Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. schedule	Phone Nos. (Partial) (1 page)	11/07/1994	P6/b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Speechwriting
OA/Box Number: 8170

FOLDER TITLE:
HRC [Hillary Rodham Clinton]/NYT [New York Times] Op-Ed October 1994

2012-1004-S
ms538

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
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C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

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b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

lm draft 10/25/94

OP-ED PIECE

It's been xx weeks since Congress adjourned without acting on health care reform, and once again anxiety is rising over the future of our health care system.

From Long Island to Los Angeles, newspaper headlines have offered these cautionary warnings: "Even Opponents Stand to Suffer," "Ills of Health System Outlive Debate on Care," "For Haves, Have-Nots, Health Cost is Key."

Health care reform is a complicated issue that requires much discussion and deliberation. But it's also an urgent challenge that cannot be shelved indefinitely. As the newspaper stories suggest, our problems will only grow worse the longer we delay.

The President remains committed to fixing our health care system because we have no alternative as a nation if we care about our economic future. As he said when he first proposed reform more than a year ago, we cannot sustain a long-term economic recovery without controlling health care costs. And we can't control health care costs until everyone has coverage.

Each year we put off reform, our health care system consumes a greater portion of our national income. This year it accounts for one-seventh of our economy. In 2004, it will account for one-fifth. And if the trend continues, one can only imagine the economic peril we will face 20 or 30 years from now.

When the health care debate began, 37 million Americans were uninsured. Earlier this month [October], the number had grown to more than 39 million -- 15 percent of our population -- most of them working Americans.

The situation is even bleaker if one considers the health care outlook for children. Nearly 14 percent of children under 18 years old do not have insurance today. You don't have to be a doctor or an economist to know that these figures represent a health catastrophe in the making -- and a fiscal one as well.

For those of us who worked hard for reform over the last year, the process certainly had its ups and downs. We made mistakes, for which I accept a good chunk of the blame. We underestimated a well-organized opposition that literally spent hundreds of millions of dollars to distort our message. And we faced historical odds that proved too difficult to surmount in so short a period of time.

should not polarize

All people hear -

- in last month -
what will happen
now

what families face.

- direction we need
to go -

→ personal end →

diffic. yr.
learned alot
graceful way to say
we have to keep going
it's quake in the body

-

- seen as false advice
from other ppl

- I know from the
last yr -
so many gd ideas
are here -
I hope they will
let me know
what they are

Clearly, we did not anticipate the power and effectiveness of the forces allied against us. We let them define the debate. We lost our audience. And we didn't articulate our motives or our vision well enough -- particularly the fact that reform is just as important for people with insurance as those without it.

Even with these disappointments, the process was an important exercise that, I think, ultimately will bear fruit. For one, it generated many good ideas from many different quarters about how to fix our health care system. It also taught us important lessons about how to move forward with reform when a new Congress convenes in Washington in January [or December?].

The key challenge we face now is how to communicate the message of reform without letting it fall victim to those bent on distorting it.

Polls show that vast majority of Americans continue to favor reform. So the issue now is how to achieve our central goals without allowing the process to get mired in political warfare.

A few facts remain:

-- If we do nothing, the endless cycle of cost shifting will continue unabated, meaning that the prices of health care services and insurance premiums will continue to skyrocket.

-- If we do nothing, necessary savings will be achieved only through huge cuts in Medicare and Medicaid.

-- If we do nothing, our competitive stature in the world economy will continue to be eroded and we will pay more for clothes, food, care houses, and services. In turn, we will have

-- If we do nothing, our deficit will be harder to control, and we will have fewer resources to invest in other programs we need, such as crime, education, job creation, and environmental protection.

-- If we do nothing, our mortality rates will continue to remain lower than our counterparts in Germany, England, Canada, and Japan, all nations that spend far less of their national income on health care than we do.

These are the economic imperatives for health care reform. But while they should be paramount in our minds, I hope Americans also will remember the moral incentives for reform. Millions of our fellow citizens are living in fear today that they will not be able to afford health care when they most need it. Millions of children are being denied the most basic treatments that every child in this country deserves.

I've been fortunate enough to travel around the country and listen to thousands of Americans talk about our health care system. I will never forget the pained voice of a woman I met in New Orleans who had worked her whole life but could not afford a biopsy when a lump was discovered in her breast. I will never forget the look of anguish I saw in the eyes of grandparents whose two grandchildren had meningitis -- one of whom lived and one of whom died, the only difference being that one had insurance and the other did not.

