Wants to wait for leadg he is
knew univ. coverge / you don't guarantee h.c. no one is secure

All diff kinds of pple here
Doesn't matter what you are
We're all

Up against pol & fin. opposition
Take adv that a system discriminates

Send a clear msg to members of Cong

If we don't guarantee, then we fail all Americans.

Univ. coverge -
have to Finance it

2 ways - single pay
Based on shared resps.
It does work
Why walk away from a system that works?
⊗ The right thing to do.

Minority of bigs that are freeloadg off the syst.
Congress saying give us the easy way out - no finang.
- Ins. reform doesn't work w/o univ cov
- hurts middle class

Disgrace that any Amer. is denied care

Not just abt an easy vote to get out of a pol. dilemma

Soc Sec = same arguments 60 yrs
30 yrs later - guaranteed h.c. coverge to over 65 Medicare
Now we need to finish the job

MEMORANDUM

To: Don Baer

From: Carolyn Curiel

Re: President's remarks for Unity Conference

Date: July 25, 1994

If the issue of crime is still being pushed as a potential topic, I would strongly argue against it. I think it would serve as a message of negative image which would not serve the President well.

I think the health care message, if couched under the larger theme of opportunity, would be a much better choice.

Consider the audience. Many are the children of blue-collar and rural workers. That they are in Atlanta is a testament to ambition. You could call them first-generation upwardly mobile. Right now they see the main obstacle to their advancement being a lack of opportunity. But another is their vulnerability to economic setbacks.

What I have suggested to Carter is that the President focus on why the health care battle is for people like those in the young middle class, whose long climb to the top could be knocked down with a single pink slip or long-term illness. The crowd should understand that unless health care is reformed, many aspirations can never be realized for this generation or the next.

I think this kind of message could resonate well.

cc: Carter Wilkie
Ann Walker

To: Lissa
From: Claire
Re: Douglass Quotes
Date: July 25, 1994

1. "The whole history of the progress of human liberty shows that all concessions yet made to her august claims have been born of earnest struggle . . . *If there is no struggle, there is no progress* . . . This struggle may be a moral one, or it may be a physical one, and it may be both moral and physical, but it must be a struggle. Power concedes nonthing without a demand. It never has and it never will."

2. "The life of the nation is secure only while the nation is honest, truthful, and virtous."

-- Bartlett's Familiar Quotations, 1992.

3. "I glory in conflict, that I may hereafter exult in victory."

4. "The simplest truths often meet the sternest resistance and are slowest in getting general acceptance." (Re: Women's suffrage)

-- Political Quotations, 1990.

To: Lissa
From: Claire
Re: Eugene McCabe/North General Hospital
Date: July 25, 1994

Euguene L. McCabe is the President and CEO of Harlem's North General Hospital. The hospital is the only private, minority-operated, voluntary hospital in Harlem. As demonstrated in its recent partnership with Hope for Kids on a comprehensive immunization project for infants and toddlers and its sponsorship of Maple Court, a 17 million dollar housing project, community outreach is very important to the facility. Moreover, when the hosptal moved to a new state-of-the-art facility, it awarded 13 million to minority contractors and utilized a large number of people of color in the project's labor force. The project was finished 6 months ahead of schedule and 13 million under budget. As of 1992, 70% of the hospital's employees are Harlem residents.

HRC

Remarks at Health Care Rally
Portland, Oregon
July 22, 1994

MRS. CLINTON: Thank you, Rachael for your introduction, and thank you and your mother for your courage to come here and tell your story. Thank you, John, for being one of the majority of small business owners who want to do the right thing by insuring their workers. (Applause). And thank you, Oregon, because you are leading the way for health care reform in the country. (Applause).

It is this state which recognized before the federal government that if you did not insure everyone, if you did not guarantee that all citizens had insurance, then no citizen was secure and there was no way to control the cost of health care. It is this state which has showed what the rest of the country needs to be doing. And I think that we owe all of you a great thank you for supporting health care reform in your state. (Applause).

You know as I look across this wonderful, huge crowd and I see people in windows and on the streets who can't even get in to the largest living room in Portland, I know that there are many different kinds of Americans here. I know there are Democrats, Republicans, and Independents. I know that there are people who work and people who are currently unemployed. I know there are young people and old people -- people of every background, race, religion, ethinicity and I know that it makes no difference what your background is, or where you live or where you work, you as an American should be entitled to health care as a right and that is what we are fighting for. (Applause).

I also know that the people in this crowd and the people behind me who will board the buses do it for many different reasons. There are business owners, like John, who are tired of fighting a health care system that discriminates against small business and charges them so much more than big business or government gets charged. I know there are mothers, like Susie here, who have children with health care problems who no longer will stand silent before a system that treats their children like second class citizens -- because they got hurt or they got injured or they got sick. (Applause).

And I know . . . I know there are nurses in this crowd who are tired of spending their time on paperwork and want to take care of patients for a change. (Applause). And I know there are doctors in this crowd who went to medical school because they (inaudible) to heal and what they do now is spend their time hassling with insurance companies to be able to get permission to treat their own patients. (Applause).

And I know, because I have been privileged to travel around this country for a year and a half, that there are so many of Americans who constitute the vast majority -- every poll says 70 to 80 percent -- who know what the right thing to do about health care is. They know that if we do not guarantee health insurance to every American, no American is secure.

Now that may be the right thing to do, but sometimes, as we all know, getting the right thing done is not so easy. Because we are up against very strong political and financial forces who make a lot of money and take political advantage from the fact that we have a system that discriminates against people.

What we are doing in the next few weeks is sending a very clear message to members of Congress. That message is simple -- that if we do not guarantee health insurance to every American, then we have failed all Americans. Because there is no way . . . (Applause) there is no way that any one of us in this crowd can know for sure that we will have health insurance, in this system, when and if we ever need it.

Now when the President started this crusade for health care reform, he said as clearly as he could, that this debate would take many different directions -- there would be many different ideas that would be put forward. But the bottom line has to be guaranteed insurance. And that means that we have to be able to finance the guaranteed insurance. There are many politicians in Washington who are happy to come before you and say they support universal coverage. But they then don't complete the thought by saying, and here is how we will finance it.

There are only two ways to make sure that everyone is covered. Either, as I see our friends in the crowd with the signs for single-payer, (Applause), either a single-payer system, which, under the President's approach would be guaranteed as a state option for any state that wanted to have a single-payer system. (Applause). Or, or we build on what works for the vast majority of Americans. We build on shared responsibility between employers and employees. And we do that because it does work and because it is fair. That is the real crux of the debate that will be taking place in the next few weeks.

Why would we turn our backs on a system that works for most Americans by walking away from shared responsibility because we were afraid to stand up to the minority of businesses that are freeloading off the health care system because they will not provide insurance for their workers. (Applause). But you have to reform the system to make it affordable for small businesses, which is what we intend to do. That is the key for making sure everyone gets to participate. If we stay the course for universal coverage, we will actually save people who are currently insured, money.

And let me just quickly explain why that will work. There are

many in Congress who say give us an easy vote. Don't make us vote on financing it. Don't make us make the minority of employers and employees pay their fair share. Let's just do insurance reform. The problem is that states have tried it. Unlike Oregon, other states have tried to have insurance reform. If you do not have universal coverage, once again, the middle class working people pay the price. Their costs go up while we take care of the poor. I am all for taking care of the poor. It is a disgrace that any person in America should be denied health care. But I want to take care of every American, the majority of Americans, who work hard, play by the rules, pay the taxes. Right now, they are paying for a system that doesn't take care of everyone. (Applause).

And if you look at the whole health care issue -- if you look at what we are on the brink of achieving -- there are economic reasons to guarantee health insurance. If we do it we will save people who currently pay for insurance money, if everybody else has to pay as well. We will save government money. We will begin to make sure that we do not have the kind of irresponsible spending in the health care system that we have had for so many years.

We will also be able to say that we have done the right thing. Because it's a question of social justice as well. It is also a moral issue for our country (Applause). You know, it may be possible for some members of Congress, who know what the right thing to do is, to turn their backs on doing it because they can't stand the political heat. That may be possible, but if we work hard enough in the next few weeks, it will be extremely uncomfortable to do. Because if we make it clear that it's real people's lives, it's the future of this country, it's economically, socially, and morally the right thing to do, than anyone who votes against universal coverage is not just casting an easy vote to get out of a political dilemma, but is going to have to be held accountable for that kind of vote. (Applause).

You know, it is very rare that we have a chance, as a country, to face up to a difficult issue. It comes about maybe once in a generation. Sixty years ago, our grandparents with Franklin Roosevelt stood up and passed Social Security. And they faced the same arguments that we face today. Thirty years later, under Presidents Kennedy and Johnson, the American people guaranteed health care coverage to Americans over the age of 65, and I am proud we did that.

But now . . .(Applause), but now we need to finish the job. We need to say to every American, you will be secure if you change jobs, if you get sick, if you get laid-off, you will have health insurance. You will have choice of doctor, choice of health plan. You will be able to afford health care in the richest country on earth.

This issue . . .(Applause) this issue is a real turning point in

American history, and it's one that I don't think will ever be posed as starkly as it is now. Will we do what we know needs to be done? Will we make sure that our country joins the ranks of other advanced countries? Will we have our multi-national companies who do business in other countries and pay for the health care of foreign workers begin to pay for the health care of American workers (Applause)? Will we have the courage to do this?

You know, this part of the country was settled by people who got on wagon trains, and went out not knowing exactly where they would end up. When we began this health care crusade, I sometimes felt that I was on a journey that I didn't know exactly where it would end up either. But every day that went on, I became more and more convinced, that if the American people had a chance to vote themselves, there would not be any question about the outcome. And if we give . . .(Applause) if we give our energy, our hearts, our souls to the next few weeks and make it clear that the American people want what the members of Congress have, guaranteed health insurance, paid for with an employer-employee shared responsibility system, we will get it for every single American. Thank you all. (Applause).

And now its time for everybody to board their buses whose going in the opposite direction, from West to East, to take a message to Washington. And I want to thank all of these Americans for taking their time to be for all of us by getting the message out. Thank you and godspeed.

(End of speech)

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3RD STORY of Focus printed in FULL format.

The Ethnic NewsWatch
New York Voice Inc./Harlem USA

March 23, 1994

SECTION: Vol. XXXVI; No. 50; Pg. 13

LENGTH: 365 words

HEADLINE: Partnership Between Harlem's North General Hospital And Hope For Kids Launches Immunization Project

BODY:
Partnership Between Harlem's North General Hospital And Hope For Kids. Launches Immunization Project

Shocking numbers -- 62% -- of New York City's children lack vaccinations, statistics that rival those of a third world nation.

In a comprehensive response to this escalating health hazard among this city's children, Hope For Kids will launch a two-year immunization project in partnership with North General Hospital, it has been announced by Eugene McCabe, President of North General and Lawton Chiles of Hope For Kids. Their goal is to identify and fully immunize thousands of babies/toddlers throughout the city.

The NYC Department of Health estimates that nearly 62% of children under the age of 2 lack complete immunizations. The vast majority of New York City's non-immunized children come from impoverished families. Children must receive the necessary vaccinations by age 2 or risk developing such crippling and life threatening diseases as polio, diphtheria, and measles.

"With such a crisis in our midst," stated Livingston S. Francis, North General's Chairman of the Board, "North General has joined forces with Hope For Kids in an aggressive effort to provide our children with the necessary preventive care. North General is not only a hospital providing quality patient care, but a community resource committed to improving the quality of life in our city."

The North General/Hope For Kids Immunization Program will involve close to 500 volunteers who will provide an intensive hands-on strategy beginning with door-to-door canvassing of neighborhoods to identify children at risk, educate parents about the importance of immunization, help to register children for immunization appointments and will follow-up with these families for the entire immunization cycle.

"Sadly, children are suffering from preventable disease," states Lawton Chiles of Hope For Kids. "Pre-school children are not receiving the necessary vaccinations that will protect them until they reach school age. The situation is serious."

5TH STORY of Focus printed in FULL format.

The Ethnic NewsWatch
New York Voice Inc./Harlem USA

December 22, 1993

SECTION: Vol. XXXVI; No. 37; Pg. 12

LENGTH: 296 words

HEADLINE: Mayor David Dinkins & North General Hospital Kick-Off Major Harlem Housing Development

BODY:
Mayor David Dinkins & North General Hospital Kick-Off Major Harlem. Housing Development

Mayor David N. Dinkins and Eugene McCabe, President of Harlem's newly constructed North General Hospital, recently held a ground-breaking ceremony to celebrate the construction of the innovative Maple Court Housing Development.

As Harlem's largest private employer, North General Hospital is sponsoring the development of Maple Court -- a 135-unit Limited Equity Cooperative -- in conjunction with the New York City Department of Housing Preservation & Development. Maple Court will be located at 123rd Street and Madison Avenue in East Harlem. This development will offer affordable home ownership opportunities to Harlem and East Harlem families. The project is expected to cost $17M.

"With the limited availability of affordable housing in Harlem, North General has joined forces with Mayor Dinkins and HPD in an aggressive effort to revitalize housing and the concomitant economic and cultural development uptown," stated McCabe. "We hope that the success of Maple Court will prove to other developers that affordable housing can be introduced successfully into our neighborhood."

Also, as part of its revitalization effort, North General is currently planning to develop 200 units of affordable rental units on the block bounded by 119th & 120th Street, between Madison and Park Avenues, as well as a 28-unit supportive housing facility serving homeless persons living with HIV/AIDS in New York City.

"Thanks to the vision and dedication of Mayor Dinkins and the efforts of HPD," added McCabe, "Harlem is, indeed, witnessing its Second Renaissance.

North General Hospital is the only private, minority operated, voluntary, community teaching hospital in New York City.

ETHNIC-GROUP: African-American

LANGUAGE: English

LOAD-DATE-MDC: February 22, 1994

12TH STORY of Focus printed in FULL format.

The Ethnic NewsWatch
Big Red News

January 18, 1992

SECTION: Vol. 17; No. 3; Pg. 23

LENGTH: 684 words

HEADLINE: North General Moves to New Facility

BYLINE: Lopez, Eric Rodney

BODY:
North General Moves to New Facility.

On December 12, 1991, thunderous applause and cheers filled the halls of North General Hospital. At 10:13 a.m., the last of approximately 150 patients was successfully moved from the old North General Hospital in Harlem, at 1919 Madison Avenue, to the new, $70million, state-of-the-art, North General Hospital at 1879 Madison Avenue.

"Everyone is enthusiastic because a new home is exciting for all involved, said president and CEO of North General Hospital, Eugene McCabe, whose leadership and ardor was a driving force behind the success of this unprecedented project.

"There's a tremendous feeling of accomplishment and pride among the staff," said Tom Long, executive vice president of North General. "It's taken 12 long years for the staff and the community to realize this dream."

North General is the only private, voluntary hospital in Harlem and is now operating out of a 240 bed facility that was completed six months ahead of schedule and $13 million under budget. The hospital was on the brink of closing in 1985, and in recent years has operated with an accumulated debt of $65 million.

The move to the new hospital was in the planning stages for quite some time. Pat Norman, vice president of finance, and member of the North General faculty for 25 years, said: "The feasibility study began in 1985 and project planning started about two years ago. Our distressed status allowed the hospital to get reimbursed from the government."

Much research was done in order to ensure the success of the move. According to project relocation manager, Sheena Mayrant, site visits were conducted to hospitals who were moving and relocating all over the country. All aspects of hospital relocation had to be investigated so that the move would be carried out smoothly.

According to McCabe, "All department had a part in making the move a success."

Much support came from outside sources as well. The New York City Police and Fire Departments ensured safety. Director of Development June Scarlett added: "The teamwork and united effort of everyone should move people all over the city to support the hospital."

The various medical departments benefit greatly from the new facility. Dr. Wanda Huff, director of the intensive care unit, said: "North General had the oppurtunity to provide medical care that is appropriate now and in the future. Medicine is changing rapidly, and it is our responsibility to respond to that."

Dr. Stanley Reichman, director of medicine, believes that North General Hospital can be, to a greater capacity, a "Mother of the community." He adds: "Our goal is an organized relationship between the doctor and patient."

North General's $15million equipment budget allows the hospital to offer the community access to the latest in medical technology. It is now able to compete with the top hospitals in the city.

Another factor contributing to the success of their venture is that the new hospital was a community project. Contractors of color were awarded $13 million. People of color made up 60 percent of the project labor force, and 70 percent of the hospital's employees are Harlem residents.

Involvement in community affairs is one of the hospital's main goals. "We did a lot of outreach with this project and the community responded favorably," said Mayrant. "We want to establish ourselves so that people will have faith in North General Hospital."

What is the prognosis for North General Hospital? Full rejuvenation and a dynamism that will positively affect the Harlem area.

But, growth will not end with only the new hospital. Within the next few months construction will begin on a housing complex for community residents and North General employees and a five story building to relocate their nursing school and house the finance and government affairs departments.

