xc: Marian Myers
orig: CHR

MEMORANDUM TO CAROL RASCO

FROM: Patsy Fleming
SUBJECT: Background on 60 Minutes piece on mandatory HIV testing
September 19, 1994

Mandatory testing of all Americans has been rejected as unsound public policy by the overwhelming majority of public health professionals. It would be very costly (literally billions of dollars) and not very effective. It makes better public health and economic sense to target testing to at-risk populations and/or geographic areas with relatively high incidence. Statistically, the more low-risk individuals you test, the greater the number of false positive test results you would have.

Even testing all hospital patients would be costly (hundreds of millions of dollars a year, even if limited to adults below age 60) and would, again, result in false positives and wasted resources as testing would not be targeted to those most likely to be infected. The Public Health Service has issued guidelines encouraging routine, voluntary screening of all individuals who are admitted to primary health care settings in geographic areas with relatively high rates of infection.

The issue of testing pregnant women for HIV is a little more complicated, now that there is a medical intervention that may seriously reduce the likelihood of an infected mother passing on HIV to her child. (Initial studies show that with AZT therapy, transmission from mother to child can be reduced from about 25% to about 8%.) The stakes are higher -- but the solution of mandatory testing might, paradoxically, actually reduce the number of high-risk mothers who seek pre-natal care -- for fear that they will be stigmatized for being infected and/or might lose custody of their children after birth. Where quality counseling is offered, 90 percent of pregnant women will accept voluntary counseling.

PHS is in the process of developing guidelines relating to HIV testing and prenatal care. There is a meeting sponsored by HRSA today on this subject. The PHS is likely to recommend (in accordance with the recommendations of most clinicians who serve women at risk) that testing remain voluntary but that it be routinely offered and strongly encouraged through quality counseling.

The issue of new-born screening has also been very controversial. All new-borns are part of a blind screening program funded by the CDC. The issue that has been raised is whether this should be unblinded so that early diagnosis and intervention with the new born could occur. The PHS has continued to recommend that these tests not be unblinded for a number of reasons -- including the fact that a positive test from a new born is telling us the infection status of the mother, not the child. Because the infant is carrying the *mother's* HIV antibodies, all infants with HIV-infected mothers will test positive, even though only between one-fourth and one-third of them will actually be infected. Clearly, those infants with infected mothers need close monitoring and follow up. But it has been the consistent recommendation of the PHS that this be accomplished through voluntary testing of the mother -- both for her benefit and for the child's benefit.

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Have the orig. ltr. to POTUS fr. Mixner.

Revised DRAFT DRAFT response to David Mixner

Dear David,

Thank you for your letter of June 3rd. Your sentiments and views are always welcome, provocative, and informative.

As you know, we are now in the midst of a search for a new National AIDS Policy Coordinator. In the interim, Patsy Fleming is filling this role, and I know that you have a long-standing relationship with her. I hope you will feel free to share with her your thoughts and ideas about this office.

We have been doing considerable outreach with the AIDS community about how to reshape this office. One thing seems clear: there are almost as many views about the appropriate role of the National AIDS Policy Coordinator as there are people expressing them. My view is that the National AIDS Policy Coordinator's principal role is to make sure that every agency in the Federal government is doing its job – assuring that the researchers are doing all they can to find a cure and prolong the lives of those with HIV; making certain that the public health establishment is doing all it can to prevent another generation of HIV infections; and guaranteeing that the services, housing, and care needed by people already sick with HIV are indeed in place. The Coordinator cannot and should not *do* any of these things; the Coordinator is a catalyst and a watchdog and cannot be a substitute for the agencies doing their jobs.

There is good news from the research front. As I am sure you know, many people (if they have access to and can afford quality care) are living longer with this infection. Sadly, the increased life expectancy that many people with HIV are experiencing is not necessarily a result of better anti-retroviral treatments. Instead, the quality and length of life improvements are a result, for the most part, of research into treatments and prophylaxis for opportunistic infections. We are a way off from an effective treatment for underlying HIV infection, as I understand the science -- and that's why the focus of the work coordinated by the NIH's Office of AIDS Research (OAR) is shifting to more basic science so we first get a better understanding of this insidious virus and then can develop better drugs. In the meantime, we must also focus research on treating and preventing opportunistic infections – on keeping people alive until the cure is found.

I agree that our ultimate goal must be a cure and a vaccine for AIDS. Within my Administration the person responsible for leading this research effort for a cure is Dr. William E. Paul, a world-renowned immunologist, who six months ago accepted the position of Director of the NIH Office of AIDS Research. NIH leads the world in AIDS research, and the NIH AIDS research budget represents nearly 90% of the total federal AIDS research effort. Thus, the authority of the OAR is far-reaching. Under its leadership of the nation's AIDS research effort, new scientific priorities have been established and resources have been redirected to address those scientific opportunities.

As you know, passage of the NIH Revitalization Act of 1993 provided expanded authority to

the OAR. I supported this legislation, along with a large coalition of AIDS advocates and researchers. I would like to tell you about the progress Dr. Paul and the OAR have made in implementing these critical new mandates.

The law requires the OAR to develop a comprehensive plan and budget for all NIH AIDS research. This plan is the first blueprint for the entire NIH AIDS research effort and will determine resource allocation across the NIH. The OAR recently completed the FY 1996 NIH Plan for HIV-Related Research, which was developed through a unique and inclusive process designed to find new approaches. The OAR sought the expertise of the NIH leadership; scientists and researchers from government agencies, academia, foundations, and industry; a number of Nobel laureates; HIV-infected men and women; and AIDS community representatives. You will be pleased to know that a number of participants from the Madison meetings were involved in the NIH process.

This diverse and eminent group of experts reached an unprecedented consensus regarding the priorities for AIDS research -- that is, that future progress against the epidemic demands a realignment of our biomedical research priorities. A rededication of efforts to basic research is required to identify new targets, facilitate drug and vaccine development, and open new frontiers for investigation. This means that scientists must go back to find answers to the very basic questions of how HIV infects cells, causes disease, and destroys the immune system. This approach will be balanced with a strong and effective clinical trials program, with a dynamic and continuing interchange between these two approaches.

The law provides further authority through a provision requiring that all NIH AIDS research funds be appropriated to the OAR for distribution to all of the individual institutes of the NIH. I believe that this authority will allow Dr. Paul to expeditiously bring about the efficient redirection of research across all of the institutes by managing the research resources based on sound scientific judgment, without seriously damaging ongoing programs, and taking advantage of the most promising scientific avenues.

The law also authorized a discretionary fund for which $10 million was appropriated in FY 1994. These funds will allow the OAR to direct funding in response to "break-throughs" or emergencies in ongoing research or for new scientific initiatives.

I appointed Dr. Harold Varmus, a Nobel Laureate, who has been deeply involved in AIDS research, as Director of NIH. Dr. Paul brings new insight and expertise to the task and has broad new authorities to establish a more collaborative and coordinated AIDS research effort. With these two eminent world-class scientists at the helm, I believe we will see a revitalized effort and new direction in AIDS research.

Progress toward meeting a number of the specific targets you mention in your letter is already underway. Dr. Varmus is a member of the National Task Force on AIDS Drug Development, which was convened by HHS Secretary Donna Shalala to involve representatives from industry, academia, and community constituency groups in identifying and resolving obstacles to AIDS drug discovery and development efforts. Another new NIH initiative is the development and implementation of an electronic database of AIDS research

information.

In his recent plenary lecture at the Tenth International Conference on AIDS in Yokohama, Japan, Dr. Paul stated that "our collective goal must be to accept nothing less than the complete elimination of AIDS from our world." I am sure that he would welcome the opportunity to meet with you, provide a briefing about the NIH research program priorities, and to work with you toward our shared goal.

All this said, progress on research does require more funding. As you know, AIDS research has been one of very few "investment" areas throughout the government identified as a priority for increased funding in my Administration. In the two budgets since FY 1993, NIH AIDS research funding has increased nearly 25%, more than for any other disease. (Had Congress not cut my FY 1995 AIDS research request, the increase would be 28.5% over two years.)

I also want to be clear that I would consider my Administration's efforts to be a failure if we focused only on research efforts. We have a tremendous obligation to continue to care for those who are sick -- which is why, even in tight fiscal times, we have seen major increases in funding for the Ryan White CARE Act and other services programs during my tenure. Passage of a comprehensive health care reform measure would have made care far more accessible to thousands of people with HIV and AIDS.

We also have a major responsibility to rethink and revitalize our prevention efforts – so that the behavior changes that are our current substitute for a preventive vaccine are incorporated into the lives of those engaging in potentially risky behaviors. We're doing that now -- with a complete review of our prevention programs and returning significant authority over prevention funding to the community level, where the best strategies for those at risk can be identified.

David, I hope these comments – and more importantly, the future actions of my Administration as we bring on a new National AIDS Policy Coordinator -- will reassure you of my commitment to ending this epidemic. I appreciate your support and your continuing critique. I hope we live up to the hope you have placed in us.

