will overnight solve all of our health care problems. Too many changes in attitudes and behavior are going to be needed. But we do know we have to take a comprehensive approach so that we look at all these problems at one time.

The President has appreciated the advice and help from the governors. We look forward to working with the governors in the weeks and months ahead, because we believe that with a health care reform plan that truly provides security for every American we will be on the way toward making it possible for this country to regain its economic leadership and it's competitive position because health care reform is part of the economic plan that the President has for America. One can not proceed without the other. Both together will not only secure security for each of us, but will ensure security and leadership for this country that we all love.

Thank you very much. (Applause.)

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