And for the future, McCabe is confident, "In the future, there will be more hard work and more success," he said. "We now have a greater ability to provide primary care than we did before and this hospital is as good as any hospital anywhere."

ETHNIC-GROUP: African-American

LANGUAGE: English

LOAD-DATE-MDC: October 28, 1992

URBAN LEAGUE NOTES

Black women
- higher rates of cervical / breast cancer death (less preventive care)
-

Blacks →
more undetected diseases
higher illness rates
more incidents of stress, diabetes
higher mortality rates
infant mortality

Doesn't have to do with biology
Conditions
Lack of access to afford. care

Frederick Douglass Award winners — Eugene L. McCabe — Pres/CEO North Shore Hosp. in Salem.

Comm'y health
Model for primary health care + comm'y dept?

Last yr. report focused on health care.

To: Lissa
From: Claire
Re: Social Security
Date: July 21,1994

I. HISTORY

The Social Security Act was signed by Franklin Roosevelt on August 14, 1935 as an attempt to provide unemployment and old-age benefits to the American public through a payroll tax on employers and employees. Although the nation had been predominantly agricultural and thus adverse to either the notion or the necessity for social insurance, the developments in the economy quickly altered this perception. First, as the nation became urbanized, its citizens began to realize that they were no longer dependent upon the land, but upon the wages from their employers. This, in turn, fostered an increased economic interdependence in the nation. Secondly, there was a rise in the philosophical concept that the government was responsible for the care of the unemployed and the underprivileged. Thirdly, the number of older Americans was increasing, which resulted in increased pressure on Congress to address their needs. Also, the older workers found themselves unable to perform with the new skills required by the economy. Finally, the Great Depression, with its plummeting wages, rising unemployment and general hardship awakened the American public and the administration to the need for protection and security for the unemployed and the aged. Despite opposition, the Act passed the House with a vote of 372-33 and the Senate with a vote of 76-6; no other New Deal measure received such approval.

-- Encyclopedia Americana, 1989

II. QUOTES FROM FDR

(FDR's overriding philosophy regarding Social Security was that, if states failed to provide adequate resources for their jobless and aged, the national government had a Constitutional and humanitarian duty to intervene. He hoped the Act would result in economic security and stability for all by providing it to the individual.)

1. ** The United States has been "given a vision to make new provisions for human welfare and happiness , and in a spirit of mutual helpfulness, we have cooperated to translate that vision into reality"

2. **"There is no tragedy in growing old, but there is tragedy in growing old without means of support"

**"(we need) a sound and uniform system which will provide

true security"

**"There can be no security for the individual in the midst of general insecurity"

--Speech to Advisory Council (created to study and develop social security), 1934.

3. **"Fear and worry based on unknown danger contribute to social unrest and economic demoralization. If, as our Constitution tells us, our Federal government was established to 'promote the general welfare', it is our plain duty to provide for that security upon which welfare depends"

**FDR wanted a "sound way" to provide security against "several of the great disturbing factors in life -- especially those which relate to unemployment and old age"

**FDR wanted Social Security to arise from cooperation between the states and the federal government, but still remain "national in scope"

**FDR had three major objectives for his administration: security of the home, security of livelihood, and security of social insurance. He declared that those objectives were, ". . . a minimum of the promise that we can offer to the American people. They constitute a right which belongs to every individual and every family willing to work. This seeking for a greater measure of welfare and happiness does not indicate a change in values. It is rather a return to values lost in the course of our economic development and expansion"

**"It is true that there are few among us who would still go back. These few offer no substitutes for the gains already made, nor any hope for making future gains for human happiness. They loudly assert that individual liberty is being restricted by the government, but when they are asked what individual liberties they have lost, they are put to it to answer"

**"We must dedicate ourselves anew to a recovery of the old and sacred possessive rights for which mankind has constantly struggled -- homes, livelihood, and individual security. The road to these values is the way of progress"

-- Presidential address to Congress on the objectives of the Administration, June 8, 1934

4. **For FDR, social security was a "sound idea and a sound ideal" which was "fundamental to our future civilization"

**The Social Security Act was both a "measure of prevention and a method of alleviation"

-- Message to Congress on Social Security, January 17, 1994

5. **The Social Security Act will protect the average citizen and his family against loss of a job and "poverty-ridden old age"

**The Social Security Act is a "cornerstone" in the whole structure of economic stability for now and the future

**The Social Security Act is a "law that will take care of human needs and at the same time provide for the United States an economic structure of vastly greater soundness"

-- Speech at signing of Social Security Act, August 14, 1935

III. OPPOSITION

The major opposition to social security arose from conservative business interests who feared expanding government spending and intervention. They called it "extravagant" and a "waste". They claimed that such government invasion into the economy destroyed "business confidence", created uncertainty, discouraged thrift, encouraged shiftlessness, destroyed individual initiative, and in general raised hell with the moral character of the citizenry and the workings of the economy". Fiscal conservatives who resented federal involvement in the treasury and organized labor who mistrusted the middle-class reformers also opposed the Social Security Act.

1. "We might as well take a child from the nursery, give him a nurse, and protect him from every experience life affords"
   -- Senator A. Harry Moore (NJ)
2. The New Deal as "un-American" and "socialistic"
   -- all opponents
3. Social Security will facilitate "ultimate socialist control of life and industry"
   -- National Association of Manufacturers
4. Social Security "will undermine our national life by 'destroying initiative, discouraging thrift, and stifling individual responsibility'"
   -- James J. Donnely; Illinois Manufacturing Association
5. Social Security will "sooner or later bring about the inevitable abandonment of private capitalism"
   -- Charles Denby; ABA
6. "The lash of the dictator will be felt"
   -- Congressman Daniel Reed
7. "Social Security . . . invites in power so vast, so powerful as to threaten the integrity of our institution and to pull the pillars of the temple down upon the heads of our descendants"
   -- James W. Wadsworth

1ST STORY of Level 1 printed in FULL format.

The Houston Chronicle

June 15, 1994, Wednesday, 2 STAR Edition

SECTION: C; Viewpoints; Pg. 13

LENGTH: 353 words

HEADLINE: Moore is a true leader

BYLINE: SYLVIA BROOKS

BODY:

In celebration of the Houston Area Urban League's leadership recognitions, I am attempting to expose our youth to community leaders who have often gone out on a limb, and continue to do so, for the disadvantaged and poorest of our community.

Harris County Hospital District President Lois Moore is among the leaders I undoubtedly will be showcasing.

Her innovative, hands-on management techniques have ensured that our hospital district continues to provide the best and most cost-effective health care to the county's neediest citizens. Why then does she receive so much criticism and less than courteous treatment from some of those on Harris County Commissioners Court?

Is it because she is black?

Is it because she is a woman? Is it because she's an effective administrator?

I'm not sure why, but I know that she is managing a health-care delivery system that requires extraordinary resources and work.

Moore's administrative highlights include:

In 1993, an average of 832 patients were treated daily. Since her tenure, the new Lyndon B. Johnson General Hospital and the new Ben Taub General Hospital have opened for patient care. In 1993, an average of 49 operations were performed in the district daily. The district's outpatient clinics had 622,848 patient visits last year and there was a 19 percent increase in commercial insurance collection to $ 13 million. The district now serves 456,000 registered, card-carrying eligible patients.

Neither Moore's color, nor her gender, nor her position, can erase the reality that a significant amount of resources are needed to provide health care for the estimated 900,000 uninsured and very underinsured county residents. As taxpayers and concerned responsible citizens, we are called upon to support the services that the hospital district provides and note that her budget

6TH STORY of Level 1 printed in FULL format.

The Ethnic NewsWatch
New York Voice Inc./Harlem USA

April 20, 1994

SECTION: Vol. XXXVII; No. 2; Pg. 17

LENGTH: 931 words

HEADLINE: Eugene L. McCabe And John J. Barrett To Receive 1994 Frederick Douglass Awards

BODY:
Eugene L. McCabe And John J. Barrett To Receive 1994 Frederick Douglass. Awards

Announcement has been made of the Honorees for the 29th Annual Frederick Douglass Awards of the New York Urban League. The awards, which constitute the highest honor that the League bestows, will be presented on Thursday, May 5, at The Sheraton New York.

This year's recipients of the coveted award are Eugene L. McCabe, President and Chief Executive Officer of North General Hospital; and John J. Barrett, Partner at Lord Day Lord, Barrett Smith.

According to Board Chairman Paul Facella, the Frederick Douglass Medallions are presented each year to New Yorkers who "have made out-standing contributions toward the cause of equal opportunity."

Eugene McCabe is best known to residents of Harlem through his achievements as President and Chief Executive Officer of North General Hospital. The 240-bed, community teaching institutiion located in Harlem, stands as a model for primary health care and community development initiatives in New York State.

Through forged relationships with public officials, business leaders and community groups, Mr. McCabe was able to work with Governor Mario Cuomo and the New York Legislature to secure passage of a bill that approved $15M in state-supported bonds to construct a new state-of-theart medical facility. With public/private sector support, McCabe captained the completion of the project six months ahead of schedule and $13M under budget. Cost savings were used to construct an adjacent five story office complex to house other essential medical and administrative services.

Prior to joining North General, Mr. McCabe was Regional Director of Deleuw Cather/Parsons. During the New York fiscal crisis in the mid 1970's, he was staff director for a special commission created by the Governor which centralized lobbying efforts to gain public support for the city's successful request for $2.5 billion in federal loan guarantees.

A graduate of Southern Connecticut State University, where he majored in Political Science and History, Mr. McCabe has over 20 years of experience in management consulting, including a stint with Booz, Allen & Hamilton, Inc. an international consulting firm.

7TH STORY of Level 1 printed in FULL format.

The National Journal

April 16, 1994

SECTION: WASHINGTON UPDATE; Policy and Politics in Brief; From the K Street Corridor; Vol. 26, No. 16; Pg. 899

LENGTH: 139 words

BYLINE: Julie Kosterlitz

BODY:

A new coalition of 150 black health care professional associations and civil rights groups is trying to ensure that the concerns of low-income and inner-city blacks are represented in the health care reform debate. The Summit '93 Coalition grew out of a meeting held late last year by such groups as the NAACP, the National Medical Association, the Urban League and a black cardiologists' group.

The coalition has hired Ruth Perot, a former management consultant, as a full-time staff member. It also signed up former House Budget Committee senior counsel Singleton McAllister and former congressional intern Peter B. Umhofer, both of whom are now at the Washington law firm of Shaw, Pittman, Potts & Trowbridge as lobbyists. The coalition recently brought more than 100 of its members to Capitol Hill to push its agenda.

LANGUAGE: ENGLISH

LOAD-DATE-MDC: April 29, 1994

13TH STORY of Level 1 printed in FULL format.

The Ethnic NewsWatch
Philadelphia Tribune, The

February 8, 1994

SECTION: Vol. 111; No. 17; Pg. 2-B

LENGTH: 662 words

HEADLINE: Urban League stresses self-development

BYLINE: Reed, William

BODY:
Urban League stresses self-development.

WASHINGTON, D.C. -- During January, addresses on "The State of the Union" and "The State of Black America 1994" were made here in the nation's capital. In his speech before the 103rd Congress, President Clinton said: "America will never be complete in its renewal, unless everyone shares in its bounty." He said that if we give people equal opportunity, quality education and a fair shot at the American dream, they will do extraordinary things.

Clinton, whose national approval rating is up to 60 percent, pledged to enforce all civil rights laws and said that the nation's recovery is tied to giving all our people the education, training, and skills they need to seize the opportunities of tomorrow.

Less than a week before Clinton spoke to the joint session of the Congress, National Urban League President John Jacob told an audience at the National Press Building, "Today, I call on the president and the Congress to create an opportunity of environment by making job training and job creation for the disadvantaged a top priority." He added, "We want to see the president press as hard for jobs as he did for NAFTA (the North American Free Trade Agreement)."

In his final "State of Black America" presentation before his retirement from the civil rights organization, Jacob said that it is the League's belief that self-development is the firmest strategic foundation to assure continual African-American progress. Taking a turn from traditional civil rights rhetoric, the veteran leader called upon African-Americans to rely less on government and more on themselves to overcome poverty and violence.

Nevertheless, in a focal point of his presentation, Jacob again called upon President Clinton to launch a "Marshall Plan" program to bring businesses and create jobs in inner-city America. "The State of Black America" is an annual presentation, and a document that examines the status and conditions of African-Americans.

In addition to outlining specific self-help efforts, the League report detailed socioeconomic conditions facing Black America, showing: Half of the 22,540 people murdered in this country in 1992 were Black, even though Blacks constitute only 12 percent of the population; homicide is the leading cause of death among Black males 15-24; 33 percent of Blacks live in poverty, and almost

half of African-American homes are headed by women.

Clinton has gained high marks from Black leaders for his efforts to create opportunity for more Americans. Shortly before State of the Union address, he told an audience at Howard University, "Five of the members of my Cabinet are African-Americans. Sixty-one percent of the federal judges I have appointed are either women or members of different minority groups." But, he pointed out, the struggle for equality must continue, saying, "It may seem to you that the struggle was over a long time ago. But if you look around you, you can see that the history of that struggle is still alive...waiting to be fully redeemed." Many in the audience said, in presenting statistical data, Clinton was "buttering up to us," because the latest Census Bureau figures reveal that Blacks -- at 12 percent of the U.S. population -- still represent the nation's largest racial group. Hispanics are at 9 percent, Asians three percent, one percent are Indians, and whites represent 75 percent.

Clinton also made a plea to Congress for an apprenticeship program for those who don't complete college, and he asked for a retraining program. In regard to his much touted health care proposal, he told the Congress -- which only has a 29 percent approval rating itself -- that he will veto any health care proposal that does not guarantee coverage for all Americans. The president's views on welfare reform, are still at odds with Black leaders in civil rights and the Congress.

William Reed is director of communications for the National Newspaper Publishers Association.

ETHNIC-GROUP: African-American

LANGUAGE: English

LOAD-DATE-MDC: May 16, 1994

16TH STORY of Level 1 printed in FULL format.

The Ethnic NewsWatch
Philadelphia Tribune, The

January 25, 1994

SECTION: Vol. 111; No. 13; Pg. 3-A

LENGTH: 871 words

HEADLINE: Urban League reports progress in 'self-development' movement

BYLINE: Mason, Winslow, Jr.

BODY:
Urban League reports progress in 'self-development' movement.

Thirty years after the legendary March on Washington in 1963, political, economic, and religious empowerment remain top issues on the agenda of the National Urban League.

The league last week released its 19th annual "State of Black America Report," which is expected to be distributed to African-American political leaders, authorities within state and federal government and social service agencies committed to change in the African-American community.

African-American leadership, self-development, and spending habits are among nine analyses included in the report.

"'Self-development' efforts have been under way for years in African-American communities and have shown signs of accelerating in the 1990s," said National Urban League President John E. Jacob.

"The National Urban League has long been in the forefront of efforts to strengthen Black families, curb violence, and assist African-American youth to develop skills and attitudes they need to survive and thrive in the 21st century," Jacob said.

Officials with the Urban League of Philadelphia, which works closely with the national organization, put out a separate report, 'The State of Black Philadelphia,' which considers Philadelphia more than the national report, said Robert Sorrell, president of the local affiliate.

"The focus this year is on community development," Sorrell said. Last April, the Urban League released its latest report, which, unlike the national one, focused on one topic, health care.

"We are trying to accomplish two initiatives in the health report," Sorrell said.

The Urban League is working on a guide that Philadelphians can turn to when they need health services.

"One of the points that came out of the health report was that sometimes people don't know where to turn to get the help they need," Sorrell said.

The second initiative involves trying to change behavior.

"We found that many people don't lead a healthy lifestyle," Sorrell said. "We're trying to change that."

The Urban League of Philadelphia, in fact, is not expected to release another State of Black Philadelphia report this year in an effort to establish concrete programs and initiatives that will address health issues brought out in the 1993 report.

"Rather than treat general areas, we want to be more specific," Sorrell said, adding the State of Black Philadelphia focuses on one issue while the national reports tend to be more broad.

"In order for us to follow the health report through, we're going to delay the next production, so when someone asks what the Urban League is doing since the last report, we have something to tell them."

"The State of Black America is the most authoritative annual document examining the current status and conditions of African-Americans," said Ralph Faust, communications officer with the National Urban League in New York.

"It presents analyses of key issues by distinguished African-American scholars.

The comprehensive text is used by influential government and corporate leaders, colleges and universities, and social service agencies.

Contributions to the report include:

"The Economic Base of African-American Communities: A Study of Consumption Patterns," by Dr. Marcus Alexis, board of trustees, professor of economics and professor of management and strategy at Northwestern University, and Geraldine R. Henderson, research assistant, Marketing Department, Kellogg Graduate School of Management, and assistant director of admissions, Northwestern University.