THE WHITE HOUSE

Carol H. Rasco

Mark
Dee Dee > fyi

Attached is an evolving background piece on the immunization program. As we get closer to Oct. 1 there will be revisions. CR

Talking points - Child Immunization 9/15/94

Millions of America's youngest children are unprotected from preventable childhood diseases. While child immunization rates have improved since the 1989-1991 measles epidemic in which more than 80 children died, more than one million American children under two are not fully vaccinated against disease. A 1993 survey found that 28 percent of pre-school children (average age 27 months) had not received a full series of the three most critical vaccines (MMR, DTP and polio). About 40 percent had not received the HIB vaccine, which protects children against bacterial meningitis; and 84 percent had not been vaccinated against Hepatitis B, which causes liver disease.

Our approach addresses several barriers that stand between our children and protection from these diseases. Parental awareness, cost, and even the health care system itself contribute to low immunization rates. Some children are unvaccinated because their parents work and health clinics aren't open in the evenings; because providers miss opportunities for vaccination; or simply because parents aren't aware that 15 vaccinations are necessary before age two. Cost can be a contributing factor for many children: the private cost of a full series of immunizations increased from about $27 in 1983 to $270 in 1994.

The Childhood Immunization Initiative is a comprehensive effort to remove these barriers to immunization. The CII is designed to increase immunization rates now, and build a system for sustaining gains into the future. It includes five key strategies to improve preschool vaccination rates: improving the quality and quantity of vaccination delivery services; reducing vaccine costs; increasing awareness, community participation, and partnerships; improving the monitoring of disease and vaccination coverage; and improving vaccines and vaccine use.

Improving preschool immunization rates is one of the Clinton Administration's highest priorities. Since taking office, the Clinton Administration has doubled funding, and guaranteed funds for new vaccines. Legislation to launch a new Childhood Immunization Initiative was introduced soon after President Clinton's inauguration. A specific goal was set for 1996: increasing vaccination levels for two-year-old children to 90 percent for the most critical doses. And a new program to provide free vaccines to millions of poor and uninsured children was instituted.

Immunization protects children and saves money. For example, every dollar spent on the MMR (measles/mumps/rubella) vaccine saves $21 in potential health care costs. For the DTP (diphtheria/tetanus/ pertussis) vaccine, the cost-benefit ratio is 30 to 1. And for polio, it's 6 to 1.

The Childhood Immunization Initiative recognizes the important role of states and local organizations in identifying their particular needs. Beginning in 1992, the federal government began helping states design individually tailored Immunization Action Plans. This year, funding for these action plans was tripled, from $45 to $128 million. And CDC experts began holding a series of ten regional outreach conferences around the country to help build local efforts.

The Vaccines for Children program is an important part of the broader initiative. Under the VFC program, vaccines will be provided free to children who are enrolled in Medicaid or uninsured, and to native Americans and Alaskan natives. That means that physicians will no longer have to refer uninsured children to public clinics, a common practice that means missed opportunities for immunizations and fragmented care. In addition, VFC will continue to provide free vaccines to children with limited insurance in rural health clinics and Federally Qualified Health Centers. And funds for new vaccines will automatically be provided.

Talking points - Vaccines for Children

The Vaccines for Children program is an important part of the broader Childhood Immunization Initiative. The CII includes five key strategies to improve preschool vaccination rates. These include improving the quality and quantity of vaccination delivery services; reducing vaccine costs; increasing community participation, education and partnerships; improving the monitoring of disease and vaccination coverage; and improving vaccines and vaccine use.

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While child immunization rates have improved since the 1989-1991 measles epidemic, VFC is a key part of the national strategy to reach the one million American children who are not fully vaccinated by age two. A 1993 survey found that 28 percent of pre-school children (average age 27 months) had not received a full series of the three most critical vaccines (MMR, DTP and polio). About 40 percent had not received the HIB vaccine, which protects children against bacterial meningitis; and 84 percent had not been vaccinated against Hepatitis B, which causes liver disease.

As an integral part of the CII, the Vaccines for Children program focuses on making free vaccines more widely available, reducing costs and missed opportunities for immunization. In the past ten years, immunization costs have increased ten-fold: the private cost of a full series of immunizations increased from about $27 in 1983 to $270 in 1994. A Spring 1992 survey by the American Academy of Pediatrics showed that 43 percent of pediatricians had increased their referrals to public clinics for vaccinations in the preceding ten years, primarily because of costs.

Under the VFC program, vaccines will be provided free to children who are enrolled in Medicaid or uninsured, and to native Americans and Alaskan natives. That means that physicians will no longer have to refer uninsured children to public clinics, a common practice that means missed opportunities for immunizations and fragmented care. And parents can choose which provider makes the most sense for their child, because the difference in price between the two settings ($270 and $129) won't be a factor.

This will make a tremendous difference for nine million uninsured American children. While Medicaid recipients can receive free vaccines under current law, working families have not had the same guarantee. Under VFC, more than one million infants and toddlers without insurance will now be guaranteed free vaccines, and their parents will pay only a modest administration fee. And because ten percent of all American children don't have health insurance, VFC will also help millions more older children who need follow-up vaccines at age four and fifteen.

Under VFC, providers must vaccinate every VFC-eligible child, even if parents cannot afford to pay the administration fee. Private doctors will continue to serve their regular patients, even if the parent or guardian cannot afford to pay the administration fee. Other needy children will not be charged a fee in public clinics.

In addition, VFC will provide free vaccines to children with limited insurance in rural health clinics and Federally Qualified Health Centers. In these settings, additional children whose insurance plans don't cover vaccinations will continue to be eligible for free vaccines.

Child immunization protects children and saves money. For example, every dollar spent on the MMR (measles/mumps/rubella) vaccine saves $21 in potential health care costs. For the DTP (diphtheria/ tetanus/pertussis) vaccine, the cost-benefit ratio is 30 to 1. And for polio, it's 6 to 1.

Funds for new vaccines will automatically be provided. Under VFC, new childhood vaccines recommended by a federal advisory committee will automatically be purchased by the federal government and provided free to eligible children -- and budget constraints will never again limit or delay federal purchase of new vaccines.

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Questions and Answers

Why did you initiate the VFC program in the first place? What was the need and rationale behind establishing the program?

- The Vaccines for Children (VFC) program is an important part of the Administration's broader Childhood Immunization Initiative. The CII includes five key strategies to improve preschool vaccination rates. These include improving the quality and quantity of vaccination delivery services; reducing vaccine costs; increasing community participation, education and partnerships; improving the monitoring of disease and vaccination coverage; and improving vaccines and vaccine use.

- While child immunization rates have improved since the 1989-1991 measles epidemic, VFC is a key part of the national strategy to reach the one million American children under two who are not fully vaccinated against deadly disease. A 1993 survey found that 28 percent of pre-school children (average age 27 months) had not received a full series of the three most critical vaccines (MMR, DTP and polio). About 40 percent had not received the HIB vaccine, which protects children against bacterial meningitis; and 84 percent had not been vaccinated against Hepatitis B, which causes liver disease.

- The Vaccines for Children program focuses on reducing costs and missed opportunities for vaccinations. In the past ten years, immunization costs have increased ten-fold: the private cost of a full series of immunizations increased from about $27 in 1983 to $270 in 1994. A Spring 1992 survey by the American Academy of Pediatrics showed that 43 percent of pediatricians had increased their referrals to public health clinics for vaccinations in the preceding ten years, primarily because of costs.

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Is your experience and track record with this program a precursor for what will happen with health care reform?

The Childhood Immunization Initiative is a separate program, designed to address the low immunization rates of children under two. It includes five public health strategies designed to meet clear goals by 1996 and the year 2000.

However, the VFC program does illustrate the shockingly large numbers of uninsured children in America. More than ten percent of all American children are uninsured. That represents more than one million children under age two; 2.5 million children under age five; and a total of nine million children under age eighteen. And millions more children have health insurance that does not cover life-saving preventive care -- such as routine immunizations.

Why in the first place did you attempt to establish the GSA warehouse and distribution system for the VFC program? Why did you recently abandon this initiative?

While 24 states plan to distribute vaccines to private physicians themselves, the remaining states have indicated that they may need federal assistance with that portion of the distribution effort. Discussions with GSA about a national distribution center were originally begun because it was a feasible and inexpensive way to help states which needed federal assistance with distribution. Plans to involve GSA were discontinued because of the preference of some members of Congress for a private sector distribution system, and because of concerns that Congressional opposition might impede successful and timely implementation of the VFC program.

Congressional sponsors of the law have since clarified that HHS does have the authority to contract for private-sector vaccine delivery. The Administration stands ready to work with the private sector and with the states in distributing vaccines, and we are continuing to discuss other options for vaccine distribution.

What type of storage/distribution system did you have before the GSA warehouse idea? What will you do now?

All States currently distribute vaccines to all public health department clinics, local boards of health, migrant/community health centers, and rural health clinics through central and/or regional depots. Some States also distribute vaccines to private providers.

Twenty-four states have told us that they now intend to deliver vaccines to ALL providers using publicly purchased vaccines. Eight states have recently indicated that they are strongly considering increasing their proposed distribution method to include all providers. Seventeen states will maintain vaccine distribution to public clinics, but may temporarily delay implementation of the VFC program for other providers. (The remaining state, Alaska, has opted not to participate in 1994.)

Medicaid providers, of course, will continue providing vaccine to Medicaid-enrolled children at no cost to the child, and public clinics will also continue to provide immunizations to all children. And we are continuing to discuss private-sector options for vaccine distribution to physicians in states which choose not to perform that function.

It's important to remember that VFC will augment the existing vaccine delivery system. Each new physician who enrolls as a VFC provider represents additional opportunities for children to receive vaccines in a doctor's office.

What is your response to the GAO report about the VFC program?

- An interim report, by its very nature, represents a snapshot in time, and is not an adequate basis for predicting success or failure. And the GAO, in releasing its interim findings, specifically stated that it was not making any recommendations. However, in implementing the VFC program, the Department has taken into account issues raised in the GAO report.

- It's important to note that the GAO agrees that, despite some progress, many areas in this country continue to have extremely low immunization rates. The President's Childhood Immunization Initiative will bring those immunization levels up -- and keep them up. The Childhood Immunization Initiative uses five key strategies to improve preschool vaccination rates: improving the quality and quantity of vaccination delivery services; reducing vaccine costs; increasing community participation, education and partnerships; improving the monitoring of disease and vaccination coverage; and improving vaccines and vaccine use.

- While other aspects of the CII focus primarily on increasing awareness and availability of vaccines, the Vaccines for Children program focuses both on reducing costs for parents and reducing missed opportunities for vaccination. In the past ten years, immunization costs have increased ten-fold: the private cost of a full series of immunizations increased from about $27 in 1983 to $270 in 1994. A Spring 1992 survey by the American Academy of Pediatrics showed that 43 percent of pediatricians had increased their referrals to public clinics for vaccinations in the preceding ten years, primarily because of costs.

- The VFC program addresses other GAO concerns. In determining the states' ability to implement the vaccine ordering and distribution system, the Department has learned that at least 24 states are ready to distribute vaccines to private physicians on October 1. HHS is also working closely with professional physicians and other provider associations to achieve optimum private provider enrollment. In addressing vaccine administrative fee concerns, the VFC program has created caps that establish the maximum amounts that providers can charge -- providers will not always charge the maximum and may not charge at all. Moreover, providers cannot refuse to give a vaccine because of a family's inability to pay, and Medicaid will pay the administration fee for Medicaid children.

What good things can we expect to happen with childhood immunization on October 1 when the VFC program is supposed to be up and running? What will change?

- Under the VFC program, vaccines will be provided free to children who are eligible for Medicaid or uninsured, or are native Americans or Alaskan natives. This will make a tremendous difference for nine million uninsured American children. While Medicaid recipients can receive free vaccines under current law, millions of working families have not had the same guarantee. Under VFC, more than one million infants and toddlers without insurance will now be guaranteed free vaccines. VFC will also help millions more older children who need follow-up vaccines at age four and fifteen. These vaccines will be available in public health clinics in all 50 states on October 1.

- Funds for new vaccines will automatically be provided. Under VFC, new childhood vaccines recommended by a federal advisory committee will automatically be purchased by the federal government and provided free to eligible children -- and budget constraints will never again limit or delay federal purchase of new vaccines.

- Under VFC, providers must vaccinate every child, even if parents cannot afford to pay the administration fee.

- In addition, VFC will provide free vaccines to children with limited insurance in rural health clinics and Federally Qualified Health Centers. In these settings, additional children whose insurance plans don't cover immunizations will continue to be eligible for free vaccines.

- Under VFC, physicians will no longer have to refer uninsured children to public clinics, a common practice that means missed opportunities for immunizations and fragmented care. Even under the most pessimistic scenario, 24 states will be ready to distribute vaccines to private physicians by October 1. The Administration stands ready to work with the private sector and with the states in distributing vaccines, and we are continuing to discuss options for vaccine distribution in the other states.

Do you agree with Senator Bumpers that vaccine manufacturers can and will do a better, more cost-effective job of vaccine distribution to the States and individual providers?

In implementing the Childhood Immunization Initiative, the Department asked GSA to lend its considerable expertise to assuring the proper distribution of vaccines in one critical part of the initiative, the VFC program. While we believe GSA could have successfully operated a distribution center, many in Congress prefer having the private sector distribute vaccine to private physicians in those states that choose not to perform this function. The Administration stands ready to work with the private sector and with the states in distributing vaccines, and we are continuing to discuss options for vaccine distribution.

Some members of Congress as well as some vaccine manufacturers have argued that the private sector can distribute vaccine as inexpensively as the GSA could have. We are encouraged by these assurances.

What real problems do you face in establishing a superior childhood immunization program for our country? Is cost the real barrier or is outreach all we need? What do you have to do to create the program we need?

Our approach addresses several barriers that stand between our children and protection from these diseases. Parental awareness, cost, and even the health care system itself contribute to low immunization rates. Some children are unvaccinated because their parents work and health clinics aren't open in the evenings; because providers miss opportunities for vaccination; or simply because parents aren't aware that 15 vaccinations are necessary before age two. Cost is a contributing factor for many children: the private cost of a full series of immunizations increased from about $27 in 1983 to $270 in 1994.

The Childhood Immunization Initiative is a comprehensive effort to remove these barriers to immunization. The CII is designed to increase immunization rates now, and build a system for sustaining gains into the future. It includes five key strategies to improve preschool vaccination rates: improving the quality and quantity of vaccination delivery services; reducing vaccine costs; increasing community participation, education and partnerships; improving the monitoring of disease and vaccination coverage; and improving vaccines and vaccine use.

Question: How will the Vaccines for Children Program change the current public and private sector vaccine markets?

Currently, about 50 percent of vaccines are purchased off CDC negotiated contracts and 50 percent are purchased in the private sector at higher catalog prices -- including most vaccines for Medicaid-eligible children. While the federal government provides grant money to help states purchase vaccines, state and local governments may also use their own funds to purchase vaccines off the CDC contract, with the manufacturer's approval. Buying vaccines at the CDC price can mean considerable savings -- $129 for a full dose of vaccines versus $270 at private market prices.

VFC will increase the amount of vaccines purchased at the lower, CDC price, saving money for the federal government and states. Even for a limited vaccine purchase, the difference in price is substantial. For example, the cost of oral polio vaccine (OPV) at the CDC contract price is $2.21 per dose in 1994, as compared with the vaccine manufacturer's catalog price of $10.47 per dose.

What is the status of CDC immunization funding in pending appropriations bills?

The Labor/HHS appropriations bill is currently before a conference committee, with the final funding level still to be decided. However, we expect a funding level of approximately $888 million for FY 1995 -- more than double the funding level when President Clinton took office.

The House Committee on Appropriations' report on the FY 1995 Appropriations Bill indicates that $463,663,000 is for immunization activities, with overall federal government funding for immunization of $887,961,000 million, including funding for the VFC program. The Senate Committee on Appropriations' report on the FY 1995 Appropriations Bill indicates that $464,143,000 is for immunization activities, with an additional $424,298,000 for the VFC program, for a total of $888,441,000.

CDC discretionary funding on child immunization has increased from $341 million in FY 1993 to $528 million in FY 1994. In addition, $80 million was provided as start-up for VFC in FY 1994.

A list of the 24 States which will be ready to initiate the program on October 1; and a list and the status/reason for the States that will not be ready on that date.

Implementation of the VFC program will occur in ALL States in public health department clinics, local boards of health, migrant/community health centers, and rural health clinics. In addition, implementation of the VFC program among other public providers and all private providers will occur on October 1 in the following 24 States: Connecticut, Florida, Idaho, Illinois, Maine, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Mexico, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Dakota, South Carolina, Vermont, Washington, West Virginia, Wisconsin, Wyoming.

Additionally, eight states recently indicated that they are considering expanding their vaccine distribution to ALL providers and may be able to implement the VFC program among all private providers on October 1 as well. They are Alabama, Arizona, Delaware, Georgia, Indiana, Kentucky, New York, Texas.

The other 17 states with only a partial distribution system may delay implementation of the VFC program among other providers. The Administration stands ready to work with the private sector and with the states in distributing vaccines, and we are continuing to discuss options for vaccine distribution in these states. In addition, one state (Alaska) has opted not to participate in the VFC program during 1994.

EXECUTIVE OFFICE OF THE PRESIDENT
COUNCIL OF ECONOMIC ADVISERS
WASHINGTON, D.C. 20500

October 19, 1994

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MEMORANDUM FOR WHITE HOUSE SENIOR STAFF

FROM: LAURA D. TYSON

SUBJECT: Goods and Services Exports and Imports in August, Commerce Department Release, Wednesday, 8:30 a.m.