"Dollars for Deeds: Some prospects and prescriptions for African-American financial institutions," by Dr. William D. Bradford, associate dean for academic affairs, professor of finance, Business School, University of Maryland, College Park.

"African-Americans in the Urban Milieu: Conditions, Trends and Development Needs," by Dr. Lenneal J. Henderson, distinguished professor, government and public administration, University of Baltimore.

"Silent Suffering: The Plight of Rural Black America," by Dr. Shirley J. Jones, distinguished service professor, School of Social Welfare, State University of New York, Albany.

"Serving The People: African-American Leadership and the Challenge of Empowerment," by Dr. Ronald Walters, chairman and professor, Department of Political Science, Howard University.

17TH STORY of Level 1 printed in FULL format.

The San Diego Union-Tribune

January 21, 1994, Friday

SECTION: LIFESTYLE; Ed. 1,2,3,4,5,6,7,8,9; Pg. E-4

LENGTH: 520 words

HEADLINE: Personal growth helps her promote others' education

SERIES: RELIGION & ETHICS

BYLINE: SANDI DOLBEE
Religion & Ethics Editor

BODY:

Five years ago, when Andrea Taylor went to work for the San Diego Urban League's HIV-AIDS education program, she thought of the churches.

"When you think of our history, the African-American churches were the first health-care providers to our community," says the 46-year-old Taylor.

She began to visit congregations, talking to pastors and lay leaders about HIV education and intervention. For Taylor, it was a simple enough plan.

"I could provide the health education message and they could bring the spiritual message," she says. "I thought that would be a really good combination."

Out of that combination has come a network of about 10 churches, which provide everything from home visits to education and prevention classes. One church-sponsored program, the 47th Street Church of God Southeast Abundant Resource Center, also provides testing and counseling. Taylor sits as a member of the board of directors of that center.

"One wonderful thing about working with churches is the degree of compassion," she says. "You hear people that say the church is not tolerant -- but I have found that the churches are working very quietly in these areas of tolerance."

Taylor also sits on the county's HIV-AIDS advisory board and is a member of the National Institute on Drug Abuse.

When she is not working with HIV education and intervention, she is at home with her two teen-age sons (she also has a grown daughter who is married, with three children) or volunteering at Happy Child Inc., a nonprofit group that provides training and interaction for parents and children.

Taylor first sought Happy Child as a participant.

The daughter of recovering alcoholics, she says she realized that she needed help in dealing with a wide range of co-dependency issues. She liked it so much, she stayed on as a facilitator.

36TH STORY of Level 1 printed in FULL format.

The Ethnic NewsWatch
Philadelphia Tribune, The

October 22, 1993

SECTION: Vol. 110; No. 91; Pg. 1a

LENGTH: 608 words

HEADLINE: Health care concerns addressed

BYLINE: Clay, Denise

BODY:
Health care concerns addressed.

A forum sponsored by the Urban League Young Professionals was the setting Wednesday night for a town meeting addressing the concerns of African-Americans about President Clinton's National Health Care Plan.

Panelists from state, federal and local levels addressed minority participation, illnesses covered, and how the business of health care would be conducted under this plan.

Dr. Lawrence Robinson, Deputy Health Commissioner for the Department of Public Health, said that there were things he liked about the plan such as the all-inclusiveness of the coverage for everyone, but there were things that concerned him such as the non-inclusion of pharmaceutical issues and the length of time it was going to take to get it passed and implemented.

"This plan will evolve over time," he said. "We are not looking at the near future, more like 1997-1998. Under the plan, community health clinics will be supported for up to five years. Right now, we still don't know."

Other panelists included: Priscilla Pearson, a member of the staff of Senator Harris Wofford, a major proponent of the Clinton plan; Valarie Chestnut, deputy assistant mayor and the Chairperson for the Mayor's Commission on Aging; Joanne Williams, Vice President of Marketing and Communications for Healthcare Management Alternatives; Priscilla Murphy of the Southeastern Pennsylvania Black Nurses Association, and Steve Pina, Executive Director of One Day At A Time.

Each panelist gave their view of the plan before the floor was opened for questions. Pearson addressed the issues of those concerned about minority participation in the health care process. She said there will be provisions in the plan to safeguard against discrimination against doctors participating due to race.

But, Pearson said, there are also allowances for minority doctors who want to form their own alliances to work in their own communities.

"There will be language in the plan which says you can't discriminate," she said, "but doctors may wish to form alliances in their own communities among the population they deal with most directly."

Williams said she was pleased with the concept behind the plan, but African-Americans should educate themselves about the plan.

"African-Americans must become educated about their benefits," she said. "Everyone is going to have to give something up under this system."

The strongest reservations about the plan were voiced by Pina.

He said from the standpoint of being in a non-profit organization the jury was out on whether the plan would be beneficial.

He said he is concerned since he has heard nothing about increasing the number of minority doctors under the plan. He also has misgivings about how much better Medicaid and Medicare patients, those needing substance abuse rehabilitation, and those with AIDS and HIV will fare.

"This plan is the same as usual, only with a different face on it," he said. "If minority participation were going to be addressed, the plan would have said so. It will restrict visits to the doctor and has no real plan for drug and alcohol rehabilitation. If AIDS is not seriously covered, we are in real trouble."

Among the questions asked when the floor was opened was one regarding the inclusion of health screenings for women over the age of 50. At present, it is believed that the plan doesn't cover mammographies and screenings for cysts for women over 50. Pina said this is a concern women may have to force the plan to address.

"It may take a group of women to write to Hillary and the task force to get these issues addressed," he said, "they will listen to that."

ETHNIC-GROUP: African-American

LANGUAGE: English

LOAD-DATE-MDC: January 27, 1994

48TH STORY of Level 1 printed in FULL format.

The Ethnic NewsWatch
Philadelphia Tribune, The

August 31, 1993

SECTION: Vol. 110; No. 76; Pg. 4a

LENGTH: 952 words

HEADLINE: Health issues lead Urban league report

BYLINE: Mason, Winslow, Jr.

BODY:
Health issues lead Urban League report.

AIDS. Self-esteem. National health care programs.

All are critical issues confronting the African-American community.

The Urban League of Philadelphia's State of Black Philadelphia report was released last week, and the entire 90-plus-page publication is devoted to health care.

Entitled, "Prescribing an Effective Health Care Agenda for Our Community," the report focuses on America's health care crisis and, in addition, on the extent to which that crisis affects the African-American community.

Though several essays address the AIDS epidemic, mental health and attitude among African-Americans, and the impact of national health care programs, the report also addresses other critical issues, among them:

Health care cost control.

The health care status of African-American children in Philadelphia.

Alcohol and drugs in the Black community in Philadelphia.

Organized labor's perspective on the status of African-American health.

The political economy of health; Implications for African-American leadership.

Each of the 13 essays is written by a leader in Philadelphia, including state Rep. David P. Richardson, whose contribution is entitled, "Pennsylvania Conference on African-American Minority Health Issues," and former city health commissioner Dr. Robert K. Ross, who addressed "The Health Care Status of African-American children in Philadelphia."

Other notables who contributed to the report are Thaddeus P. Mathis, Ph.D., and labor leader Henry Nicholas.

Self-reliance and self-development served as a key theme to improving health care for African-Americans.

"Self-reliance dictates that an individual would not be an ignorant, passive recipient and follower of orders from the physician, but an active participant in the decision-making process of health," Therman E. Evans, M.D., wrote.

"The more a person has faith or believes that he or she can have an impact on circumstances, or believes in a higher good, a supreme being or God, the greater the likelihood he or she will remain healthy. And, if the individual gets sick, he or she is more likely to deal successfully with the illness," Thurman wrote.

A.J. Henley, chief executive officer of Healthcare Management Alternatives, stressed that although a national program would be an effective way to improve the health care of most Americans, it will not be enough to make significant, long-term changes in the improved health of African-Americans.

According to his essay, "Is National Health Insurance a Cure for Black America?" Henley reports that "African-Americans are three times more likely than whites to live in poverty, and therefore are more likely than whites to lack adequate health care insurance. Nationally, about 18 percent of African-Americans, in contrast to 9 percent of whites, have no health insurance. Almost 20 percent of Philadelphians lack adequate insurance."

Regarding the infant mortality rate, Henley reports that in 1989, the overall rate in Philadelphia was 17.7 deaths per 1,000 live births. The rate for whites was 11.2 deaths per 1,000 live births, in contrast to 22.6 deaths per 1,000 live births for non-white infants.

The infant mortality rate among non-white Philadelphians has not improved since 1978, he said, adding that the rate of infant deaths has begun to increase among non-whites.

The report also addresses violence as a national health issue.

"Violence is the leading cause of death for African-American men between the ages of 15 and 34. The national homicide rate for African-Americans has increased since 1970, while remaining almost constant for whites.

"Local data are consistent with national patterns. In 1989, in Philadelphia, the rate of homicide among white men was 18 deaths per 100,000 population; among non-whites, the rate was 91.4 deaths per 100,000. Of the 462 persons who died from homicide in Philadelphia in 1989, fifty-three percent (247) were non-white men between ages 15 and 34."

Critical to the health care crisis is the spread of AIDS throughout the African-American community. The report notes:

"In Philadelphia, the spread of AIDS has followed national patterns. By the end of 1991, there were 2,845 reported cases of AIDS and 1,895 deaths. In 1991, of the 628 new reported cases, 403 were African-American, 166 were white and 59 were Hispanic. A growing number of young persons have HIV infection; they are likely to develop AIDS with the next decade. Unless a cure is found, it is reasonable to assume that HIV infection will continue to constitute a major threat to the survival of African-Americans."

Rashidah L. Hassan, R.N., in her essay, "HIV/AIDS and the African-American community," provided a wake-up call for African-Americans.

"HIV/AIDS disease was first recognized in 1981 among gay white men. It was not until 1985 that the spread into the African-American community was recognized. This community has struggled to confront this critical health situation. Fear, denial, scarce resources, and limited access to adequate health care and education have allowed this disease to take hold in a community already besieged with enormous social and economic difficulties," she wrote.

"The belief that AIDS is a disease of African origin is now discounted by many scientists, although the damage of the African connection myth has been done. This blaming process has its roots in slavery, when racism and sexual harassment were fused. This fusion makes education and service delivery a challenge. Around the world, people of color are being devastated by this illness, while Western science holds the research and related knowledge hostage for what appear to be purely economic gains."

ETHNIC-GROUP: African-American

LANGUAGE: English

LOAD-DATE-MDC: November 24, 1993

51ST STORY of Level 1 printed in FULL format.

The Ethnic NewsWatch
Bay State Banner

August 19, 1993

SECTION: Vol. 28; No. 48; Pg. 7

LENGTH: 2176 words

HEADLINE: Urban League sets agenda at weighty national meeting

BYLINE: Overbea, Luix Virgil

BODY:
Urban League sets agenda at weighty national meeting.

Luix Virgil Overbea

WASHINGTON -- Capitol Hill moved to the Washington Convention Center, Aug. 1 to 4, as President William Clinton and six of his Cabinet members took turns addressing and conferring with black leaders at the Urban League's National Conference at the convention center.

More than 15,000 delegates and participants crowded downtown and federal agencies to discuss the conference theme, "Developing 21st Century African American Communities."

In that 15,000 was a healthy delegation from the local chapter, the Urban League of Eastern Massachusetts, led by Dr. Joan Wallace-Benjamin.

"After attending the recent National Urban League convention in Washington, many Urban League local presidents have decided that African American self-development is the basic key to solving our problems of today," said an inspired Wallace-Benjamin upon her return to Boston.

"We see the self-development of our children and our young people to meet the problems of the 21st century as our long-range goal at the Urban League of Eastern Massachusetts."

Wallace-Banjamin was a key figure in discussions among staff members of affiliates of the National Urban League. They agreed that they must concentrate on the "third movement" if the 21st century is to prove an era of significant progress for black Americans.

This third movement, said Wallace-Benjamin, is human development. The first movement was the Thurgood Marshall revolution, and the second movement was the civil rights activism of the 1960s and 1970s and early 1980s.

"Locally, our ULEM perceives that conditions for our youth are worsening just as they are in communities nationwide," Wallace-Benjamin said. "It is apparent that they will not be able to meet the demands of the 21st century if things continue as they are today.

Of Elders, the Senate's first African American woman member said: "Dr. Joycelyn Elders is the most qualified nominee for surgeon general in American history, but right-wing radical conservatives are against her. I am asking this group to call the Capitol switchboard and ask senators to vote for her. America needs Dr. Elders. She needs America."

If every American is willing to do the right thing, each one can be the cutting edge on the table for bringing true diversity to this nation, she said. She listed three actions that can "make a difference" in bringing Americans together in today's crises:

Ask for the right things -- tax credits for the poor, policies to help urban communities, open finances to minorities.

Seek policymakers with programs to develop the potential in criticial areas of responsibility.

"Speak softly, but carry a big stick" as once suggested by President Theodore Roosevelt. "Let your clout be known. Voting power is the bottom line. Give us the capacity to grow as a people, as a nation."

John E. Jacob, president and chief executive officer of the Urban League, delivered the keynote address and the closing remarks. In his keynote he spoke of the "new" in the nation -- a new administration, a new Congress and a new, post-Cold War world order in the making.

"The central issue facing America today is how to create a 21st century nation, socially just and economically competitive.

"The central issue facing African Americans today is how to develop 21st century African American communities capable of leading this nation and the world to new standards of prosperity and accomplishment."

America's unfinished war on racism must be resolved, he said, but not by skinheads, neo-Nazis and the like.

Jacob issued his report card on the new Clinton administration, "elected with an overwhelming majority of black votes."

He praised the administration for its appointment of unprecedented numbers of African Americans, minorities and women to his Cabinet, but denounced the administration for dumping Lani Guinier. He gave the Clinton economic plan a passing grade, but recommended a national "domestic Marshall Plan" as first proposed by Whitney M. Young Jr., of the Urban League years earlier.

Jacob called for both the public and the private sector to work together to upgrade the nation's economy. "The single most important task for the African American community today is self-development," he said.

"We have to be the force for change -- no one else will do it for us." He concluded, "Get mad. Get organized. Get change going. Get our communities obsessed with self-development. . . . That is what this conference is all about."

In a concluding press conference, Jacob told the media: "We are building and organizing a coalition with the NAACP and SCLC for self-development, to build in the 21st century. Our commitment is to change. Our goal is parity, community development and growth.

"We of the Urban League shall advocate for the black and poor of America, to develop ourselves, our communities and our children. Let this conference end; let the noble struggle begin!"

The new alliance was announced by Dr. Benjamin F. Chavis, the new executive secretary and CEO of the National Association for the Advancement of Colored People (NAACP). "Transition into the 21st century is based on the state of the multicultural, multiethnic and multiracial society," he told the NUL. "The answer is jobs, jobs, jobs, including a constructive training program that assures employment at the other end of training.

"I'd like to call a strategic alliance of the NAACP and the National Urban League for economic power. We must work together, create young people who want to work with us." He pleaded, "President Clinton, we helped put you into the White House. We respect you. Now, you respect us."

He called for the president to be pro-active -- do not let what happened to Lani Guinier happen to Joycelyn Elders. Dr. Elders must be confirmed as surgeon general of the United States."

Chavis called for the African American public to join with the NAACP, the Southern Christian Leadership Conference and the NUL in sponsoring a 1993 march on Washington Saturday, Aug. 23, the 30th anniversary of the 1963 march at which Dr. Martin Luther King Jr., delivered his "I Have a Dream" speech.

President Clinton headed the list of speakers for the closing day of the conference. He emphasized support of his budget and of his program for the recovery of the economy. "We need the Urban League to stand up against bigotry," he declared. "We have lots to do . . . health care . . . reduce crime. . . . I ask you as Americans to make public service work; to take care of health care costs; to bring down the deficit."

The president promised that he will work hard with Congress to support the Family Leave Act giving workers time off (without pay) to take care of family emergencies, to pass a health care bill, to bring dramatic change to cleaning the environment, to approve a national service program for college students.

"Our big challenge is the approval of our economic package," Clinton said. "Cutting the budget will help small business, will help Head Start, will help the economy grow. . . . I am tired of hearing what we cannot do. There is nothing before us we can't do with vision and wisdom. I ask your prayers and support."

Cabinet secretaries addressing various sessions included: Henry Cisneros, secretary of housing and urban development, and Robert Reich, secretary of labor. They discussed "Rebuilding Urban Communities" at the Human Resources Luncheon. Cisneros was the first Spanish American to head a major city (mayor of San Antonio, Texas).

Without universal coverage, millions of Americans will remain uninsured. Those most at risk of losing their jobs -- including many minorities and women -- will remain at the greatest risk of losing their insurance.

Today, the infant mortality rate is about double among African Americans as the rest of the population. Today, the mortality rates among African Americans for preventable diseases is higher than for almost everyone else. The rate of illness is higher, and so are incidents of stress and related diseases.