The August trade report showed that the trade deficit improved to $9.7 billion from the $11.2 billion deficit posted in July. The improvement was somewhat better than market analysts had expected.

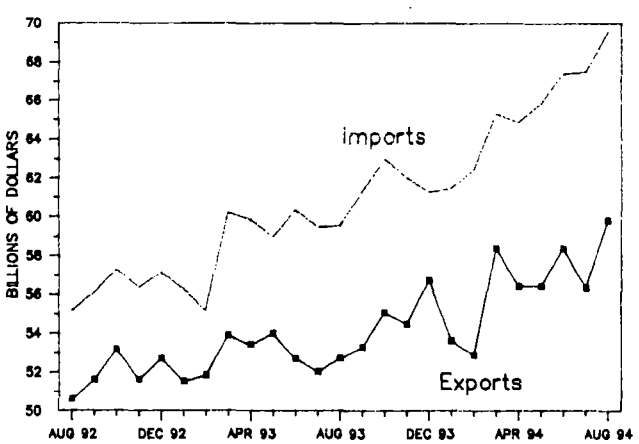
- Merchandise exports and imports both increased to record high levels in August. Merchandise exports increased by $3.7 billion while imports increased by $2.1 billion. Decreases in travel and passenger fares contributed to a decrease in services exports, while services imports were virtually unchanged. As a result net exports of services decreased for the second consecutive month.

- During the first 8 months of this year, the U.S. merchandise trade deficit was 25 percent greater than during the same period in 1993.

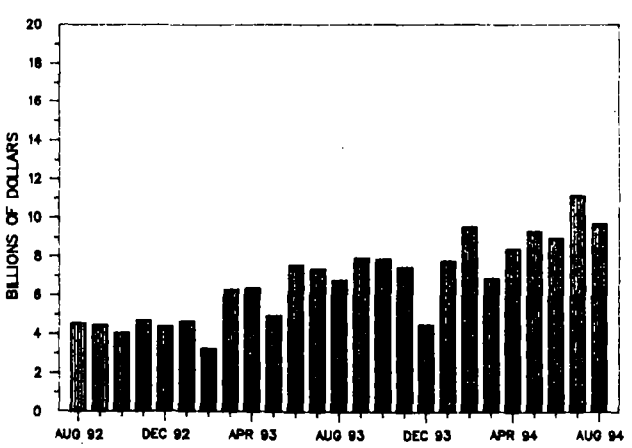
- The merchandise trade deficit with Japan worsened by $136 million in August. During the first 8 months of this year the cumulative trade deficit with Japan was $4.9 billion larger than the total for the first 8 months of 1993.

- The merchandise trade deficit with Western Europe improved by $748 million in August, reflecting the economic recovery there. However, during the first 8 months of this year the United States accumulated a $7.4 billion trade deficit with Western Europe, compared with an $88 million trade surplus accumulated during the same period in 1993.

Exports and Imports of Goods and Services



Trade Deficit for Goods and Services



EXECUTIVE OFFICE OF THE PRESIDENT
COUNCIL OF ECONOMIC ADVISERS
WASHINGTON, D.C. 20500

October 19, 1994

MEMORANDUM FOR DEE DEE MYERS

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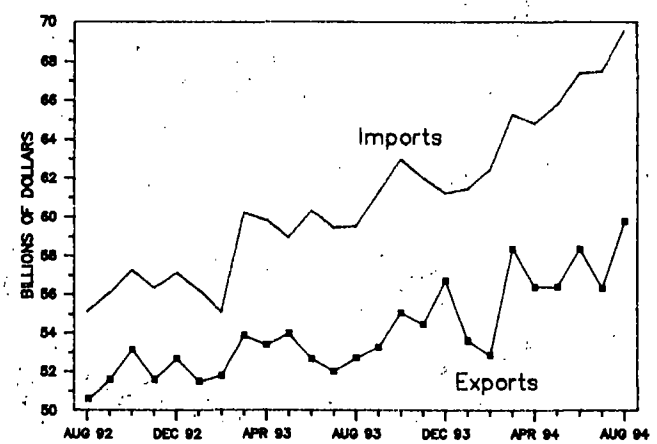
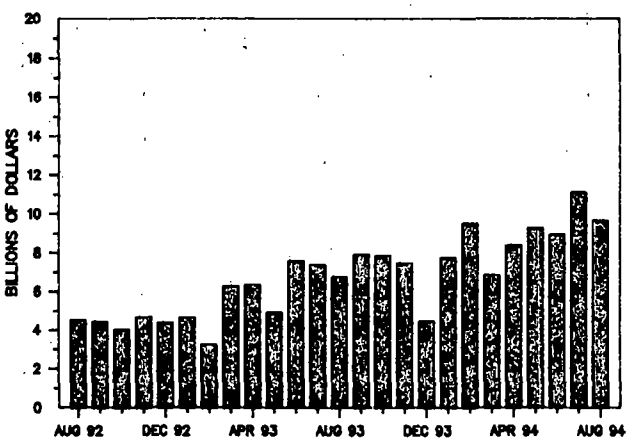
- The merchandise trade deficit with Japan worsened by $136 million in August. During the first 8 months of this year the cumulative trade deficit with Japan was $4.9 billion larger than the total for the first 8 months of 1993.

- The merchandise trade deficit with Western Europe improved by $748 million in August, reflecting the economic recovery there. However, during the first 8 months of this year the United States accumulated a $7.4 billion trade deficit with Western Europe, compared with an $88 million trade surplus accumulated during the same period in 1993.

Exports and Imports of Goods and Services



Trade Deficit for Goods and Services



The Atkins Chronicle

The Heart of the Arkansas River Valley

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By The Atkins Chronicle, Inc.

P.O. Box 188 — Phone 641-7161

FAX: (501) 641-1604

GS | Mack | Bruce
interesting — an old critic — B.

THE PRESIDENT HAS SEEN
10-20-94

Dog-piling the President

The press and public treatment of President Clinton have created a problem for me.

My natural inclination is to be an adversary to anyone in power. This comes with the need for journalists to be on the side of the underdog, assuming that those in power deserve suspicion if not opposition.

So I would be more comfortable to concentrate on negative things about his administration, and, as with any leader, there are plenty to write about. Everyone makes mistakes.

The problem is, it seems that the press has been unusually harsh in its treatment of this president. I wondered if this was just my impression because I especially wanted our first president from Arkansas to be successful, but now there is a study by a conservative group, the Center from Media and Public Affairs, confirming my impression. The study shows that the television evening news *coverage* of Clinton has been negative 62 percent of the time, based on examination of 4,256 stories in the first six months of 1994.

These statistics support what others have been writing. As Donald Kaul wrote in his column in our paper a couple of weeks ago, if Clinton discovered a cure for cancer, he would be attacked for practicing medicine without a license.

It's no wonder that many shallowly-informed members of the public think he is not accomplishing much, despite the fact that he is lowering the national debt created by 12 years of Republican rule, has maintained prosperity and low unemployment, and has succeeded in passing several major pieces of legislation despite monolithic opposition from Republicans.

On the agenda

He hasn't succeeded in passing any medical care reform, because of massive lobbying by all the groups that profit from the high prices we are paying, but he put the subject on the agenda, and reform is taking place by the private groups, such as insurance companies because of the pressure created by the Clinton reform movement.

The pressure is also speeding up the process of reform at the state level. It will be better, of course, if it is done voluntarily by private agencies. Anti-Clinton writers keep saying health-care reform is when it fact it is proceeding apace at the private level.

There's no question but that the Clinton administration has done a poor job communicating its successes to the public through the f[illegible] of an anti-Clinton mass media. And as long as the public is bombarded by stories by lazy reporters and those who just don't like Clinton, polls will continue to give the president low approval ratings. The editorial pages of the Arkansas Democrat-Gazette are among the most hostile, an exceedingly strange phenomenon, considering Clinton's Arks connections.

Anyway, to come back to my original point, the hostile media, working with Republicans, have cast Clinton as an underdog. Thus, those of us who favor the underdog feel compelled to support him.
on. As children, we called that dog-piling and attributed the behavior to those too cowardly to buck the bullies and the majority of bully-followers.

Now, I want to make it clear that there are some legitimate reasons to criticize Clinton, and those people who oppose him on specific issues or general philosophy are doing their duty. The dog-pilers are those who are taking the easy, trendy route of least resistance.

On the playground

They are like the kids I remember on the playground who, at bullies pounced on a lone kid, joined in the pushing, punching or piling-on after the outnumbered guy was down.

I have been delaying any comment about national politics for several weeks, in my general feeling that I don't want to use *The Chronicle* editorial column for much of that kind of discussion. I see our r[illegible]n role on this page as dealing with community issues, preferably th[illegible] not directly related to politics or religion.

In other words, things that we can work together on or just enjoy as members of a congenial community.