This is not a matter of biology. It's a matter of access to affordable, quality health care. If you don't have comprehensive coverage that stresses preventive medicine -- including prenatal care, immunizations, well-baby exams, and other diagnostic services -- you are creating conditions for more serious, more costly illnesses. And that's what happens in too many of our urban communities.

Not much will change if we don't incorporate everyone into the insurance pool and guarantee comprehensive benefits that last throughout a lifetime.

ier stage.

that is those lines will get even longer in the local emergency rooms. The infant mortality rate among African Americans -- which is now double Universal coverage isair way to solve our health care problems. A piecemeal approach to reform is not going to offer security to people whose health benefits do not include xxxx. It's not going to offer security to people whose doctor's office is the local emergency room. It's not going to offer security to African Americans who now have the hightest infant mortality rates, the highest rate of death from preventable diseases, the least access to affordable health care, xxxx.

These statistics are not the result of biology. They are the result of a health care system in which too many people are denied the care they need.

What happens if we cover everyone?

A father who loses a job won't lose insurance coverage for himself and his family. A woman who is pregnant will get decent prenatal care. A mother of young children will be able to afford immunizations and well-baby exams. preventive care.....

FIRST LADY HILLARY RODHAM CLINTON
REMARKS VIA SATELLITE TO THE URBAN LEAGUE ANNUAL CONVENTION
JULY 26, 1994

DRAFT

I'm sorry I can't be with you in Indianapolis to congratulate Hugh Price and all the rest of you for the xxxxxxx. Our nation owes you a debt of thanks -- not only for your hard work over the past 84 years -- but also for the inspiration you lend us today as we try to solve one of the most pressing social problems of this century.

It's no secret that we are at a watershed moment for health care reform. Like so many of the causes the Urban League has fought for over the years, this one is fundamentally about rights and responsibilities. It's about the right of every American to have health security that can never be taken away. And it's about our responsibility -- individually and collectively -- to share the burden of paying for it.

Not surprisingly, the closer we get to achieving real reform, the more we hear from a very noisy, very well-financed opposition. They don't care about progress or justice. They just want to keep taking advantage of a system that discriminates against millions of Americans. And that's why they're resorting to rhetoric and misinformation to convince members of Congress to take the easy way out.

We can't let that happen. We have come too far along the path toward reform to be stymied by those who are motivated solely by political convenience. Now it's time to insist that members of Congress do the right thing and give America what America gives them: guaranteed health security financed through the workplace.

It's been fashionable lately to get caught up in statistics, and numbers, and analyses of ~~this proposal and that~~ proposal. But that obscures the larger goal. is is not a partisan or ideological issue. It's ~~not~~ an issue that is good for some Americans, and bad for others.

If we fail to achieve universal coverage, we fail everyone. We fail Democrats, Republicans, and Independents. We fail all races and ethnic groups. We fail the old, the young, the rich, the middle class, and the poor.

And we fail the people who really need a boost -- the people your organization has worked for decades to help.

National Urban League, Inc.

The Equal Opportunity Building
500 East 62nd Street, New York, N.Y. 10021
Telephone (212) 310-9000

NATIONAL URBAN LEAGUE

FACT SHEET

Founded in 1910, the National Urban League is the premier social service and civil rights organization in America. The League is a nonprofit, nonpartisan community-based organization headquartered in New York City, with 113 affiliates in 34 states and the District of Columbia. The mission of the National Urban League is to assist African Americans in the achievement of social and economic equality. The League implements its mission through advocacy, bridge-building between the races, program services, and research.

The League also has an office in Washington, D.C. that oversees the activities of Congress and the federal government as they pertain to African Americans and minorities and maintains a renowned Research Department.

The National Urban League is governed by an interracial Board of Trustees composed of outstanding men and women from the professions, business, labor, civic and religious communities. Another hallmark of the League is its highly trained professional staff at the national and local levels.

Today, while the National Urban league continues to provide assistance in traditional areas of concern, such as employment, housing, education and social welfare, it has been a leader in a number of new areas -- African American male development, AIDS education, political empowerment and crime reduction in the black community.

The National Urban League has sought to emphasize greater reliance on the unique resources and strengths of the African American community to find solutions to its own problems. To accomplish this, the League's approach has been to utilize fully the tools of advocacy, research, program service and bridge building. The result has been an organization with strong roots in the community, which serves more than a million individuals each year.

Contributions to the National Urban League are tax deductible.

NEWS

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FOR IMMEDIATE RELEASE

HUGH B. PRICE, NEWLY-ELECTED NATIONAL URBAN LEAGUE PRESIDENT AND CHIEF EXECUTIVE OFFICER TO KEYNOTE ANNUAL CONFERENCE

NEW YORK (June 27, 1994) -- Hugh B. Price the newly-elected President and Chief Executive Officer of the National Urban League will set the tone for the organization's annual conference during his keynote address speech on Sunday, July 24, in Indianapolis, Indiana around the theme "Mobilising for Community Empowerment."

The conference, to be held at the Indianapolis Convention Center, will also mark the first major public appearance of Mr. Price who was formerly a senior officer of the Rockefeller Foundation and a frequent commentator on social issues.

Held concurrently with the conference will be the fifth annual National Urban League Youth Conference meeting on the campus of Indiana University, Bloomington. The theme of the conference is "Youth and Unity -- Rebuilding our Communities."

The National Urban League Conference will be in session through July 27, where conferees will attend forums and plenary sessions addressing critical issues facing America.

Featured on the conference program will be more than 65 prominent speakers to include Lani Guinier, University of Pennsylvania Law School Professor, who will be the conference dinner speaker; The Honorable Deval L. Patrick, Assistant Attorney General for Civil Rights, the speaker for the Human Resources Luncheon; and The Honorable Alexis M.

more.....

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22222 - Hugh B. Price, Newly-elected NUL President and CEO to Keynote Annual Conference

Herman, Assistant to the President of the United States and Director of the White House Office of Public Liaison, who will be the guest speaker at the National Council of Urban League Guilds luncheon.

Other noted participants include Earl G. Graves, Publisher and CEO of Black Enterprise Magazine who will be addressing the issue of Black Economic Empowerment; Two well-known authors, Ellis Cose who wrote, "The Rage of a Priviledged Class: Why are Middle-Class Blacks Angry? Why Should America Care?" and George Fraser who penned, "Success Runs in our Race: The Complete Guide to Effective Networking in the African-American Community," will be panelists on a forum entitled Reflections on the Contemporary Black Experience.

Featured also at this year's conference are Dr. James A. Forbes, Jr., Senior Minister of The Riverside Church in New York City, who will be part of the forum on Our Future is Rooted in Our Legacy; the Rev. Cecil Williams, Minister of Liberation Glide Memorial United Methodist of San Francisco, bringing to this year's Family Session an Inspirational Message; The Honorable Andrew M. Cuomo, Assistant Secretary, Community Planning & Development, Housing and Urban Development; Mario F. Sanabria, Executive Director of 100 Black Men of America, Inc; William Lucy, International Secretary-Treasurer, AFSCME; and the Rev. Dr. W. Franklyn Richardson, General Secretary, National Baptist Convention, USA, Inc., and Pastor of Grace Baptist Church of Mt. Vernon, NY. Rev. Richardson is also a member of the Board of Trustees of the National Urban League.

Many other powerful forums centered around this year's conference theme are:

- **Housing Development for Community Empowerment.** Decent and affordable housing is a prerequisite for an economically viable community.
- **Reflections on the Contemporary Black Experience.** Reflecting on the more recent experiences of black Americans.

more.....

33333 - Hugh B. Price, Newly-elected NUL President and CEO to Keynote Annual Conference

- **Mobilizing Parents and Communities for Educational Excellence.** This session examines different perspectives on community and parent mobilization and the potential for change through utilization of this historic strategy.

- **African-American Leadership Development.** The panelists will seek to define effective leadership for the 1990s and beyond; what can be done to enhance the performance of today's leaders, and how to prepare the next generation of leaders to excel.

- **Fair lending: will it Boost Community Development?** An analysis of the economic potential of different strategies and the Community Reinvestment Act.

- **Government Privatization and its impact on African-American Employment.** What adverse human consequences might result and the concern about African Americans employed in the public sector.

- **The Black Church's Community Development Agenda.** This forum discusses the recent record of the church's performance.

- **The Hope Factor in Corporate America.** This forum presents a distinguished group of African Americans who will discuss how their paths have been previously blocked in Corporate America by race and gender.

- **Child Care: Meeting Community Needs.** Key child care policy and programming issues from a broader perspective will be discussed in this forum.

- **African-American Prisoners: Can They Be Reclaimed?** This forum discusses the need to reduce recidivism.

One of the more exciting programs of the conference is the National Urban League's exhibit program, "Showcase for Commitment to Equal Opportunity," which is now in its 26th year and will attract more than 375 exhibitors.

Another long-standing feature of the Conference, the "Job

more.....

44444 - Hugh B. Price, Newly-elected NUL President and CEO to Keynote Annual Conference

Opportunity Showcase," will offer computerized job matching service free of charge to registered attendees and the general public.

Founded in 1910, the National Urban League is a nonprofit social service and civil rights organization headquartered in New York City, with affiliates in 113 cities, in 34 states, and the District of Columbia. The mission of the National Urban League is to assist African Americans in the achievement of social and economic equality.

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Conf. Rel. #2
6/28/94

TALKING POINTS

HILLARY RODHAM CLINTON

HEALTHRIGHT EVENT

JULY 20,1994

o The only way we can guarantee that people who need health coverage will have it is through universal coverage. Every American should have health coverage, no matter whether they are sick and need it today, or will need it tomorrow.

o Universal coverage means that every American would be guaranteed in the law that he or she would have coverage.

o What happens without universal coverage -- not only are people left uncovered, things get worse. Since 1988, the number of uninsured has grown; more employers have dropped coverage.

  o Piecemeal reform means that working people continue without coverage, and everyone is in danger of losing health insurance when they change jobs, or an employer drops coverage because a sick child makes insurance unaffordable.

  o Piecemeal reform means that premiums will increase for working people who maintain coverage. A Catholic Health Association/Lewin study this week documented how the cost of health insurance will actually increase under incremental reform.

  o In several states that have attempted incremental reform, such as Iowa and South Carolina, the number of uninsured has increased, state spending on health care has increased, and premiums have increased.

  o Even reforms like eliminating pre-existing conditions, portability, and guaranteeing affordable insurance cannot be achieved without universal coverage.

o We can cover every American, or we can pretend we are achieving health reform and leave millions of hard-working Americans without coverage.

Would you ever really achieve 100%

* Obviously, there will always be someone sitting under a bridge who will not be in the system. But the President remains absolutely committed to guaranteeing that every American have health care coverage that can never be taken away.

* Social Security is a universal coverage program and not everyone eligible takes advantage of it.

* Every child is required to go to school, but not all do.

The President and First Lady indicated that universal coverage is a goal to work toward, not an absolute bottom line. Is this true?

* We have a phase-in our bill. We have said that we would be flexible on phase-in but it needed to be within a reasonable time period and by a date certain. This is our position.

* Obviously, we are not going to achieve universal coverage overnight. That's why we phase it in. There will be a road toward universal coverage, but the road must achieve universal coverage. Every American must have a guarantee in law of health care coverage that can never be taken away.

Wasn't the President signalling new flexibility on employer mandates?

* The President has said all along that he is flexible on how we get to universal coverage, but not whether we get to universal coverage.

* As the President said yesterday, he still believes that shared responsibility is the "best and fairest" way to achieve universal coverage.

CNN said that this new change in strategy was Leon Panetta's idea. Is this true?

* There is no change in strategy. The President remains absolutely committed to achieving universal coverage.

Talking Points on Universal Coverage - July 19, 1994

* The President's bottom line is what it has always been - guaranteed health care coverage.

* We have always said that we are flexible on HOW we achieve universal coverage, but not WHETHER we achieve universal coverage.

* The President understands that 78% (Washington Post/ABC News) of the American people want universal coverage. And he's committed to providing it.

* Let's look at what has been said already this week on what will happen without universal coverage: AFSCME released a study saying that there would be a $115 unfunded mandate on states from the non-universal Dole plan. The Catholic Health Association released a Lewin Study showing middle class premiums will increase by as much as $700 each year in some categories under non-universal vs. universal plans. And groups representing older Americans shot down non-universal plans that raid Medicare and do nothing to help seniors. Today, Secretary Bentsen will release a study which illustrates that 84% of the uninsured are in working families.

* Universal coverage is about giving every American - especially hard working middle class Americans - an ironclad guarantee of health care coverage that will never be taken away, even if they get sick or lose their job.

* We are going to continue to fight hard for universal coverage. We are going to continue to fight for the millions of hard working middle class Americans who will be left out in the cold if we enact legislation that does not achieve universal coverage.

The President said that we would never reach 100% He seemed to indicate that 95% would be acceptable. Is 95% the Administration's definition of universal coverage?

* Our definition is that every American have a guarantee in law of health care coverage that can never be taken away.

* The President was saying that we must have a guarantee in law that every American have health care coverage. That's the only way the system will work.

* The real question here is what happens if we don't achieve universal coverage. The fact is that if we don't guarantee that every American has health care coverage, we will not be able to truly protect the middle class and control costs.

The Health Security Act

HEALTH CARE COVERAGE FOR AFRICAN-AMERICANS

African-Americans face a health care system stacked against them -- they are among those Americans most at risk of going without care and coverage today. Losing or changing jobs often means losing health insurance, and African-Americans have one of the highest unemployment rates in the country. The health of African-Americans is also aggravated by:

- *African-American infant mortality rates are double (18.5%) those in white communities (8.1%).*
- *High mortality rates from preventable diseases -- including heart disease, cancer, and stroke .*
- *Homicide and legal intervention rates which are seven times higher among African-American males (61.5%) than white males (8.1%).*

Guaranteed Comprehensive Benefits

- The Health Security Act will guarantee all Americans comprehensive health care benefits they can never lose. Health alliances and plans are prohibited from discriminating on the basis of race, ethnicity, gender, religion, or country of origin.
- All low income individuals, including those currently eligible for Medicaid, will be covered by the same comprehensive benefits and will be offered a choice of health plans.
- Alliances will be prevented from creating two-tier systems of care, and a system for redressing grievances quickly will be required of all plans and alliances.

Community-Based Investments

- Community-based plans that can best address the needs of a particular community will be encouraged through special incentives, capital development programs, and public health initiatives.

Focuses on Prevention and Research

- The comprehensive benefits package covers a wide range of preventive services including prenatal care, well-baby care and nutritional counseling to reduce infant mortality and get children off to a healthy start.

- The Health Security Act will increase funding for prevention research into many conditions that affect African Americans, including chronic conditions, mental illness and substance abuse, and child health problems.

Incentives for Providers

- New initiatives designed to expand access to care and encourage primary care will bring high quality medicine to millions of African-Americans who now live in medically underserved areas.

- The Act's health care workforce initiatives will increase funds for medical schools that train primary care doctors and expand the National Health Service Corp. The Act will increase the number of African-American physicians, nurses and other health professionals.

- Under the Health Security Act, health plans serving the poor, inner city communities will receive additional payments to adjust for the higher costs of providing services to individuals with complex needs.

Community Input

- Alliances will have a Board of Directors composed of equal numbers of consumers and employers who purchase care in that area.

- Health plans will conduct annual consumer surveys and must seek out those in communities that have historically been denied access to high quality care.

April 1, 1994

URBAN LEAGUE AND AFRICAN-AMERICANS AND HEALTH CARE REFORM TALKING POINTS

I want to thank Ann Hill for her hard work and participation in aseries of meetings on health care reform held at the OEOB with Ira Magaziner and members of the working groups. Ann worked with a number of other minority interest groups to make suggestions for improving the health plan as then conceived.

From the beginning of the process to make recommendations to the President on health care reform, we have ensured that we addressed the problems of underserved populations, particularly access to health care, lack of health insurance coverage and the need for primary and preventive care.

Our working groups included hands-on health care providers, as well as health policy experts, from all the minority communities, including African-Americans, Hispanics and Native Americans.

Just some of the notable African-American providers are:

Dr. Claudia Baquet (BACK-QUAY), who is the director of the Office for Minority Health at the Department of Health and Human Service;

Dr. Risa Lavisso-Mourey, Deputy Administrator Agency for Health Care Policy and Research at HHS and a geriatrician from Philadelphia;

Dr. Mark Smith, of the Kaiser Foundation in San Francisco and an expert on AIDS;

Dr. Aaron Shirley, from Jackson, Mississippi and the clinic he founded (I am also proud to note that he just received a MacArthur Foundation Genius Grant for and to continue his work in his community;

Dr. Marian Gray Secundy, a noted medical ethicist at Howard University School of Medicine;

Dr. David Satcher, the President of Meharry Medical School, which educates the majority of African-American physicians in America. (I am proud to say that Dr. Satcher is the President's choice to be the new Director of the Centers for Disease Control in Atlanta); and

Dr. Reed Tuckson, President of Drew Medical School in Los Angeles.

We met and consulted, multiple times, with many minority health interest groups, including groups like the National Medical Association and the National Black Nurses Association.

You and I know that minority Americans suffer disproportionately more from diseases such as

cancer, hypertension, diabetes, AIDS, infant mortality, and chemical dependency than white Americans.

That is why we are emphasizing that primary and preventive care are key for all Americans, especially minorities, who have lacked access to care because of who they are, where they live, and because they do not have insurance coverage.

We know that we must increase the number of minority providers; and, therefore historically black medical schools and schools like Drew are key because they educate most of the African-American physicians who have tended to practice in low-income areas and serve minorities.

We support an expanded National Health Service Corps to increase the number of primary care physicians in areas with a shortage of health care professionals.

We have worked to craft a proposal that is sensitive to preserving the important role of minority health care providers in their communities as we create a new system that relies on health plans serving large geographic areas with diverse populations.

In addition there are many other elements of the new system we have talked about to ensure that the most vulnerable populations are receive quality care.

URGENT HEALTH NEEDS OF AFRICAN-AMERICAN AND OTHER MINORITY COMMUNITIES

No matter what type of health insurance is enacted, we believe that the following fundamental issues also must be addressed if we are to improve the health status of African-Americans and other minorities:

ACCESS TO AND COST OF COMPREHENSIVE HEALTH CARE

1. Minority Americans should have access to a minimum package of benefits that include preventive and acute services for those specific health problems for which they are disproportionately at-risk.

The excess incidence of chronic illness and serious diseases that afflict Minority Americans requires basic health benefits that increase access to preventive and primary health care. This includes prenatal and well-baby care, mental health services, substance abuse treatment, and prescription drugs. Early detection and screening programs for cancer and other illnesses must also be provided.

2. Access to community-based services should be greatly expanded and collaborations with hospitals encouraged to increase access to primary care.

A major expansion of school-based health clinics, health care for residents of public housing, and health centers for the homeless, including a doubling of the number of Community and Migrant Health Centers is especially critical to the minority community. C.H.Cs should be encouraged to collaborate with hospitals to increase access to primary care.

3. Coverage for services provided by alternative care-givers should be equivalent to the coverage that would be available if provided by a physician.

Coverage for services received from a nurse, midwife, nurse-practitioner, nutritionist, physician assistant, or other non-physician provider should be equivalent to the coverage that would apply if the same services were provided by a physician. In addition to expanding access to affordable primary and preventive care it would lower costs for the services provided.

4. Historically Black Hospitals should be adequately supported and reimbursed for the health services provided to minority communities.

These facilities have played a key role in addressing the critical health problems of minorities, serving the indigent and

The Health Security Act

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January 5, 1994

underserved, providing trauma care and AIDS-related care, and increasing the number of minority health professionals.

5. The specific needs and experiences of minority patients and providers must be accomodated in crafting the standards and policies for any managed care systems.

African-American patients and providers must have easy access to membership in managed health care systems, and severity of illness which the patient presents must be factored into the reimbursement.

HEALTH CARE PERSONNEL

1. The number of minority health providers should be increased for the purpose of improving the minority community's access to care.

Minority physicians and other health professionals have historically tended to practice in low-income areas, serve minorities, and engage in the general practice of medicine or primary care specializations. For these reasons, increased support of the programs in the Disadvantaged Minority Health Act is essential.

2. National Health Service Corp funding should be increased in order to double the number of primary care physicians in areas with a shortage of health care professionals.

Doubling the number of primary care physicians who could serve through Community Health Centers and other preventive care for medically underserved communities.

PUBLIC HEALTH

1. The epidemic of violence and its impact on our minority communities mandates that decisive action be taken to develop a multi-faceted public health approach to violence.

Strategies to prevent violence should emphasize the socio-economic conditions in the minority communities in hich violence manifests itself. Examining the root ccauses of violence -- such as the easy accessibility of firearms, employment opportunities, and education -- should be the framework for our deliberations.

2. Women's rights of reproductive choice should be guaranteed.

For minority women, many of whom are poor and suffer high rates of medical complications related to pregnancies, the ability to exercise this choice has been limited in recent years.

We encourage an increase in research on alternative forms of contraception and the immediate reversal, through legislation and otherwise, of policies relating to a woman's right to choose.

3. Public education and access to a national vaccinations system and treatment for contagious childhood diseases should be expanded.

The Center for Disease Control has recommended that a national vaccination system be instituted to prevent the outbreak and spread of measles, mumps, and other diseases, as well as to avoid the onset of entirely preventable conditions, such as polio and diphtheria. Rapid treatment of diagnosed cases also must be assured.

4. Environmental hazards to minority communities, such as lead poisoning and exposure to toxics, must be mitigated and regulations must be established to limit the impact of environmental risks on the health of minority communities.

Studies have shown that a disproportionate share of facilities that emit substances which pose potential health hazards are sited in communities where their greatest impacts are absorbed by minority residents. "Environmental equity" must be promoted and regulations must be embraced to limit the influx of environmental hazards into these communities.

5. Public health education and outreach programs targeted to minorities at the community level must be promoted.

The specific health problems of the minority community should be the focus of outreach efforts that are racially, socio-economically and linguistically diverse in order to penetrate cultural barriers.

TREATMENT OF AND RESEARCH ON PARTICULAR CONDITIONS

1. Research on the health problems of African-Americans and other minorities must be expanded, with minority researchers and institutions as major participants.

Since illnesses often manifest themselves differently in Minority Americans, targeted research will provide a more accurate assessment of the health needs of minority populations.

2. Efforts to prevent and control the spread of HIV virus and the AIDS epidemic, as well as efforts to treat patients, must target the African-American and Hispanic-American communities, as detailed by the National Minority AIDS Council.

Currently, the African-American and Hispanic-American populations are experiencing the sharpest growth in the numbers

9/4

M-TN--Minority Health, Bjt,360

New CDC Director Says Minorities Have Big State in Health Care Reform

tdstmwstf

^By TOM SHARP= ^Associated Press Writer=

KNOXVILLE, Tenn. (AP) Minorities have a larger stake in health care reform in America because their problem is bigger, the new director of the Centers for Disease Control and Prevention said Friday.

Dr. David Satcher, who takes office Jan. 1, said African Americans have a higher infant mortality rate, a lower life expectancy and a greater likelihood of contracting AIDS.

Speaking to a symposium on minority health issues sponsored by the East Tennessee Minority Professionals Association, he said African Americans have very few resources with which to fight.

``So we have a disproportionate problem, but only 3 percent of physicians are African Americans, only 3.5 percent of dentists and 5 to 6 percent of the nurses,'' Satcher said.

``We have a resource problem in terms of health professionals, and we're overburdened in terms of the health status problem. So we have a major stake in health care reform.

Satcher, former president of Meharry Medical College in Nashville, worked with Hillary Clinton's task force on health care reform for five months this year. He believes the plan will make some fundamental changes in health care delivery in America.

``The biggest problem in this country is the way we pay for health care. We don't provide any incentives to keep people healthy,'' Satcher said. ``If you want to make money in health care, you don't make money by keeping people healthy, you make it by treating people who are really sick, and the sicker they are the more money you make.

``But with health care reform, that's going to change.''

Satcher said he believes many categories of problems among minorities teen pregnancies, drug abuse, violence, early departure from school are symptoms of today's society that translate into health care problems.

``The CDC's role would be to find out what buttons to push to prevent teen-age pregnancy, violence and et cetera,'' he said.

``If the buttons relate to changing the attitude of teen-agers toward the future and working with partners like schools and churches and communities, the CDC can provide resources.''

wouldn't even say where the tough cuts were coming from.

Q. Retroactivity is what he——

The President. Well, the retroactivity, my answer to that is twofold. Number one, on the merits, it applies to the same couples with incomes above $200,000, individuals with incomes above $150,000 to $160,000; that they will be given 3 years without penalty, a subsequent 3 years to pay the taxes; that all the tax cuts are retroactive and some of the tax incentives go back to the middle of 1992, not just to the first of '93.

So those would be my answers to the attacks he made on the program.

NOTE: The President spoke at 10:07 a.m. in Statuary Hall at the Capitol. A tape was not available for verification of the content of these remarks.

Remarks to the National Urban League

August 4, 1993

Thank you very much. Reg Brock, John Jacob, distinguished dais guests, and ladies and gentlemen. It was just about a year ago that we were together at the Urban League convention in San Diego. What a difference a year makes.

Many of you in this audience have been friends of mine for a very long time. Those of you from my home State of Arkansas have worked with me in partnership there for many years. I know what the Urban League can do to make a difference in the lives of people and in the minds and hearts of people.

I want to say at the outset today that while I came here to talk about what we're trying to do in Washington, what we can do in Washington is in no small measure determined by what lives in the hearts and minds and visions of Americans throughout this land. I know that the Urban League, for more years than I have by far, has struggled to remind Americans that, without regard to our race or creed or station in life, we must go forward together; that there is no place for hatred or division.

And yet we know today that we are challenged by that on every hand. When people would bomb the NAACP headquarters in Tacoma or Sacramento, when people would threaten your own John Mack in Los Angeles, when people would seek again to divide us by race instead of to take the hard and difficult path of making the changes we all need to make together as a country, we need the Urban League. America needs it. The President, the Congress, the politicians alone cannot do nearly as much as you can do to reach to the truth of the human heart and stand up against bigotry. But there are things that we can do. I know the Attorney General appeared before you in this conference, along with at least four other members of my Cabinet. No wonder I couldn't find any of them this week. They were over here. [*Laughter*]

But I tell you, one of the reasons that we picked Judge Louis Freeh from New York to head the FBI is that he was not only committed to continuing the long overdue work of opening the FBI to women and minorities but also because he had successfully, heroically, and determinedly prosecuted the criminals who murdered a Federal judge and a civil rights leader in the South when others had given up and thought it could not be done.

I am especially in debt to the Urban League because the Urban League not only gave to the Nation such great leaders as Whitney Young, but you gave to me a lifelong friendship and the service in this administration of Vernon Jordan and Ron Brown. I would have never met either one of them if it hadn't been for the Urban League.

I also want to say to all of you that it is terribly important as we seek to bring America together that we continue our struggle to remind the doubters and the naysayers that we can go forward together.

There was an especially reassuring article, at least to me, in the Washington Post a few days ago by the distinguished columnist William Raspberry, in which he pointed out that when I said I wanted a Cabinet that looked like America I was subject to ridicule in many quarters, who claimed that I was about to diminish the quality of the Government by imposing some sort of quota system on the

Cabinet. Well, it turned out that I produced a Cabinet with more women and more minorities than had ever served in a President's Cabinet. And most people think it's one of the best Cabinets that ever served the United States of America.

And as Mr. Raspberry pointed out, when Janet Reno speaks as Attorney General now, people don't think of her as the first woman Attorney General. When Mike Espy's out there up to his ears in mud in the middle of the Mississippi River Valley flooding, and people are saying we've got the best response to a national emergency they've ever seen, nobody says he's the first black Secretary of Agriculture; he's somebody out there helping the farmers to put their lives back together.

In the last 6 months, a great deal has happened in this town. The pace of change has been dizzying. And with all the change there has been strong opposition, and it's been a little ragged around the edges from time to time. But let me ask you this: If on Inauguration Day someone had told you that this administration, with the most diverse Cabinet in history, would work with the Congress and with our allies in the country and around the world to produce the Family and Medical Leave Act, twice vetoed by the previous administration, which became effective this week, to guarantee that working people can take a little time off when a baby's born, a child's sick, or a parent's ill, won't lose their jobs; would produce the motor voter bill, which is a significant advance in voting rights for the young, the poor, and the dispossessed; would produce a bill with the National Institutes of Health, which would take the politics out of medical research and finally do what ought to be done in medical research with regard to women and their health care problems; would produce a dramatic change in environmental policy, which would be applauded all around the world for putting the United States back in the forefront of energy conservation, of responsible efforts to deal with the population explosion, of all kinds of efforts to reconcile the conflicts between the environment and the economy; if someone had told you that we would take the lead in trying to keep democracy alive in Russia in ways that would be good for ordinary Americans by continuing to reduce the threat that nuclear weapons will ever be used and by opening up future markets there; that the United States would be able to go to a meeting of the great industrial nations of the world in Tokyo and for the first time in a decade not be attacked because we are a drag on world growth because of our deficit, and instead, we would be complimented and they would agree with us to lower tariffs on goods in a way that every American analyst concedes will add hundreds of thousands of jobs, good, high-paying manufacturing jobs, to the world economy if we can get all the other nations to agree with it; and that in the middle of this budget debate we would pass the program for national service which will give Americans a chance to bridge the gaps of race and income and earn credit against their college education by dealing with the human problems of Americans at the grassroots level—I'd say that's a pretty good record for 6 months, and I think the American people ought to be proud of it.

But let me say to you that there is much, much more to be done. And whether we can get about the business of doing it will be determined in the next 48 hours or 72 hours or so by how the Congress of the United States responds to the challenge presented by the economic plan.

I thank the Urban League for its early endorsement and support of this plan, and I would remind you here briefly how you did it, what is in it, how it makes a difference to ordinary Americans. Remember that for 20 years now, literally 20 years in 1993, most working Americans have seen the power of their incomes eroded. Wages for wage earners have been virtually stagnant for 20 years as the cost of health care, housing, and education had exploded.

In 1980, we had a Presidential election which said that this problem that the American people were having paying their bills and dealing with global economic forces was a problem of too much Government in America and what we needed to do was to cut taxes, get Government out of the way, and everything would be wonderful. What that rhetoric masked was an old-fashioned attempt to cut taxes and increase spending, except it was done in a different way. We cut taxes on the wealthiest Americans, increased

primarily defense spending, and got out of the way.

And for a couple of years it worked. We had a couple of years in which jobs came into the economy because we were spending a lot more than we were taking in and putting a lot of people to work in defense industries. But after that, the patterns imposed on the United States by the realities of the global economy returned with a vengeance and were made worse by the decisions made in the early eighties where we cut taxes on the wealthy, ran the deficit up.

What happened later? When the Congress and the President started going back at it, we had a decade in which taxes were cut on the wealthy, and the top one percent got more than half of the income gains on the 1980's. Taxes were raised on the middle class whose incomes were going down. We reduced our investment in our children, their education, our economy, and our future. We cut defense spending without reinvesting in California, Connecticut, Massachusetts, and the other States that were hurt. And all of the money went to pay more for the same health care, to pay more interest on the massive debt, and to deal with the fact that we were creating a whole new class of poor people. It reached the point that by 1992, 1 in 10 Americans was on food stamps.

So I say to you, that path didn't work very well. We now have evidence that it didn't work. In the last 4 years, only a million new jobs came into the economy. We are 3.5 million jobs behind where we would have been in a normal economic recovery.

And so I presented a plan to the Congress—and I have asked them to adopt it, and I asked the American people to support it last night—which brings down the deficit by $500 billion over the next 5 years. Why should liberals be for that? Why should people in urban constituencies be for that? I'll tell you why. Because as long as that deficit keeps getting bigger, we'll spend more and more of your tax money, hard-working middle class people's tax money, paying bond payments to wealthy bond holders instead of investing in reinvigorating the American economy. Interest rates will go back up, and we won't be able to provide the things that people need.

If we pay the deficit down—look what happened against yesterday. It looks like we're going to pass the plan—the interest rates dropped to an all-time low. I'm telling you, folks, we need to have a consensus in America without regard to race or political philosophy that we have to gain control over our economic destiny again and stop being paralyzed. If we don't do something about this, within 5 years we'll be spending all of our money paying more for the same health care and interest on the debt. And there will be nothing to grow America and grow our people and bring us together. That is the first issue.

The second thing is that this plan is fair. This plan is fair: 80 percent of the new revenues will come from people with incomes above $200,000—80 percent—80 percent; no income tax increases on couples with incomes below $200,000, actually $180,000 in adjusted gross income. The 4.3-cent gas tax that is in this plan amounts to about $35 a year for a family of four with an income of $50,000. Working families with incomes of under $30,000 are held harmless. This is a fair plan. In 1990 when there was virtually no burden on the wealthiest Americans in the budget plan, the burden on the middle class was 2½ times as great as this.

The third point I want to make is, unlike 1990 and unlike the other plans which have been offered to the Congress this year, this plan has real incentives for economic growth that will affect a lot of you in this room. Every small business in America will be eligible to increase their expensing provision by almost double. What does that mean in plain terms? It means that over 90 percent of the small businesses in this country are going to get a tax cut out of this bill if they reinvest more money in their business. Now, that's something the Republicans haven't told you in the last few weeks: Over 90 percent will get a tax cut.