But occasionally, I feel the need to wade back into politics. One reason for this column is to show some of our readers that there are people who still want our Arkansas president to succeed — who want our *American* president to succeed. This effect seems to be needed in the face of some especially shrill and ugly propaganda by people whose only purpose seems to be to attack Clinton and "liberals."

One question to ask this element is to come up with constructive proposals. Their only purpose seems to be to obstruct attempts to accomplish improvements in society.

Finally, I will just emphasize, once again, that I hear from a lot of people who want Clinton to succeed and feel that he is doing a good job, generally, although they may not agree with all he proposes. I feel that some of these people hesitate to make their views known because they don't want to risk inciting the rabid anti-Clinton comments.

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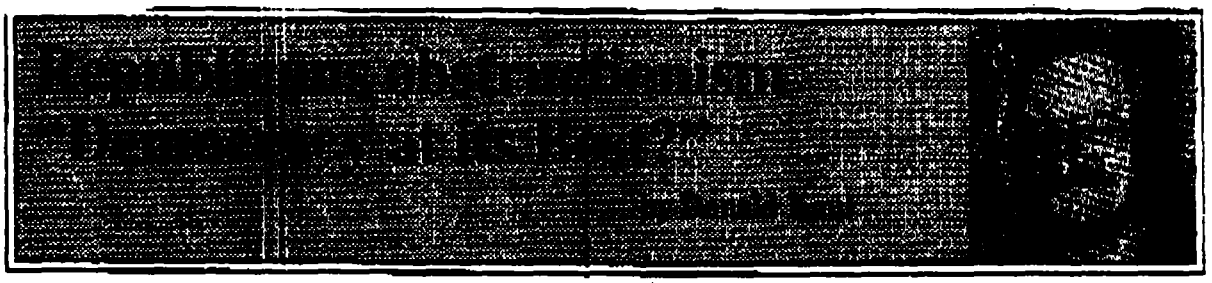

Health care reform died this week, strangled in its crib by Republicans.

They deny it, of course. They say that the brat was Rosemary's Baby and that it was the American people, in their righteous wisdom, who did the deed.

"I think America rejoices that the president's health care plan is dead," said Sen. Phil Gramm of Texas, the Republicans' designated gloater. "This is American democracy at its best."

The Republicans say that the health plan offered by President Clinton was a loser, and there's some truth in that. Surely it seemed complex, confused and overly bureaucratic. But every time the Democrats moved toward the Republicans in an effort at compromise, the Republicans backed away.

Bob Dole, the Republican leader in the Senate, started out with an alternative plan that didn't do much and he progressively weakened it, out of fear of support.

What the whole thing was, really, was an exercise in obstructionism. The Republicans were simply unwilling to let Clinton have anything that might be construed as a victory in health care lest voters be impressed, so they used the threat of a filibuster in the Senate to stifle the issue. They would have done the same no matter what the substance of the plan was.

In the meantime, the Department of Health and Human Services announced that the number of uninsured Americans went to 37.4 million, up from 35.4 million on the year before; that spending on health care consumed 14-14.2 percent of the nation's output in 1993 (up from 13.7-13.9 the year before); and that by the year 2003, Medicare and Medicaid would be taking up 26.4 percent of the federal budget.

This is an avalanche on the way, and Congress chose to do absolutely nothing about it. You have to wonder what Gramm thinks democracy at its worst looks like.

Nor have the Republicans limited their obstructionism to health care. In the Senate, where the rules allow the thwarting of majority rule by a 40 percent minority, they've pretty much shut things down.

Last week and this they've been trying to talk a campaign reform bill to death, in order to make the world safe for special interests. To do it, they used an arcane procedural technicality, which, so far as anyone has been able to find out, had never been used before.

Dirty pool, say the Democrats.

Democracy at its best, say the Republicans.

The important thing, of course, is what the American people are going to say. The early returns, sadly, indicate that it's going to be: "Isn't that cute."

It's a long wait until November but the initial signals — special elections, polls, voter interviews — suggest a Democratic catastrophe in the making. One can imagine a Republican Party next year that has absolute veto power over anything the president suggests and that controls the statehouse in eight or 10 of the biggest states. As a matter of fact, one can hardly imagine less.

Which would be endurable, I suppose, if all we were confronted with were gridlock, but the Republicans have relieved themselves of a set of legislative goals for the coming year that sends chills up the spine of a fiscal conservative like myself.

They would cut taxes for married people with children, for high-income old people and for all rich people, without regard to race, creed or spats. They would cut corporate taxes and increase miliary spending. And, they would balance the federal budget. How?

By passing a balanced budget amendment.

If you think you've seen that movie, you have. It was called "Ronald Reagan Triples the National Debt."

An even dippier plan is being put forward by Dick Armey, a Republican representative from Texas. He wants to throw out our present tax system and replace it with a "flat tax" of 17 percent, a plan that would cut taxes in half for rich folk, add $200 billion a year to the deficit and require you to file a tax return every month.

And that's the party that's winning the hearts and minds of the American people.

One is reminded of the definition of democracy offered by H. L. Mencken, who wrote: "Democracy is the theory that the common people know what they want, and deserve to get it good and hard."

It looks as though we're in for a heavy dose.

(Donald Kaul is a nationally syndicated columnist who lives near Washington, D. C.)

fhg

Memorandum

October 13, 1994

TO: Secretary Lloyd Bentsen
Secretary Donna Shalala
Director Alice Rivlin
Chair Laura Tyson
Chief of Staff Leon Panetta
Deputy Chief of Staff Harold Ickes
Bob Rubin
Carol Rasco

FROM: Mark Gearan
Lorrie McHugh

RE: Health Care Talking Points

We hope the following will be helpful in discussing the the Administration's future efforts on health care reform.

If you have any questions, please do not hestitate to contact us.

cc: Bo Cutter
Bill Galston
Pat Griffin
Skila Harris
Judy Feder
Harold Ickes
Jerry Klepner
Dee Dee Meyers
George Stephanopoulos
Barry Toiv
Melanne Verveer
Marina Weiss

Health Care Talking Points - October 13, 1994

* Last year marked a milestone in the long journey toward health care for all Americans. A comprehensive proposal was developed and those recommendations were presented to Congress.

* The Administration developed an extensive data base and technical expertise which advanced the understanding of policy makers about the difficult trade-offs involved in health care reform.

* The Administration's groundbreaking work put health care at the top of the national agenda and engaged the public, the press and Congress in the most serious and thoughtful debate about the American health care system in sixty years.

* Building on last year's health care initiative, the administration will move its health care reform efforts forward through its normal policy processes. The Domestic Policy Council (DPC) and the National Economic Council (NEC) will coordinate the future health care reform efforts.

Questions and Answers

Q. Was there a White House meeting to relaunch the health care effort?

A. The Domestic Policy Council and National Economic Council convened a meeting today to discuss the President's commitment to health care reform and to begin initial discussions on health care issues.

Q. Given that the First Lady was at the meeting today, does this mean that the President has asked her to stay on and run the Administration's efforts next year?

A. Mrs. Clinton will remain extremely involved in the Administration's efforts. She will continue her role as the Administration's public advocate on health care. She, of course, brings a great deal of knowledge and commitment to the issue and will be a key and vital part of health care policy and strategy discussions.

Q. What will Ira Magaziner's role be?

A. Ira Magaziner, Senior Advisor to the President for Policy Development on the Domestic Policy Council, will continue in this position. The President has asked Mr. Magaziner to be a part of this coordinated effort.

Q. The Administration has said for a long time that care reform is needed to keep the deficit down. With the death of health care, what is your plan now to keep the deficit under control?

Three points:
One, Historic Progress: First of all, it is important to recognize that we have made historic progress. The deficit is now projected to be nearly $700 billion less following the passage of our plan, and it will be the lowest as a percentage of our national income since 1979. And our plans to cut $255 billion in spending and cut 272,000 workers from the federal bureaucracy are on track. This month we will get the final report showing that the deficit is down for the second year in a row for the first time in over 20 years. And next year it will be down three years in a row for the first time since Harry Truman was in office.

Two, Health Care Costs Remain the Issue We Must Attack: It is true, however, that the deficit does start to creep up -- and the overwhelming reason is the rate of growth of health care costs. We have no choice but to try in the next years to bring down our long-term deficit through health care reform. Whatever the details of what we fight for next year, it must seek to address the long-term deficit issue.

* Certainly, we will also look to see what specific entitlement measures have garnered true bipartisan support in the Kerrey Commission.

Three, We will not allow Slashing of Medicare -- hidden tax on middle class and unfair to Seniors: Just slashing Medicare -- which seems to be the implied means of many others seeking to deal with paying for getting the deficit down -- will shift costs to the private sector and result in a hidden tax increase on people's premiums.

Q. It has been reported that a new health care plan will be developed in December in time to be included in your January budget proposal to Congress and that the emphasis will be placed on controlling costs instead of universal coverage. Is the Administration going to back away from universal coverage given the problems you encountered trying to achieve this goal? And are you going to be stressing an economic message instead of a universal coverage message?

A. Throughout this debate on health care reform, the Administration has repeatedly stated that covering every American and controlling escalating health care costs should be our goals. Our commitment to this mission has not changed. We still believe that every American deserves health care coverage. Every month that we don't act to reform our system, 100,000 more Americans will lose their insurance. And, if we want to ensure that the deficit that we have worked so hard to contain does not balloon again over time, we need to address rising health care costs. In 1994, we will spend nearly 14% of our GDP on health care services. If this trend continues, we will spend nearly 20% of our GDP on health care by 2001.

There are obviously decisions that need to be made on how to proceed on health care reform. The one thing that is sure is that we are serious about continuing our fight for reform.

Health Care Qs and As - October 20, 1994

Q. **Is the new health care process a recognition that the Task Force was a failure?**

A. We are simply moving health care through the same policy process that we use for other major domestic policy issues. The Domestic Policy Council (DPC) and the National Economic Council (NEC) will coordinate our future health reform efforts. We are just beginning this process and it will be a while before decisions are reached.

Q. **Secretary Shalala said yesterday that you will be presenting recommendations to Congress on health care reform and that these recommendations will be part of your budget. Are you going to submit a new plan and, if yes, have you given thought to what these recommendations will include?**

A. I have not had a chance to think exactly about where we will go or even in what form any such proposal would be presented. Could recommendations be submitted as part of the budget? Yes, but it is also possible it won't.

Q. **So, Secretary Shalala misspoke yesterday?**

A. Secretary Shalala was speculating on possible options. Again, no decisions have been reached. In fact, I have not even discussed options yet. Secretary Shalala herself said that decisions have not been made.

Q. **Secretary Shalala also said that obvious revenue sources will be cuts in Medicare and a tobacco tax. Are these your options that you are considering given that they were in your original plan?**

A. Let me first say that this Administration will not slash Medicare. In my original proposal, we took the Medicare savings and used them to provide benefits to older Americans. We - like every bill that came out of Committee - had a tobacco tax. Again, however, no decisions on any financing options for any proposal has even been discussed let alone decided.

Q. **Secretary Shalala indicated that you would be producing a scaled back health care plan. Does this mean that you will give up on your goal of universal coverage?**

A. Throughout this debate on health care reform, I have repeatedly stated that covering every American and controlling escalating health care costs should be our goals. My commitment to this mission has not changed. I still believe that every American deserves health care coverage. Every month that we don't act to reform our system, 100,000 more Americans will lose their insurance. And, if we want to ensure that the deficit that we have worked so hard to contain does not balloon again over time, we need to address rising health care costs. Americans will spend $982 billion on health care services in 1994 - nearly 14 percent of our gross domestic product. If this trend continues, we will spend $2.1 trillion on health care in 2001 - 20% of our GDP.

There are obviously decisions that need to be made on how to proceed on health care reform. The one thing that is sure is that we are serious about continuing our fight for reform.

Q. **Will you veto a bill that does not achieve universal coverage?**

A. I still believe that every American deserves health care coverage. Our goal is universal coverage. And we're going to do everything possible to assure that Americans have health care coverage when they need it. And we're going to do everything possible to control escalating health care costs.

The American people still overwhelmingly support universal coverage. The latest NYT/CBS News poll (September 8-11) stated that nearly 70% of the public believes that every American deserves health care coverage. We must continue to work toward achieving what the American people want and deserve.

Q. **Secretary Shalala said that you have not decided if you will call for an employer mandate next year. You have repeatedly stated that an employer mandate is the best way to provide coverage for every American. Are you backing away from requiring employers to share in their employees health care costs?**

A. I still believe that shared responsibility, which builds on the current system where nine out of ten Americans get private insurance through the workplace, is the best way to ensure that all Americans have health coverage. As I have repeatedly said I am open to any kind of new idea.

Q. **Is the new health care process a recognition that the Task Force was a failure?**

A. We are simply moving health care through the same policy process that we use for other major domestic policy issues. The Domestic Policy Council (DPC) and the National Economic Council (NEC) will coordinate our future health reform efforts. We are just beginning this process and it will be a while before decisions are reached.

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NATIONAL MARKET COVERAGE

TRANSCRIPT

FOR DEPARTMENT OF ENERGY STATION [redacted] Radio

PROGRAM Aviation Week Friday Alert CITY Washington, D.C.

DATE October 21, 1994 11:36 AM AUDIENCE

SUBJECT Hazel O'Leary and Deutch

BROADCAST EXCERPT

ANNOUNCER: The following Aviation Week Friday Alert is sponsored by Airbus Industry, employing 800 U.S. companies in 40 states to help build their world-class family of Airbus jetliners.

Now, here is Aviation Week and Space Technologies Washington bureau chief Paul Mann.

PAUL MANN: Pentagon insiders say Deputy Defense Secretary John Deutch is in line to become the next Secretary of Energy. They say Deutch is slated to replace Hazel O'Leary by next spring if current White House plans pan out.

Top defense officials also say Deutch's replacement is expected to be Paul Cominskie (?) who, only this summer, was named the Pentagon's chief of Acquisition & Technology.

There's also a new conjecture that Senate Armed Services Committee chairman Sam Nunn may replace Warren Christopher as Secretary of State in the not too distant future.

Fax

United States Department of State
Office of Press Relations
Phone: (202) 647-2492
Fax: (202) 647-0244

TO: White House - Dee Dee Myers (Fax: 456-6423)
Defense Dept - Ken Bacon (Fax: 703-695-1149)
USUN - Jamie Rubin (Fax: x44053)

FROM: State Dept Press Office

DATE:

Message

This is today's uncleared and very selective portion of our press guidance for your noon conference call.

Following this cov r s leet, there will be _____ pag .

ARA PRESS GUIDANCE
October 20, 1994

HAITI: TRUTH COMMISSION

Q: What is the U.S. Government's position on the establishment of a truth commission in Haiti?

A. WE STRONGLY SUPPORT PRESIDENT ARISTIDE'S FREQUENT CALLS FOR RECONCILIATION. THE HAITIAN PARLIAMENT HAS GIVEN PRESIDENT ARISTIDE BROAD LEEWAY TO GRANT AMNESTY. IT IS UP TO THE HAITIAN GOVERNMENT TO DECIDE IF IT WANTS TO PURSUE SETTING UP A TRUTH COMMISSION/A CONCEPT WHICH HAS BEEN APPLIED SUCCESSFULLY IN A NUMBER OF COUNTRIES. WE ARE PREPARED TO COOPERATE WITH THE HAITIAN AUTHORITIES IN THIS REGARD.

ARA PRESS GUIDANCE
October 20, 1994

HAITI: ARISTIDE'S PRESS CONFERENCE YESTERDAY

Q: What reaction or comment do you have on President Aristide's press conference yesterday?

A. THAT PRESIDENT ARISTIDE HELD A PRESS CONFERENCE YESTERDAY IS A HEALTHY SIGN THAT HE IS REACHING OUT TO ENSURE THAT THE HAITIAN PEOPLE ARE INFORMED IN A TRANSPARENT FASHION OF HIS GOVERNMENT'S POLICIES AND PROGRAMS. WE ARE PLEASED THAT HE USED THE OCCASION TO "CONDEMN ALL ACTS OF VIOLENCE, VENGEANCE AND LOOTING" -- A MESSAGE THAT BEARS REPEATING.

IO PRESS GUIDANCE
October 20, 1994

HAITI - TRANSITION TO UNMIH

Q. When will the UN Mission in Haiti (UNMIH) take over from the MNF?

A: -- THE MULTINATIONAL FORCE WILL TERMINATE ITS MISSION AND UNMIH WILL ASSUME THE FULL RANGE OF ITS FUNCTIONS WHEN A SECURE AND STABLE ENVIRONMENT HAS BEEN ESTABLISHED AND UNMIH HAS ADEQUATE FORCE CAPABILITY AND STRUCTURE.

-- THE DETERMINATION WILL BE MADE BY THE UN SECURITY COUNCIL, TAKING INTO ACCOUNT RECOMMENDATIONS FROM THE MNF COMMANDER AND FROM THE SECRETARY GENERAL.

-- THE SECRETARY GENERAL WILL BE INFORMED BY THE 60-PERSON UNMIH ADVANCE TEAM WHICH IS IN HAITI TO, AMONG OTHER TASKS, ESTABLISH THE APPROPRIATE MEANS OF COORDINATION WITH THE MNF AND PREPARE FOR THE DEPLOYMENT OF UNMIH.

(IF PRESSED) WE EXPECT THE TRANSITION TO OCCUR BY EARLY NEXT YEAR, AT THE LATEST.