For those of you who live in California and are worried about the economy out there, this plan increases the incentives for companies out there to invest in research and experimentation. That's where a lot of it is going on. That will create more jobs. For those of you who live in Michigan, Ohio, other States with heavy industry, this plan

gives those big companies some relief from the minimum tax provisions if, but only if, they invest in new plant, new equipment, and they do things that will make them more competitive and able to hire more people and create new jobs.

This plan gives a sweeping new investment incentive for people with the courage to invest in new and small businesses. It says if you do it and hold the investment for 5 years, you get a 50 percent cut in the tax you'd otherwise have to pay to get people into that. This plan will grow the economy.

Finally, let me say this plan is fair to people who deserve our support. There is some more money in this plan for Head Start, to help pregnant mothers, to start people off well, to invest in the apprenticeship training of our young people, to help to pay for national service, and for more access to college education. And the most important thing of all, which has received very little attention until the last few days, this plan arguably has the most important piece of social reform in the last 20 years because it puts $21 billion into the earned-income tax credit program, which means we can say to the working poor, if you have children in your house and you work 40 hours a week, you will be lifted out of poverty. We are tired of seeing people work their heads off and work their fingers to the bone and be in poverty.

That is something that every conservative in this country who's talked about how well the welfare system is for years ought to embrace with tears of joy. Think about it. For the first time in the history of the country we can say, "If you go out and work hard and play by the rules and you're still living in poverty"—and almost one in five, 18 percent of the workers in this country work for a wage that will not support a family of four above the poverty line—this says "the tax system, not a Government bureaucracy, not a program, the tax system will lift you out. You will be rewarded for your work."

That is a dramatic advance. It will change the lives of millions of Americans who are out there just killing themselves to raise their kids and to obey the law and to do what is right. And that, too, is in this program.

But when they say, our opponents, "This thing doesn't do anything for jobs. It doesn't do anything to cut the deficit. It taxes the middle class, not any different from what we've done, before." It is just not so. And I ask you in these closing hours if you have a Senator or a Representative who is potentially a vote for this, call them and tell them you'll be with them.

I've spent a lot of time talking to the Members of Congress. I hear two arguments from people who say they may not or they won't vote for the program. Argument number one is a terrible indictment of democracy, but a lot of them have said it: "This is a good program; it's good for America; it's good for my district, but our people don't believe it. So much misinformation has been put out. They don't believe there's any deficit reduction. They don't believe there's any spending cuts. They believe the middle class is paying the taxes. They don't think there's any incentives for growth. And we'll never convince them of that. So even though it's good for America, I can't vote for it because my people are not capable of hearing the truth." I think that is wrong.

As soon as this bill passes, we will clear away the murky fog of misinformation and reality will take over. And we've been doing a better job of that in the last month. But you need to give courage to those people.

There are others who say, quite rightly, that "This bill doesn't solve every problem America has, and therefore, I won't vote for it." Well, we'll never vote for any bill if that's the test.

It is true, this bill brings the deficit down for 5 years, and then it will start going up again unless we do something about health care costs. But the time to do that is when we reform the health care system and provide affordable health care to all Americans and control health care costs in the private sector as well as the public sector. It is not fair to say we're going to control health care costs and doing it by slashing Medicare benefits to middle class elderly people or by simply shifting the costs onto the private sectors.

Now, I want to say this again. This is something we all have a common interest in. We do spend too much on health care. We spend it in the private sector and in the public sector. We spend over 14 percent of our income on health care. Only Canada, of all the other

countries in the world, spends as much as 9 percent of their income on health care. Everybody else is less. And we spent it partly because the whole system costs too much to administer—it is a bureaucratic nightmare—and because we are the only advanced country that doesn't provide some quality coverage to all of our citizens and security of people so that they'll have health care coverage even if they lose their jobs or if they move jobs or if somebody in their family has been sick before. We have to deal with this.

But if we did what these folks are saying and tried to solve the health care problem now by slashing what we spend on Medicare and Medicaid without reforming the system, do you know what would happen? We'd either hurt the middle class elderly or the poor, or we'd keep on doing what's been done in this country now for about 15 years. We'd be sending the bill to the private sector. All of you who are in the private sector—most of you are paying health insurance premiums that cost too much already. If we just cut what the Government pays, you'll pay more.

So I say to those people who say we have to do something about these entitlement programs and health care, you are right. Let's do it right. Let's not use that as an excuse not to move forward with this program. There's too much good in it.

And finally, let me say we have a lot more to do. We have to move on to health care. We have to move on to welfare reform. We have to move on to the crime bill, which will do a great deal to help us to put more police officers on the street in community policing settings where we will be working with people in the community to make them safer and to prevent crime from occurring in the first place. We need to pass the Brady bill. We have fooled around with this too long. It is time to pass it.

I had a heartbreaking conversation over the weekend with a friend of mine who is a Member of Congress who had a friend whose son was shot in one of these blind, mad encounters between children over the weekend where four young boys got in a fight with four others, and they didn't know the other guys had guns. And finally they just took out the guns and started shooting them. This is crazy. This is crazy.

Our television news is filled at night with horrible incidents of violence in Bosnia and other places in the world that break our heart. Twenty-four people were killed in this town, our Nation's Capital, in one week last month. We have to get on with that.

You had Hugh McCall here the other day, my friend, Hugh McCall, one of the most enlightened bankers in America, a supporter of our community development banking proposal. We've got to prove we can bring free enterprise and investment back to distressed urban and rural areas in this country. That is out there waiting for action. None of this stuff is going to be addressed until we get this budget economic plan passed and get it behind us and move forward.

The Vice President is going to present a stimulating plan to reorganize the Federal Government in ways that serve you better at the grassroots level and still save the taxpayers money. We are not done with trying to control the budget. But we cannot move forward unless we act on this now.

And so I say to you, my fellow Americans, we have tried delay, denial, gridlock. We've had all this tough talk and easy action. I've been criticized in some quarters for not talking tough enough. My theory is if you do the tough things, your actions can speak louder than your words. We've had too many words that didn't mean a thing in this town for too long.

So I ask you as Americans to continue your support of these endeavors. I ask for your partnership for the future. Let's make the national service program work and make it an instrument of healing and unity and real problemsolving, just what the Urban League has always been about. Let's prove we can deal with the health care issue in America, that we don't have to be the only advanced country in the world that can't seem to find a way to either control health care costs or provide security to our families. Let's prove that we can bring our deficit down and grow our economy.

In short, let us prove that together we will assume more responsibility, create more opportunity, and come together again in this great American community. I am tired of hearing about all the things we cannot do. I am tired of hearing about cynicism and

skepticism being the excuse for inaction and paralysis.

This is a very great country. And when you travel abroad and you see the problems that these other nations are having and you see all these other rich countries with higher unemployment than we have, you know that there is nothing before us that we cannot deal with if we simply have the vision and the will to do it. We are being given a chance now to demonstrate that vision and that will. It is consistent with everything the Urban League has ever stood for or done.

I ask for your prayers, your support, and your memory that—President Kennedy once said it better than I ever could, "Here on Earth, God's work must truly be our own." Our work is before us. I'm trying to do my part. I hope you will do yours.

Thank you, and God bless you all.

NOTE: The President spoke at 10:48 a.m. at the Washington Convention Center. In his remarks, he referred to Reginald K. Brock, Jr., chairman and chief executive officer, Time, Inc.; John Jacob, president and chief executive officer, National Urban League, Inc.; and John W. Mack, president, Los Angeles Urban League. A tape was not available for verification of the content of these remarks.

Remarks on Signing Executive Orders on Budget Control and Deficit Reduction and an Exchange With Reporters

August 4, 1993

The President. Before I sign these orders, I'd like to make a brief statement, if I might. Nothing has done more to erode the confidence of the American people in our Government than our chronic failure to manage our finances and to stabilize the economy so that it can create jobs. Year after year, the public has been told that sustained economic growth and deficit reduction would come from actions taken here. And as deficits have grown larger and incomes have shrunk, the people have become more and more skeptical, even cynical, about everything that is said and done here even with the best of intentions.

We have a budget deficit, we have an investment deficit, and we clearly have a trust deficit in America. I am determined to do something about all three. I know the American people are doubtful about any claim by our Government, and I know they wonder if the cuts that we are proposing are real and if the taxes will really be used to pay down the deficit. That's why I want to go the extra mile to ensure that this plan is fundamentally different from what has been done in the past.

This plan is based on conservative revenue estimates of future revenues, with year-by-year, line-by-line specific spending cuts; new incentives to expand the private sector's contribution to economic growth; minimizes the burdens on the middle class; and now creates two safeguards to keep a watchful eye on future spending, especially in entitlements, while protecting the savings produced by the plan.

We owe the Executive orders I am about to sign to the hard work of the Members of Congress who are here today. The House included both provisions in its version of the reconciliation bill. The Senate would have done the same with similar amendments supported by Senator DeConcini, Senator Feingold, recommended publicly by Senator Bradley and others, but for the procedural maneuvering by people who feed the public cynicism by talking about deficit reduction on the one hand and nonetheless have prepared to block action for these needed reforms on the other.

The fact that the Senate required these Executive orders today, that we could not do it by statute, is something that should be debated at a later time. But I want to make it clear that the Senators who are here and others, strongly support what is being done.

These orders are almost completely identical to the provisions adopted by the House and approved by a majority in the Senate. The deficit reduction order creates a deficit reduction trust fund, an account in the Treasury that guarantees that the savings from the reconciliation bill are dedicated exclusively to reducing the deficit. This locks in deficit reduction and mandates all members of the executive branch to follow these procedures.

Protections for Minority Providers

The Health Security Act contains several provisions to assure that minority providers have a full opportunity to participate in health plans. The Act also contains a number of provisions to increase choices of providers available to low-income and culturally isolated communities.

Increased Inclusion of Minority Providers

The Health Security Act imposes the following provisions to ensure adequate choice of provider for the consumer, and important assurances for the provider to be reimbursed by health plans:

State laws that restrict health plans from limiting providers from networks, the so-called "any willing provider" provision, will be preempted in plans that are not fee-for-service plans. This enables plans to form networks of providers. However, providers are guaranteed participation in all fee-for-service plans which must accept all providers or "any willing provider," under the Health Security Act (Section 1322 (b)(2), page 133). Every regional alliance must have at least one fee-for-service plan.

Health plans which are fee-for-service plans must provide coverage for the entire comprehensive benefits package that is "furnished by any lawful health care provider of the enrollee's choice, subject to reasonable restrictions." These restrictions only include "utilization review, prior approval for specified services and exclusion of providers on basis of poor quality of care, based on evidence obtainable by the plan."

In addition, all health plans with restricted networks (such as group or staff model HMOs) must, under the Health Security Act, offer a point-of-service option to their enrollees which enables them to be reimbursed for covered services outside of the network. Plans must reimburse providers for all items and services rendered through the point-of-service option on a fee-for-service basis.

Additionally, the Essential Community Provider (ECP) provision mandates all health plans to include ECPs in their network. The Essential Community Provider provision will guarantee providers payment for covered services from all health plans. Health plans must either contract with all ECPs, or arrange to reimburse at the provider- negotiated rate. The Health Security Act delineates those federally funded providers which will receive automatic designation, and the Secretary has the authority to designate other Essential Community Providers. Privately and publicly funded providers may apply for designation. The ECP provision will assure that vulnerable populations have continuing access to practitioners with experience meeting their special needs, regardless of which health plan in which they choose to enroll.

Increasing Access to Minority Providers

Special initiatives contained in Title III will assure that all Americans -- no matter who they are or where they live -- not only have access to the full range of services included in the comprehensive benefits package under health care reform, but also have an adequate choice of culturally sensitive providers and health plans. The policies that the President has put forward build on the success of providers who have been serving special populations and assure that these providers are given the resources they need to participate successfully in the new system. Under the current system, our challenge is to find and fund providers to care for indigent, uninsured populations.

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The Title III Public Health initiatives contain flexible programs that will help diverse types of undeserved communities attract the types of primary care practitioners and specialists that are currently in short supply in their areas, and offer their residents an array of practitioners and practice settings from which to receive health care services. The initiatives in Title III were created to assure access for diverse populations, and link up different types of providers with each other so as to assure the availability of the full range of services in the comprehensive benefits package.

Increased Training of Minority Providers

The Health Security Act increases funds available to enhance training of underrepresented minorities and disadvantaged persons. Funds will be directed towards recruitment, retention and financial assistance for persons entering medicine, nursing, public health and other health professions and faculty development.

The Health Security Act envisions redirecting the focus of post-graduate education to primary care, reaching a goal of 55% primary care beginning in the year 1998-99. Primary care is defined as family medicine, general internal medicine, general pediatrics or obstetrics and gynecology. When allocating the number of training positions, the National Council on Graduate Medical Education will take into consideration the minority representation in the medical workforce so as to increase opportunity for minority providers to specialize.

Capacity Expansion and Community Practice Networks

Capacity expansion in inner-city and rural areas will be actively supported under reform. This will be accomplished both by expanding the successful community and migrant health center program and through a new competitive grant and loan program supporting the development of community-oriented practice networks and health plans ($2.7 billion over FY 1995-2000) . Community-based practice networks increase opportunities for providers who have expertise in serving undeserved communities and encourages communities to educate and enhance training of minorities in the health professions, and encourage the establishment of networks and health plans that are responsive to the needs of minority populations.

The new program is designed to integrate federally funded providers with other providers in undeserved areas, bolstering their ability to coordinate care, negotiate effectively with health plans, and form their own health plans. It will increase the level of service available in undeserved areas by supporting the creation of new practice sites and by renovating and converting existing practice sites, including public and rural hospitals. In addition, it will improve access to specialty care in urban and rural undeserved areas -- and improve coordination of care -- by linking providers in practice networks with each other and with regional and academic medical centers through information systems and telecommunications.

Grants and loans under the new program will be made to groups of providers working in medically undeserved areas or caring for undeserved populations. In making awards, preference will be given to groups that include the maximum number of different types of federally funded providers and that link these providers with those not supported by public funds. All providers included in the community practice networks will receive automatic designation as Essential Community Providers.

The new community practice network and health plan program will meet most of the remaining need for new practice sites in undeserved areas; support renovations to improve the practice environment for 3800 practitioners working in community and migrant health centers and other existing sites in undeserved areas; address much of the capital needs of rural and public hospitals; and fully address the estimated need

for information systems and telecommunications (exclusive of highway costs) in undeserved areas.

Protection for Minority Providers

The Health Security Act specifically prohibits discrimination against providers based on the personal characteristics of the provider or of the provider's patients. Section 1402 (c)(2) reads "In selecting among providers of health services for membership in a provider network, or in establishing the terms and conditions of such membership, a health plan may not engage in any practice that has the effect of discriminating against a provider- based on the race, national origin, language, age or disability of the provider and based on the socioeconomic status, disability, health status, or anticipated need for health services of a patient of the provider."

In addition, the broader anti-discrimination provisions in the Act cover both intentional discrimination and acts that have the effect of discriminating. There is no defense to discrimination that is intentional. Acts that are neutral on their face (eg. advertise in publications that are not widely circulated) but have the effect of discriminating are barred unless the health plan can show that they are justified by "business necessity," the same kind of defense that is embodied in other existing civil rights laws. The Secretary will issue regulations within one year of enactment to carry out this section.

Minorities 9/17

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^Blacks in Congress Question Fairness of Clinton Health Plan (Washn)
^By Karen Hosler= ^(c) 1993, The Baltimore Sun=

WASHINGTON Health care reform was described Thursday as a ``life and death'' issue for black Americans, but members of the Congressional Black Caucus are not convinced that President Clinton's proposal is the best approach.

The proposed new system of guaranteed access to a standard package of basic health benefits, emphasizing primary and preventive care, could potentially rescue millions of uninsured African-Americans from needless disease and premature death, supporters of the plan say.

At a meeting with first lady Hillary Rodman Clinton Thursday, key black legislators questioned, though, whether the administration plan to blend a private system of managed competition with an overlay of government regulation might continue or even aggravate discrimination against the poor.

``There are cultural, linguistic, racial, educational, and attitudinal differences that impose special barriers to effective delivery of care to our community,'' said Rep. Louis Stokes, the Ohio Democrat who chairs the Black Caucus Health Braintrust. ``We must be assured that any new system does not continue to differentiate between the haves and the have-nots, the unemployed and the working, minorities and whites.''

The Clinton program would allow people to pay more to purchase a traditional health care plan that allows them to see any doctor. Most people, however, will be forced by cost to select a cheaper health maintenance organization, which provides the same benefits but does not permit as much choice of physicians or hospitals.

Black lawmakers warned that the intense competition between health care providers would squeeze out inner-city health centers that for years have catered to black communities for little or no profit.

Risa Lavizzo-Maurey, deputy administrator of the agency for health care policy and research of the U.S. Public Health Service, noted that the administration's proposal includes a provision that would forbid discrimination by health care providers or the alliances that provide insurance.