(CAN CONFIRM SOME PRELIMINARY

EAP PRESS GUIDANCE
October 20, 1994

KOREA: INTER-KOREAN RELATIONS

Q. Do you have any comment on South Korea's plan to relax restrictions on travel and investment in the North?

A. -- WE HAVE SEEN THE PRESS REPORTS ABOUT SOUTH KOREAN CONSIDERATION OF PLANS TO ENCOURAGE NORTH-SOUTH CONTACTS. THE U.S. STRONGLY SUPPORTS INTER-KOREAN DIALOGUE.

Q. What has been the reaction to the agreement from key allies in the region?

A. -- KOREAN PRESIDENT KIM YOUNG SAM PUBLICLY WELCOMED THE AGREEMENT WITH THE NORTH IN REMARKS TO THE NATIONAL ASSEMBLY. JAPAN, CHINA AND RUSSIA HAVE ALSO PUBLICLY STATED THEIR SUPPORT FOR THE AGREEMENT.

EUR PRESS GUIDANCE

OCTOBER 20, 1994

BOSNIA: CONTACT GROUP MEETING

Q: What happened at the Contact Group meeting in New York?

A: -- CONTACT GROUP MEMBERS MET OVER THE PAST THREE DAYS IN NEW YORK TO DISCUSS ISSUES RELATED TO OUR JOINT EFFORTS TO ARRIVE AT A NEGOTIATED SETTLEMENT OF THE BOSNIAN CONFLICT.

-- AMONG THE ISSUES DISCUSSED WAS PRESIDENT CLINTON'S FIRM COMMITMENT TO INTRODUCE A UN SECURITY COUNCIL RESOLUTION IN THE NEXT FEW WEEKS THAT LIFTS THE ARMS EMBARGO AGAINST THE BOSNIAN GOVERNMENT, WITH A SIX-MONTH DEFERRAL OF IMPLEMENTATION OF LIFT, ALONG THE LINES OF PRESIDENT IZETBEGOVIC'S REQUEST.

CG cont.

-- WE WANT TO EMPHASIZE THAT THE CONTACT GROUP'S PLAN IS STILL ON THE TABLE. ACCEPTANCE OF THIS PLAN REMAINS THE FOUNDATION FOR PEACE.

-- THE ISSUE OF CONSTITUTIONAL ARRANGEMENTS IS TO BE DISCUSSED BY THE INTERESTED PARTIES AFTER ALL PARTIES ACCEPT THE PLAN.

-- WE AND THE OTHER CONTACT GROUP MEMBERS TO ISOLATE THE PALE SERBS UNTIL THEY ACCEPT THE PLAN. IT SHOULD BE CLEAR TO ALL THAT THIS PLAN IS IN THE INTEREST OF ALL PARTIES, INCLUDING THE PALE SERBS.

Q: Has the plan been changed?

A: NO.

EUR PRESS GUIDANCE
OCTOBER 20, 1994

KRAJINA PROPOSAL

Q: What can you tell us about a new international strategy to handle the Krajina?

A: -- A GROUP CONSISTING OF THE U.S. AND RUSSIAN AMBASSADORS AND REPRESENTATIVES OF THE EUROPEAN UNION AND THE UNITED NATIONS HAVE BEEN MEETING WITH THE PARTIES TO ADDRESS A SETTLEMENT IN THE KRAJINA. A PROPOSAL IS BEING SUBMITTED TO THE PARTIES; IT WOULD BE INAPPROPRIATE TO GET INTO THE DETAILS OF THE PROPOSAL BEFORE THEY HAVE HAD THE CHANCE TO CONSIDER IT.

NEA PRESS GUIDANCE
Thursday, 20 October 1994

ME PEACE PROCESS: IMPACT OF BOMB ATTACK/UPDATE

Q: Any reaction to an Israeli cabinet decision to close the border and "create a separation" between Israeli and Palestinian populations?

for details refer to Israeli govt

A: WE ARE STUDYING THE CABINET'S DECISIONS. AT THIS STAGE, WE HAVE SEEN NOTHING TO CONFIRM ANY PRESS REPORTS EMERGING FROM THE CABINET MEETING.

ISRAELI OFFICIALS HAVE INDICATED THAT THE PEACE PROCESS WOULD GO ON AND THAT HAMAS WOULD NOT BE ALLOWED TO DICTATE ITS PACE OR DIRECTION.

Q: Have we had any contact with Chairman Arafat following this attack?

we're satisfied w/ PLO public condemnation.

A: OUR CONSUL GENERAL IN JERUSALEM CONTACTED CHAIRMAN ARAFAT'S OFFICE IMMEDIATELY UPON LEARNING OF THIS ATTACK.

Q: Any update on the President's travel plans? Is this attack going to influence his itinerary?

A: AGAIN, I WOULD REFER YOU TO THE WHITE HOUSE FOR INFORMATION ON THE PRESIDENT'S TRAVEL.

Q: What about the Secretary's travel, then? Any plans for him to visit Syria on this trip?

A: THE SECRETARY'S TRAVEL OBVIOUSLY WILL BE DECIDED ON THE BASIS OF THE PRESIDENT'S ITINERARY. WE'LL KEEP YOU POSTED ONCE THE INFORMATION IS AVAILABLE.

Q: The Spokesman indicated yesterday that we were pressing a number of capitals to clamp down on Hamas activities. Can you go into more detail? Who are we pressing and what kinds of responses have we gotten, for example from Syria?

A: YES, WE ARE PRESSING FOR INTERNATIONAL CONDEMNATION AND FOR ACTION AGAINST THIS KIND OF TERRORISM, BOTH IN AND OUT OF THE REGION.

I'M NOT GOING TO COMMENT ON THE DETAILS OF OUR DIPLOMATIC EXCHANGES.

WE WOULD EXPECT STRONG PUBLIC STATEMENT COMMENSURATE WITH THE BRUTALITY OF THE ACT

Q: Have we heard anything from the Syrian government condemning this latest attack? (PUBLIC)

A: I'M NOT AWARE OF ANY STATEMENT CONDEMNING THE ATTACK.

Q: So you're confirming that they haven't said anything privately?

A: I'M NOT GOING TO GET INTO THE DETAILS OF CONFIDENTIAL EXCHANGES. WE'VE HAVE DISCUSSED THE INCIDENT.

Q: The PLO is calling for changes in the text of the Israeli-Jordanian peace treaty on the grounds that it accords Jordan special status with respect to Jerusalem in contravention of the Declaration of Principles. Any reaction? Don't we have an obligation as "honest broker" in these negotiations to help mediate this kind of dispute?

A: NO, OUR OBLIGATION IS TO SUPPORT AGREEMENTS REACHED BETWEEN THE PARTIES.

Drafted: NEA/P:DJones
SEPDEP, 10/20/94, 7-5151
Cleared: NEA:MRParris
NEA:DCKurtzer
SMEC:AMiller

SA Press Guidance
October 20, 1994

PAKISTAN: FOREIGN SECRETARY MEETS CHRISTOPHER

Q: What can you tell us about Secretary Christopher's meeting today with the Foreign Secretary of Pakistan, Najmuddin Shaikh?

A: NAJMUDDIN SHAIKH SAW THE SECRETARY THIS MORNING TO REVIEW THE U.S.-PAKISTAN RELATIONSHIP. THEY HAD A GOOD HALF HOUR MEETING. THE FOREIGN SECRETARY WILL BE SEEING OTHER DEPARTMENT OFFICIALS, INCLUDING UNDER SECRETARIES TARNOFF AND DAVIS AND ASSISTANT SECRETARY RAPHEL.

THE MEETING WAS PART OF OUR MUTUAL EFFORTS TO BROADEN THE TRADITIONAL STRONG TIES BETWEEN PAKISTAN AND THE UNITED STATES. WE HAVE MANY SHARED CONCERNS AND ARE COOPERATING CLOSELY TO ADDRESS THEM. RECENTLY, THE UNITED STATES AND PAKISTAN HAVE WORKED TOGETHER AT THE CAIRO POPULATION CONFERENCE, ON MAJOR PEACEKEEPING OPERATIONS, AND IN GLOBAL NONPROLIFERATION FORA.

THE SECRETARY AND FOREIGN SECRETARY SHAIKH DISCUSSED OUR BILATERAL RELATIONSHIP, INCLUDING COMMERCIAL TIES, REGIONAL SECURITY, INDO-PAKISTANI RELATIONS AND THE KASHMIR DISPUTE, AND NONPROLIFERATION ISSUES.

(M-11)

Q: What about problems over nuclear and missile proliferation?

THE U.S. HAS SERIOUS CONCERNS ABOUT THE DANGERS OF NUCLEAR AND MISSILE PROLIFERATION IN SOUTH ASIA. WE RECOGNIZE THAT THE SECURITY CONCERNS OF THE COUNTRIES IN THE REGION ARE A KEY PART OF THIS PROBLEM. WE ARE CONTINUING TO DISCUSS WITH PAKISTAN OUR DIFFERENCES OVER THESE ISSUES.