But many black lawmakers favor an alternative proposal sponsored by Democratic Rep. John Conyers of Michigan to establish a single, government-run health insurance program because they believe it would screen out more subtle racism that might otherwise creep into a blended system.

Mrs. Clinton observed that the Conyers proposal would require a major new tax increase to pay for it, which would probably be impossible to pass. But the first lady assured the caucus members the administration shares their goals.

``We're all trying to get to the same place,'' Mrs. Clinton said.

^(Optional add end)

Stokes called health care reform a ``life and death'' issue for blacks because they are most likely to fall through holes in the current health care system, which has left between 35 and 37 million Americans without any health coverage.

Twenty-one percent of black Americans currently fall into that category compared with 11 percent of whites, according to government figures released earlier this week. They are mostly working poor who neither have private insurance nor qualify for care through the federal programs of Medicare for the elderly and Medicaid for the poor.

The lack of primary care and preventive care, which is not even available to those who have Medicaid, is believed to be directly responsible for the disportionately high death rate among blacks.

Rep. Robert C. Scott, D-Va., noted that 1.58 black adults die of heart disease, cancer and strokes for every white adult who dies from those causes. Life expectancy for blacks is 70 compared to 76 for whites.

^Distributed by the Los Angeles Times-Washington Post News Service=

M-TN--Minority Health, Bjt,360 CDC 9/4

New CDC Director Says Minorities Have Big State in Health Care Reform

tdstmwstf

^By TOM SHARP= ^Associated Press Writer=

KNOXVILLE, Tenn. (AP) Minorities have a larger stake in health care reform in America because their problem is bigger, the new director of the Centers for Disease Control and Prevention said Friday.

Dr. David Satcher, who takes office Jan. 1, said African Americans have a higher infant mortality rate, a lower life expectancy and a greater likelihood of contracting AIDS.

Speaking to a symposium on minority health issues sponsored by the East Tennessee Minority Professionals Association, he said African Americans have very few resources with which to fight.

``So we have a disproportionate problem, but only 3 percent of physicians are African Americans, only 3.5 percent of dentists and 5 to 6 percent of the nurses,'' Satcher said.

``We have a resource problem in terms of health professionals, and we're overburdened in terms of the health status problem. So we have a major stake in health care reform.

Satcher, former president of Meharry Medical College in Nashville, worked with Hillary Clinton's task force on health care reform for five months this year. He believes the plan will make some fundamental changes in health care delivery in America.

``The biggest problem in this country is the way we pay for health care. We don't provide any incentives to keep people healthy,'' Satcher said. ``If you want to make money in health care, you don't make money by keeping people healthy, you make it by treating people who are really sick, and the sicker they are the more money you make.

``But with health care reform, that's going to change.''

Satcher said he believes many categories of problems among minorities teen pregnancies, drug abuse, violence, early departure from school are symptoms of today's society that translate into health care problems.

``The CDC's role would be to find out what buttons to push to prevent teen-age pregnancy, violence and et cetera,'' he said.

``If the buttons relate to changing the attitude of teen-agers toward the future and working with partners like schools and churches and communities, the CDC can provide resources.''

PUTTING PEOPLE FIRST

The Congressional Black Caucus Position on Health Care Reform

The American health care system is in need of major surgery. Bandaid solutions will not cure what ails it. It is a national disgrace that 35 million Americans lack health insurance, 25% more than a decade ago. Sixty million more are underinsured, many only an illness away from bankruptcy. Children make up one quarter of the uninsured; over two-thirds of the uninsured are in working families, with the breadwinner working full-time. Three out of ten Americans feel locked into their jobs -- afraid to pursue a better or higher paying job out of fear of losing health coverage. Too many families are seeing their health benefits erode as insurance companies cut back on covered services and reduce lifetime coverage limits.

Minority Americans suffer an even greater burden as illness and death fall disproportionately on their families as compared to white Americans. The incidence of cancer, hypertension, diabetes, AIDS, infant mortality, homicide and chemical dependency, take a devastating toll on our communities. In addition, African Americans and Hispanics account for over 50% of the number of Americans added to the rolls of the uninsured between 1977 and 1987. They are also disproportionately represented in the kinds of families at the greatest risk of being uninsured -- families where no one is working and families that are poor.

We take great hope in President-elect Clinton's commitment to ensuring comprehensive health care to all Americans, while getting costs in line with the general rate of inflation. To that end, we strongly urge that the President-elect and the Congress work together to create a national health insurance program with the following features:

1. Universal Coverage. All citizens and nationals should be entitled to receive comprehensive benefits.

2. Comprehensive Benefits. The following comprehensive benefits should be provided:

- **Acute Services:** All hospital and clinic care; physicians, dentists and other practitioners; all necessary tests.

- **Preventive Services:** Including immunizations; pre-natal and post-natal care; well baby and well child care (under 18 years); mammograms and Pap smears; dental and eye exams; family planning services.

- **Prescription Drugs:** All necessary prescription drugs

needed for the treatment or prevention of illness.

- **Drug and Alcohol Abuse Treatment:** Inpatient, outpatient and community-based services to provide treatment on demand.

- **Mental Health Services:** Inpatient, outpatient and community-based services.

- **Long-term Care:** Institutional/nursing home services; home and community-based care services; respite or temporary care such as day care.

3. Deductibles and Co-payments. There should be only minimal deductibles and co-payments on a sliding scale, with a maximum chargeable amount per service and/or per year.

4. Freedom to change jobs or move to another region. People should have complete freedom to change jobs or move because coverage should not depend on their place of employment or on whether they had a preexisting medical condition.

5. Freedom to Choose Providers. Our present high-quality system of private, non-profit, or public hospitals should still deliver health care. People should have complete freedom to choose their own health provider.

6. Role of the Federal Government. The Federal Government should guarantee the provision of comprehensive benefits to all citizens and nationals. It should establish an independent national health insurance board to oversee the implementation of the national health insurance program, which should establish a national budget for health spending. The board should set minimum standards and policies for the provision of health care. Consumers should play a significant role in all decision-making of the board and in advisory bodies to the board.

7. Strong Cost Containment. The national health insurance program should have the power to contain costs and plan for the efficient distribution of health facilities through:

- **Health Care Budget:** The Federal Government should set and adhere to an annual health insurance budget to control costs.

- **Managed Care Networks:** Consumer-oriented managed care networks should be strongly promoted as an alternative to fee-for-service medicine. Offering a continuum of care at a fixed annual price, they should be required to provide a wide range of services. At least one-third of the board of each managed care entity should be members of the network. A strong grievance procedure should be

in place and there should be prohibitions against physician incentive plans that limit utilization and reduce medically-necessary care.

- **Hospital Global Budgets:** Negotiations with hospitals should establish an annual lump-sum budget for all services. This will provide stable funding, make hospitals more efficient, limit unnecessary services, and contain costs.

- **Physician Fees:** Fees should be negotiated with physicians and other practitioners to control the rate of increase and limit unnecessary services.

- **Capital and Technology Controls:** Planning entities including consumers, providers and public officials should determine when and where to build new hospitals and clinics and buy new equipment. This will limit duplication that results in unnecessary procedures, underutilized equipment, and increased prices.

- **Prescription Drug Prices:** Prescription drug prices should be negotiated to limit excessive increases and provide a fair rate of reimbursement.

8. Emphasis on Primary and Preventive Care. Health care should be reoriented towards primary care and prevention by requiring medical schools, as a condition of public reimbursement, to achieve a national goal of producing at least 50% primary care physicians; currently our schools produce fewer than 30%. The Federal Government should also greatly expand research on primary care and prevention.

9. Assistance to the Medically Underserved. Special attention should be given to expanding health services to medically underserved communities. In particular, significant increases in funding are needed to expand community-based health care facilities and programs and to educate and train primary care practitioners who practice in underserved communities.

10. Financing. Premiums collected from individuals to finance a national health insurance program should be significantly progressive, based on ability to pay. Premiums on employers should place the greatest burden on the most profitable corporations, limiting the effect on small businesses.

of new cases of HIV and AIDS. These communities must, therefore, be targeted for curbing the spread of the disease and in crafting treatment innovations, including the development of new drugs.

3. Treatment of hypertension through early detection, pharmaceutical, and other options should be a top priority.

Hypertension (or high blood pressure), endemic among African-Americans, is often undetected until it becomes severe or results in complications, leading to less effective and more costly treatment. Access to free blood-pressure exams, other early detection methods, and treatment once diagnosed must be assured.

4. Additional funding and dedication is needed at the Federal level to help already financially impaired cities to respond quickly and effectively to outbreaks of Tuberculosis.

The recent resurgence of T.B. as a serious threat to public health in American cities requires a greater Federal role and increased Federal funding to combat this disease.

5. Patient education and training on monitoring and complying with a regimen to control certain conditions must be covered.

Many complications and deaths relating to hypertension, diabetes, tobacco smoking and substance abuse stem from a failure of patients to fully understand and receive support with their regimen. Covering classes as well as other tools for these situations would lessen the incidence of costly complications.

HEALTH PERSONNEL IN THE UNITED STATES

Eighth Report to Congress

1991

September 1992

U. S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Health Resources and Services Administration
Bureau of Health Professions
DHHS Pub. No. HRS-P-OD-92-1

Appendix

Appendix table 1. Employed Civilians in Selected Health Occupations and Percent Women, Black, and Hispanic, 1989

Occupation	Total Employed	Percent of Total		
		Women	Black	Hispanic
Health Diagnosing Occupations	854,000	16.5	3.2	4.4
Physicians	548,000	17.9	3.3	5.4
Dentists	170,000	8.6	4.3	2.9
Health Assessment and Treating Occupations	2,240,000	84.8	7.3	3.1
Registered Nurses[1/]	1,599,000	94.2	7.2	3.0
Pharmacists	174,000	32.3	4.7	2.2
Dietitians	83,000	90.8	17.1	5.3
Therapists	324,000	76.3	6.4	3.0
Inhalation Therapists	63,000	52.5	12.5	2.7
Physical Therapists	90,000	77.3	4.8	6.1
Speech Therapists	63,000	88.6	3.3	0.9
Health Technologists and Technicians	1,276,000	82.3	14.6	4.6
Clinical Lab Technologists and Technicians	308,000	74.4	14.7	4.1
Dental Hygienists	80,000	99.2	1.7	0.9
Radiologic Technicians	124,000	75.8	10.1	4.3
Licensed Practical Nurses	414,000	96.1	19.0	4.4
Health Service Occupations	2,042,000	90.0	26.4	6.5
Dental Assistants	187,000	98.9	7.4	9.0
Health Aides, except Nursing	416,000	84.5	17.7	7.0
Nursing Aides, Orderlies, and Attendants	1,439,000	90.4	31.4	6.0

1/ Estimates from the 1988 Sample Survey of Registered Nurses sponsored by the Bureau of Health Professions indicate that the percentages of employed registered nurses who are women, Black, and Hispanic are 96.3, 4.0, and 1.4 percent, respectively.

Source: Bureau of Labor Statistics, Employment and Earnings, January, 1990.

Appendix table 2. Graduates from Selected Health Professions Schools by Racial/Ethnic Category, 1980-1989

Health Profession	1980	1985	1989	Percent Change 1980-89	Percent Change 1985-89
Allopathic Medicine	15,135	16,138	15,398[1/]	1.7	-4.6
Non-Minority	13,462	13,788	12,075[1/]	-10.3	-12.4
Minority	1,673	2,450	3,178[1/]	90.0	29.7
Asian/Pacific Islander	395	750	1,433[1/]	262.8	91.1
Underrepresented Minority	1,278	1,700	1,745[1/]	36.5	2.6
Black	768	828	874[1/]	13.8	5.6
Hispanic	477	807	819[1/]	71.7	1.5
American Indian/Alaska Native	33	65	52[1/]	57.6	-20.0
Dentistry	5,193	5,289	4,312	-17.0	-18.5
Non-Minority	4,673	4,512	3,288	-29.6	-27.1
Minority	520	777	1,024	96.9	31.8
Asian/Pacific Islander	197	378	521	164.5	37.8
Underrepresented Minority	323	389	503	55.7	29.3
Black	190	223	193	1.6	-13.5
Hispanic	119	149	296	148.7	98.7
American Indian/Alaska Native	14	17	14	0.0	-17.6
Pharmacy[2/]	7,432	5,724	6,557	-11.8	14.6
Non-Minority	6,335	4,591	4,561	-28.0	-0.7
Minority	875	829	952	8.8	14.8
Asian/Pacific Islander	292	320	454	55.5	41.9
Underrepresented Minority	534	501	571	6.9	14.0
Black	249	250	310	24.5	24.0
Hispanic	277	245	249	-10.1	1.6
American Indian/Alaska Native	8	6	12	50.0	100.0

1/ Data are for 1990.
2/ Includes minority students in categories other than those shown.

Note: Underrepresented minorities include black, Hispanic, and American Indian/Alaska Native.

Source: Association of American Medical Colleges, American Dental Association, American Association of Dental Schools, American Association of Colleges of Pharmacy.

Appendix table 3. Total Enrollments in Selected Health Professions Schools/Programs by Racial/Ethnic Minority Group, 1980-81 and 1989-90

	All Students	Black	Hispanic	Asian/ Pacific Islander	American Indian	All Students	Black	Hispanic	Asian/ Pacific Islander	American Indian
	Number					Percent				
	1980-81									
Medicine										
Allopathic	65,189	3,708	2,761	1,924	221	100.0	5.7	4.2	3.0	0.3
Osteopathic	4,940	94	52	87	19	100.0	1.9	1.1	1.8	0.4
Dentistry	22,842	1,022	519	1,040	53	100.0	4.5	2.3	4.6	0.2
Pharmacy	21,628	945	459	1,035	36	100.0	4.4	2.1	4.8	0.2
Podiatric Medicine	2,577	110	39	69	6	100.0	4.3	1.5	2.7	0.2
Optometry	4,540	57	80	243	12	100.0	1.3	1.8	5.4	0.3
Nursing (RN only)[2/]	219,188	14,365	5,785	*	*	100.0	6.6	2.6	*	*
	1989-90									
Medicine										
Allopathic	65,163[1/]	4,241[1/]	3,537[1/]	8,436[1/]	277[1/]	100.0	6.5	5.4	12.9	0.4
Osteopathic	6,615	173	246	463	39	100.0	2.6	3.7	7.0	0.6
Dentistry	16,412	983	1,278	2,393	57	100.0	6.0	7.8	14.6	0.3
Pharmacy	22,764	1,301	945	2,130	63	100.0	5.7	4.2	9.4	0.3
Podiatric Medicine	2,397	240	123	156	6	100.0	10.0	5.1	6.6	0.3
Optometry	4,723	132	293	534	16	100.0	2.8	6.2	11.3	0.3
Nursing (RN only)[2/]	201,458[1/]	20,789[1/]	6,046[1/]	5,201[1/]	1,064[1/]	100.0	10.3	3.0	2.6	0.5

1/ Data are for 1990-91.
2/ Based on those students in schools responding to questions on minority enrollment, male enrollment or both.

Source: Association of American Medical Colleges, Association of Colleges of Osteopathic Medicine, American Dental Association, American Association of Dental Schools, American Association of Colleges of Pharmacy, American Association of Colleges of Podiatric Medicine, Association of Schools and Colleges of Optometry, and National League for Nursing.

Financing of Graduate Medical Education. Graduate Medical Education (GME) is financed primarily by third-party payers to hospitals for patient care services. While other third-party payers may be paying for GME implicitly as part of the overall cost of services rendered, Medicare explicitly identifies the GME direct cost components in its payments for hospital services. The Health Care Financing Administration (HCFA) estimated that 1990 Medicare direct GME costs were $1.1 billion. In addition, in 1990 HCFA spent an additional $2.9 billion in support of medical education through the indirect medical education teaching adjustment (IMEA). This adjustment is to help compensate hospitals for some of the costs related to the existence of teaching programs at hospitals.

Table 6

Supply of Physicians, 1978-1989

	Aggregate Supply 1/			
	1978	1983	1986	1989
Total Number of Physicians	437,486	519,546	569,160	600,789
U.S. Graduates	339,114	399,678	437,922	461,919
Canadian	7,021	7,863	8,148	8,209
International Medical Graduates	91,351	112,005	123,090	129,340
Percent IMG's	20.9	21.6	21.6	21.9

1/ Includes inactive MDs.

Source: Seventh Report to the President and Congress on the Status of Health Personnel in the United States, Table VI-A-1.

American Medical Association. Physician Characteristics and Distribution in the U.S., 1990. U.S. Department of Commerce, Bureau of the Census, p. 25, No. 1069.

Table 5

Number and Percent of Female Federal and Non-Federal Physicians, Selected Years, 1970-1990

Year	All Physicians 1/	Number Female	Percent Female
1970	330,824	25,507	7.7
1975	393,742	35,636	9.1
1980	467,679	54,284	11.6
1983	519,546	69,588	13.4
1989	600,789	98,446	16.4

1/ Excludes 3,204 physicians with unknown addresses.

Source: American Medical Association. Physician Characteristics and Distribution in the U.S., 1990.

Physician Supply

Although the supply of allopathic physicians increased between 1986 and 1989, the rate of increase slowed to an average annual increase of 1.9 percent, from 3.1 percent between 1983 and 1986 (Appendix table 4). Data from the AMA show that at the beginning of 1989 there was a total of 600,789 (including inactive) allopathic physicians. Growth in physician supply exceeded population growth, and the U.S. physician to population ratio rose from 232 per 100,000 in 1986 to 244 per 100,000 in 1989, continuing a growth pattern that began two decades earlier. The number of active MDs, which had grown more slowly than the total between 1983 and 1986, grew at approximately the same rate between 1986 and 1989.

Table 7

Active Allopathic Physicians, Selected Years, 1980-1989

	Active Physicians 1/			
	1980	1983	1986	1989
Number	414,916	466,797	505,755	536,755
Ratio per 100,000 Population	179.4	196.0	206.3	218.0
	Average Annual Percent Change			
	1980-83	1983-86	1986-89	
Number	4.2	2.8	2.0	
Ratio per 100,000 Population	3.1	1.8	1.9	

1/ Excludes those not classified and with unknown address.

Source: American Medical Association, Physician Characteristics and Distribution in the U.S., 1990 and previous editions.

Population data from Bureau of the Census.

With slightly more than 50 percent of all MDs having graduated from medical school since 1970 the age distribution of physicians remains skewed toward the under 45 age group (AMA, 1990). As the flow of new physicians stabilizes the median age will rise, following the trend of the general population. Changes in physician age distribution are likely to produce changes in activity status, specialty distribution, physician income distribution, productivity and board certification.

The five specialties with the largest number of active physicians were the same in 1989 as in 1986: internal medicine, general/family practice, pediatrics, general surgery, and psychiatry. Of note is the increase between 1986 and 1989 in the number of pediatricians making it the third largest specialty. Pediatricians ranked fourth in 1986. The number of family practitioners increased, but the proportional representation of general/family practitioners decreased, continuing the gradual long-term decline from 13.4 percent in 1986 to 13.1 percent in 1989 (AMA, 1990).

Both general internal medicine physicians and general pediatricians retained an unchanged specialty representation between 1986 and 1989. In both years, general internal medicine physicians comprised 13.8 percent of active physicians. That was the largest representation of any distinct specialty group. General pediatricians constituted 6.6 percent of active physicians.

In 1989 nine out of ten active physicians were involved in patient care, while only one in three were practicing primary care.

Table 8

Black Medical Student Enrollment, 1980-90

	First Year		Total	
Year	Number	Percent of total	Number	Percent of total
1980	1,128	6.6	3,708	5.7
1981	1,196	6.9	3,884	5.9
1982	1,145	6.6	3,869	5.8
1983	1,173	6.8	3,892	5.8
1984	1,148	6.8	3,944	5.9
1985	1,117	6.6	3,849	5.8
1986	1,174	7.0	3,892	5.9
1987	1,221	7.3	3,968	6.0
1988	1,210	7.2	3,995	6.1
1989	1,221	7.3	4,145	6.4
1990	1,263	7.5	4,241	6.5

Source: Data from AAMC Data Book, January 1991.

Table 9

Medical School First Year and Total Enrollment, by Sex and Race

	1985	1990	Percent Change 1985-90
	First Year Enrollment		
White Males	9,015	7,460	-17.2
White Females	4,363	4,370	.2
Black Males	535	564	5.4
Black Females	582	699	20.1
	Total Enrollment		
White Males	37,322	30,922	-17.1
White Females	17,013	16,971	-.2
Black Males	2,053	1,874	-8.7
Black Females	1,796	2,367	31.8

Source: Data from AAMC Section for Minority Affairs.

Gender, Age and Ethnicity. One in six physicians in 1989 were women, showing continued growth in representation since 1970. In 1989, 73 percent of women physicians were under age 45, a higher percentage than in earlier years. The proportion of males under age 45 has remained constant at about 50 percent. Enrollment patterns at allopathic medical schools indicate that the number of women physicians will continue to grow (JAMA, 1990).

The practicing physician pool of underrepresented minorities—Blacks, Native Americans, and Mexican American/mainland Puerto Rican Hispanics—continues to be relatively low compared with their representation in the U.S. population. There have been numerous efforts to increase minority representation in medical schools. The numbers of minority accepted applicants, enrollees, and graduates have increased in the last decade (AAMC, 1989). But their representation in medicine is still much lower than it is in the U.S. population. The percent of black physicians is still estimated at 3.4 percent of all physicians in 1990 (DHHS, 1986). At the same time, blacks comprise 12.1 percent of the U.S. population (Census Bureau, 1990).

Although there is a dearth of data on practitioners by race and gender, an examination of statistics on 1990 medical school applicants, enrollments, and graduates shows that growth has occurred for black females. Unlike their white and male counterparts, black females have shown a steady increase in the number and percentage in medical school. From 1985 to 1990 the number of black female accepted applicants increased 22.2 percent, total enrollment 31.8 percent and graduates 21.8 percent (Table 9).

The percent of Hispanic physicians is estimated at 3.3 percent in 1990 while Hispanics comprise 9 percent of U.S. population. Improvement in their physician representation is unlikely to be readily forthcoming; in 1990 they accounted for only 5 percent of medical school enrollment.

The Council on Graduate Medical Education (COGME) concluded that greater participation of underrepresented minorities in medicine is vitally important to increased availability of providers and access of minority populations to health care, as well as to ensure that minorities have equal access to a career in medicine. Problems remain in the areas of attracting minority applicants, indebtedness, and recruitment and retention of minority faculty (COGME 1988, 1990).

Characteristics of Practice. Growth in the number of physicians affects both the market for their services and the characteristics of their practice. The mean number of patient visits per physician per week, which had been declining since 1976, reached a low point in 1985 at 117.1 and then increased slightly but steadily each year reaching 121.6 in 1989. Sixty-five percent of these visits took place in an office setting compared to 62 percent in 1982. There was a corresponding decline in the proportion of total physician

17 February, 1994

Note to Dian McCulloch

The attached information could be provided to Senator Mitchell re: minority providers. The issue that generally concerns minority professionals is that they will be excluded from healthplans in the Alliances. This paper responded to such concerns as voiced by Rep. Lewis at a recent Ways and Means hearing. Because of its origin, the memo begins with a discussion of anti-discrimination provisions. A better starting point for general presentation is the opportunity Health Security offers minority providers to be fully compensated for the services they provide to undeserved communities, and the significant improvements in care that they will be able to give their patients, many of whom will have adequate insurance coverage for the first time.

Thus H.S. offers minority health professionals the opportunity provide the quality of care they know their patients need, without concern that the patient will not be able to afford the treatment. Second, because reimbursement for low-income patients will now be equal to payment for all others, providers serving undeserved communities will no longer have such a large volume of uncompensated care or reimbursement levels (as in current Medicaid) that do not meet their cost of providing the service.

This is an issue that we know is of growing interest, so work is underway to provide a better fact sheet. The information I have provided you has not been cleared, however it is taken from OMB cleared testimony and other materials.

Susanne A. Stoiber

Protections for Minority Providers

The Health Security Act contains several provisions to assure that minority providers have a full opportunity to participate in health plans. The Act also contains a number of provisions to increase choices of providers available to low-income and culturally isolated communities.

Increased Inclusion of Minority Providers

The Health Security Act imposes the following provisions to ensure adequate choice of provider for the consumer, and important assurances for the provider to be reimbursed by health plans:

State laws that restrict health plans from limiting providers from networks, the so-called "any willing provider" provision, will be preempted in plans that are not fee-for-service plans. This enables plans to form networks of providers. However, providers are guaranteed participation in all fee-for-service plans which must accept all providers or "any willing provider," under the Health Security Act (Section 1322 (b)(2), page 133). Every regional alliance must have at least one fee-for-service plan.

Health plans which are fee-for-service plans must provide coverage for the entire comprehensive benefits package that is "furnished by any lawful health care provider of the enrollee's choice, subject to reasonable restrictions." These restrictions only include "utilization review, prior approval for specified services and exclusion of providers on basis of poor quality of care, based on evidence obtainable by the plan."

In addition, all health plans with restricted networks (such as group or staff model HMOs) must, under the Health Security Act, offer a point-of-service option to their enrollees which enables them to be reimbursed for covered services outside of the network. Plans must reimburse providers for all items and services rendered through the point-of-service option on a fee-for-service basis.

Additionally, the Essential Community Provider (ECP) provision mandates all health plans to include ECPs in their network. The Essential Community Provider provision will guarantee providers payment for covered services from all health plans. Health plans must either contract with all ECPs, or arrange to reimburse at the provider- negotiated rate. The Health Security Act delineates those federally funded providers which will receive automatic designation, and the Secretary has the authority to designate other Essential Community Providers. Privately and publicly funded providers may apply for designation. The ECP provision will assure that vulnerable populations have continuing access to practitioners with experience meeting their special needs, regardless of which health plan in which they choose to enroll.

Increasing Access to Minority Providers

Special initiatives contained in Title III will assure that all Americans -- no matter who they are or where they live -- not only have access to the full range of services included in the comprehensive benefits package under health care reform, but also have an adequate choice of culturally sensitive providers and health plans. The policies that the President has put forward build on the success of providers who have been serving special populations and assure that these providers are given the resources they need to participate successfully in the new system. Under the current system, our challenge is to find and fund providers to care for indigent, uninsured populations.

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The Title III Public Health initiatives contain flexible programs that will help diverse types of undeserved communities attract the types of primary care practitioners and specialists that are currently in short supply in their areas, and offer their residents an array of practitioners and practice settings from which to receive health care services. The initiatives in Title III were created to assure access for diverse populations, and link up different types of providers with each other so as to assure the availability of the full range of services in the comprehensive benefits package.

Increased Training of Minority Providers

The Health Security Act increases funds available to enhance training of underrepresented minorities and disadvantaged persons. Funds will be directed towards recruitment, retention and financial assistance for persons entering medicine, nursing, public health and other health professions and faculty development.

The Health Security Act envisions redirecting the focus of post-graduate education to primary care, reaching a goal of 55% primary care beginning in the year 1998-99. Primary care is defined as family medicine, general internal medicine, general pediatrics or obstetrics and gynecology. When allocating the number of training positions, the National Council on Graduate Medical Education will take into consideration the minority representation in the medical workforce so as to increase opportunity for minority providers to specialize.

Capacity Expansion and Community Practice Networks

Capacity expansion in inner-city and rural areas will be actively supported under reform. This will be accomplished both by expanding the successful community and migrant health center program and through a new competitive grant and loan program supporting the development of community-oriented practice networks and health plans ($2.7 billion over FY 1995-2000) . Community-based practice networks increase opportunities for providers who have expertise in serving undeserved communities and encourages communities to educate and enhance training of minorities in the health professions, and encourage the establishment of networks and health plans that are responsive to the needs of minority populations.

The new program is designed to integrate federally funded providers with other providers in undeserved areas, bolstering their ability to coordinate care, negotiate effectively with health plans, and form their own health plans. It will increase the level of service available in undeserved areas by supporting the creation of new practice sites and by renovating and converting existing practice sites, including public and rural hospitals. In addition, it will improve access to specialty care in urban and rural undeserved areas -- and improve coordination of care – by linking providers in practice networks with each other and with regional and academic medical centers through information systems and telecommunications.

Grants and loans under the new program will be made to groups of providers working in medically undeserved areas or caring for undeserved populations. In making awards, preference will be given to groups that include the maximum number of different types of federally funded providers and that link these providers with those not supported by public funds. All providers included in the community practice networks will receive automatic designation as Essential Community Providers.

The new community practice network and health plan program will meet most of the remaining need for new practice sites in undeserved areas; support renovations to improve the practice environment for 3800 practitioners working in community and migrant health centers and other existing sites in undeserved areas; address much of the capital needs of rural and public hospitals; and fully address the estimated need

for information systems and telecommunications (exclusive of highway costs) in underserved areas.

Protection for Minority Providers

The Health Security Act specifically prohibits discrimination against providers based on the personal characteristics of the provider or of the provider's patients. Section 1402 (c)(2) reads "In selecting among providers of health services for membership in a provider network, or in establishing the terms and conditions of such membership, a health plan may not engage in any practice that has the effect of discriminating against a provider- based on the race, national origin, language, age or disability of the provider and based on the socioeconomic status, disability, health status, or anticipated need for health services of a patient of the provider."

In addition, the broader anti-discrimination provisions in the Act cover both intentional discrimination and acts that have the effect of discriminating. There is no defense to discrimination that is intentional. Acts that are neutral on their face (eg. advertise in publications that are not widely circulated) but have the effect of discriminating are barred unless the health plan can show that they are justified by "business necessity," the same kind of defense that is embodied in other existing civil rights laws. The Secretary will issue regulations within one year of enactment to carry out this section.

AFRICAN AMERICAN HEALTHCARE & CHILDREN & FAMILIES

^BC-Health Report Card, ^Survey Shows Sharp Racial Disparity in Infant Mortality
^Eds: LEADS with 7 grafs to UPDATE with report released at news conference, quotes from Shalala; picks up 7th graf pvs, Among the
^By CASSANDRA BURRELL= ^Associated Press Writer=

WASHINGTON (AP) Infant mortality hit an all-time low last year, but the rate among black infants was still double that of whites, the government said today in its annual survey of the nation's health.

Americans also are cutting back on smoking and cholesterol and reducing chronic diseases and premature deaths, the Department of Health and Human Service reported in the survey, ``Health, United States, 1992.''

But no progress is being made in reducing homicide rates, increasing prenatal care for many women and preventing low birth weight, especially among black infants.

``This report documents some troubling health patterns in particular, continuing disparities in health status, depending on education, on where you live and your race,'' Health and Human Services Secretary Donna Shalala said at a news conference. ``It also documents the need for strong prevention strategies to combat major health problems.''

The 390-page survey included a separate report, ``Healthy People 2000,'' the first evaluation of the national effort to meet 300 health goals by the year 2000. Those goals include increasing the healthy life span, reducing disparities in health care among racial and ethnic groups and making preventive care available to all Americans by the end of the century.

The mixed findings underscore the pressing need for health care reform, Shalala said.

``The report contains compelling evidence of the need to restructure our health care system so that all Americans can receive the care they need at an affordable cost,'' she said.

Among the survey's most positive findings was that the overall infant mortality rate fell to a record low of 8.5 per 1,000 live births in 1992. Preliminary statistics show the rate declined 4 percent from 1991's rate 8.9 deaths per 1,000 live births.

The 1992 number also represents a dramatic decline since 1970, when there were 20 deaths per 1,000 live births, the department said.

But a striking disparity persists between blacks and whites.

In 1990 the latest year for which comparative figures were available the infant mortality rate for whites was 7.7 per 1,000 live births. For blacks, it was 17 per 1,000 live births. The overall rate was 9.1.

Noting that low birth weight is the most significant factor in infant mortality, the survey said there was an 18 percent rise in very low birth weight among black infants, compared with a 6 percent rise for white infants, between 1980 and 1990.

``The rise in very low birth weight infants parallels the increase in preterm births (less than 37 weeks gestation) over the past decade as well as the continued rise in births to unmarried mothers and the recent jump in teen births,'' the health department said.

In another report underscoring racial disparities, the Census Bureau reported today that even though the proportion of black Americans getting college degrees increased during the 1980s, blacks still receive lower pay than white graduates for doing essentially the same jobs.

Among the some of the other findings in the HHS survey:

Thirty-seven million Americans had no health insurance last year, an increase of 6 million since 1987. The uninsured comprised 21 percent of blacks, 32 percent of Hispanics and 11 percent of whites.

The number of AIDS cases increased again in 1992 to become the 8th leading cause of death. It ranked 9th in 1991. The AIDS death rate increased by 60 percent from 1987 to 1989, but has increased at a less rapid pace since then. It increased 10 percent from 1991 to 1992.

Education apparently can help lengthen life. Death rates for 1989 and 1990

for men and women age 25 to 44 without a high school education were three times the rates for college graduates.

Asian Americans had the lowest death rates for many of the major causes of death. Blacks had higher death rates for many of those causes.

American Indians had the highest suicide and motor vehicle crash-related deaths.

Life expectancy at birth increased by almost two years in the past decade. It now stands at 75.5 years for the average American.

From 1980 to 1990, the age-adjusted death rate for heart disease, the leading cause of death for men and women, declined 25 percent, continuing the downward trend of the 1970s.

Only 20 percent of Americans have high cholesterol compared to a decade ago, when 26 percent had it.

The homicide rate has continued to rise, and homicide ranked as the 10th leading cause of death for all Americans in 1991.