Q: The Pakistani's have said they will introduce a resolution on Kashmir in the UNGA. Will the U.S. support this initiative?

A: PAKISTAN HAS NOT FORMALLY PROPOSED A KASHMIR RESOLUTION. IF IT DOES, THE U.S. WILL STUDY THE RESOLUTION CAREFULLY.

PM & S/AL Press Guidance
October 20, 1994

U.S.-DPRK AGREED FRAMEWORK

Q. What arrangements have been made for the signing of the agreed framework in Geneva?

A. -- THE TIMING AND LOCATION OF THE SIGNING WILL BE DECIDED UPON BY THE TWO DELEGATIONS. THE PUBLIC AFFAIRS OFFICE AT THE U.S. MISSION IN GENEVA SHOULD HAVE INFORMATION ON THIS TOMORROW MORNING GENEVA TIME.

Q. Ambassador Gallucci mentioned a "Confidential Minute" to the agreement, what can you tell us about it?

A. -- ITS CONFIDENTIAL

-- IT IS NOT UNUSUAL FOR INTERNATIONAL ACCORDS TO HAVE CONFIDENTIAL ANNEXES. THESE DO NOT DEAL WITH THE SUBSTANCE OF THE OBLIGATIONS UNDERTAKEN IN THE AGREEMENT TO WHICH THE ANNEX IS APPENDED, BUT THEY OFTEN PROVIDE TECHNICAL DETAILS RELATED TO THE IMPLEMENTATION OF THE AGREEMENT ITSELF THAT ONE OR MORE PARTIES DO NOT WANT TO MAKE PUBLIC FOR LEGITIMATE NATIONAL SECURITY REASONS.

PM & S/AL
October 19, 1994

U.S.-DPRK NUKE AGREEMENT: HARDLINE QUESTIONS

Q. Doesn't this agreement demonstrate that proliferators can benefit from their actions by waiting to be bribed into acceptable behavior?

A. -- WE REJECT SUCH A CATAGORIZATION; SUCH AN ASSERTION SHOWS AN OVERLY SIMPLISTIC VIEW OF A VERY COMPLEX PROBLEM.

-- WE HAVE SUCCEEDED IN WINNING NORTH KOREA'S AGREEMENT TO MEET ITS INTERNATIONAL OBLIGATIONS FULLY.

-- IN ADDITION, NORTH KOREA HAS AGREED TO FREEZE ITS PRESENT NUCLEAR ACTIVITIES AND TO DISMANTLE ITS EXISTING NUCLEAR FACILITIES; THIS GOES BEYOND THE REQUIREMENTS OF THE IAEA AND NPT OBLIGATIONS.

-- IN CONNECTION WITH THESE ACTIONS, THE U.S. HAS AGREED TO HELP NORTH KOREA OBTAIN REPLACEMENT LIGHT-WATER REACTORS THAT POSE LESS OF A PROLIFERATION THREAT AND TO OBTAIN FUEL SUPPLIES TO REPLACE THE ENERGY GENERATING CAPACITY LOST

-- IN VIEW OF NORTH KOREA'S AGREEMENT TO ADDRESS OUR CONCERNS, WE AGREED TO MOVE TOWARD IMPROVING BILATERAL POLITICAL AND ECONOMIC RELATIONS.

-- THESE STEPS ARE ALL IN THE INTERESTS OF THE U.S. AS WELL AS NORTH KOREA.

Q. How much will this deal cost the U.S.?

A. -- IT IS ESTIMATED THAT THE TWO LIGHT-WATER REACTORS MAY COST AS MUCH AS $4 BILLION. WE DO NOT HAVE AN ACCURATE ESTIMATE OF THE COST OF THE SUPPLEMENTAL FUEL PROVIDED TO FILL THE DPRK'S ENERGY NEEDS IN THE INTERIM PERIOD.

-- ALMOST ALL OF THE COST OF CONSTRUCTING THE LWRS WILL BE BORNE BY OTHER CONSORTIUM MEMBERS, SPECIFICALLY THE REPUBLIC OF KOREA AND JAPAN.

-- IN TERMS OF DIRECT COSTS TO THE U.S., WE ARE IN CONSULTATION WITH CONGRESS ON THIS ISSUE.

-- THE U.S. HAS UNDERTAKEN TO PAY FOR THE INITIAL SHIPMENT OF HEAVY FUEL OIL TO BE SHIPPED TO THE DPRK. THAT WILL PROBABLY COME TO ABOUT $6 MILLION. SUBSEQUENT ALTERNATE ENERGY NEEDS WILL BE FUNDED BY A MULTILATERAL CONSORTIUM WHICH WILL BE ESTABLISHED IN THE NEAR-FUTURE.

-- I WOULD ALSO ADD THAT THE U.S. AND NORTH KOREA WILL BEGIN TECHNICAL TALKS SOON ON THE STORAGE OF THE SPENT FUEL RECENTLY REMOVED FROM ITS NUCLEAR RESEARCH REACTOR. PROPER STORAGE WILL ALLOW THE DPRK TO KEEP THE FUEL IN ITS PRESENT FORM WITHOUT REPROCESSING AND TO EVENTUALLY SHIP IT OUT OF THE COUNTRY. BOTH OF THESE ARE IMPORTANT FOR IMPLEMENTATION OF THE AGREED FRAMEWORK AND FOR OUR NON-PROLIFERATION GOALS.

-- THE TOTAL COST OF SAFE STORAGE FOR THE U.S. WILL PROBABLY BE IN THE TENS OF MILLIONS OF DOLLARS.

Q. Don't you expect North Korea to cheat on this agreement?

A. -- AS THE PRESIDENT SAID, VERIFICATION OF COMPLIANCE WITH THIS AGREEMENT IS NOT BASED ON TRUST. A VIGOROUS ON-SITE INSPECTION PROGRAM BY THE IAEA WILL VERIFY THAT THE REPROCESSING PLANT IS SEALED, THAT THE 5 MEGAWATT REACTOR IS SHUT DOWN, AND THAT NO FURTHER WORK IS BEING UNDERTAKEN ON THE PARTIALLY COMPLETED REACTORS. WE WILL ALSO HAVE AVAILABLE OUR OWN NATIONAL TECHNICAL MEANS FOR VERIFYING NORTH KOREA'S ADHERENCE TO THE AGREED FRAMEWORK.

-- I WOULD ALSO ADD THAT, ONLY AS THE DPRK COMPLIES WITH THE AGREEMENT, IN A STEP-BY-STEP MANNER, WOULD WE BEGIN TO IMPLEMENT OUR SIDE OF THE AGREEMENT AND SELECTIVELY REDUCE ECONOMIC AND FINANCIAL RESTRICTIONS AGAINST THE DPRK -- IN CLOSE CONSULTATION WITH CONGRESS.

Q. Why couldn't Iraq and Iran and other states sit back and wait to be "bribed" to meet their international commitments as well?

A. -- WE REJECT ANY CHARACTERIZATION OF THE AGREED FRAMEWORK AS A "BRIBE;" SUCH AN ASSERTION IS INACCURATE AND AN OVERSIMPLIFICATION.

-- AS IAEA DIRECTOR BLIX SAID, "NO TWO CASES ARE ALIKE."

-- THIS AGREEMENT IS WITH THE DPRK AND DEALS WITH CIRCUMSTANCE RELATED TO THAT STATE'S NUCLEAR PROGRAM. THERE IS NO BASIS FOR EXTRAPOLATE FROM THIS AGREEMENT HYPOTHETICAL ACCORDS WITH OTHER STATES, WHERE CIRCUMSTANCES ARE DIFFERENT.

-- I WOULD NOTE THAT OUR AGREED FRAMEWORK GOES BEYOND EXISTING INTERNATIONAL NON-PROLIFERATION OBLIGATIONS UNDER THE NPT. IN ADDITION TO PROHIBITING NORTH KOREA FROM CONDUCTING REPROCESSING, THE AGREED FRAMEWORK REQUIRES THE DPRK TO CONVERT ITS ENTIRE GRAPHITE MODERATED REACTOR SYSTEM TO A LESS PROLIFERATION-PRONE

Q. Isn't it a significant concessions to wait five years to conduct IAEA special inspections not give North Korea more time to build a nuclear device in secret?

A. -- IN TERMS OF THE RELATIVE IMPORTANCE TO PROMOTING U.S. AND INTERNATIONAL NON-PROLIFERATION OBJECTIVES, OBTAINING IMMEDIATE CESSATION OF THE NORTH KOREAN NUCLEAR PROGRAM AND SEALING OF THE REPROCESSING PLANT WERE OF A HIGHER PRIORITY THAN THE SPECIAL INSPECTIONS.

-- IF THE CURRENT REACTOR HAD REMAINED IN OPERATION, AND THE TWO REACTORS UNDER CONSTRUCTION COME ON LINE, THERE WOULD HAVE BEEN A POTENTIAL FOR THE PRODUCTION OF SUFFICIENT PLUTONIUM FOR MANY BOMBS.

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