I'll never forget the despair I heard in the voice of a mother and father from Cleveland who were told by an insurance agent that no company would insure their chronically ill daughters because, "we don't insure burning houses."

This is not a vision of America that makes me proud. I believe we can be better than that.

Not long ago, I visited children's hospitals in Boston, Washington, and Memphis. In each one I saw babies recovering from all kinds of illnesses. I wondered what would happen to them. Today, I still wonder about them, and the 11,000 babies born each day across this country.

There are still too many babies who don't have access to preventive care, regular check-ups, and immunizations. There are still too many adults who don't have access to health care, except in emergency rooms. And there are still too many families paying far too much for the care they receive -- and worrying every day about whether they can afford the cost tomorrow.

These are human problems, not political problems. So when people ask me whether it is worth continuing the fight for health care reform, I'm always reminded of Aesop's fable about the crow and the pitcher.

Like the thirsty crow whose perseverance finally enabled her to drink water from the bottom of a pitcher, we must keep working toward health care reform even if the journey is longer and more arduous than we initially hoped.

lm draft 10/19/94

OP-ED PIECE

People frequently ask me about the future of health care reform, and each time I'm reminded of Aesop's fable about the crow and the pitcher.

Like the thirsty crow whose perseverance finally enabled her to drink water from the bottom of a pitcher, we must keep working toward health care reform even if the journey is longer and more arduous than we initially hoped.

We didn't make as much progress this year as we expected we could. Clearly we made some mistakes in our approach to reform. But in the course of the historic discussion that took place across the country, we also learned a lot. We learned that there are many good ideas out there about how to fix our health care system. And we learned that the majority of Americans still want something to be done.

Simply put, we have no alternative as a nation if we care about our economic future. When the President first proposed reform more than a year ago, his motivation was clear: sustaining a long-term economic recovery was impossible without controlling health care costs. And controlling health care costs was impossible until every American had health coverage.

Today, the economic imperative is even greater. Each year we delay, health care costs consume a greater portion of our national income. This year they account for one-seventh of our economy. In 2004, they will account for one-fifth. And if the trend continues, one can only imagine the economic peril we will face 20 or 30 years from now.

When the health care debate began, 37 million Americans were uninsured. Just this week, the xxxx reported that more than 39 million -- 15 percent of our population -- lack coverage, most of them working Americans. That means that in xxx months, two million more Americans were priced out of the insurance market for one reason or another.

The situation is even bleaker if one considers the health care outlook for children. Nearly 14 percent of children under 18 years old do not have insurance. Obviously this is a health catastrophe in the making -- and an economic one as well.

When 40 million men, women, and children who lack insurance get sick and need treatment, or are in an accident and are rushed to the emergency room, they usually receive care, at least

minimally. And someone pays for it. The hospital or doctor covers their own costs by charging other patients -- those with insurance -- more for services. Hence, the stories we have all heard about hospital patients paying $25 for a Tylenol.

As the cost of care goes up, so do the prices of insurance premiums. In turn, more and more employers decline to provide insurance for their workers. More workers find themselves without insurance through their workplace and unable to buy it on their own.

The vicious cycle of rising costs, uninsured patients, and economic consumption continues unabated. And every American feels the effects.

The more our nation spends on health care, the worse our competitive stature in the global economy. We pay more for clothes, food, cars, houses, and services. We have more difficulty producing jobs. Our deficit is harder to cut. And our investments in other programs we need -- crime, education, job training, environmental protection, economic development, and so on -- diminish.

Equally distressing is that, even as we spend more and more on health care, Americans remain less healthy than their counterparts in other industrialized nations. With health care available from cradle to grave [check this], men and women in Germany, England, Canada, and Japan all have longer life expectancies than men and women in the United States.

Unfortunately, this picture hasn't changed much in the last year.

What has changed is that discussions of our health care system became regular fare in town halls, hospitals, senior centers, offices, schools, and around the kitchen tables of America. Hopefully, those discussions will continue among family members and friends, colleagues at work, and also among lawmakers when the new session of Congress convenes in Washington.

While the economic repercussions of inaction should be paramount in our minds, I hope Americans also will remember the moral incentives for reform. Millions of our fellow citizens are living in fear today that they will not be able to afford health care when they most need it. Millions of children are being denied the most basic treatments that every child in this country deserves.

I've been fortunate enough to travel around the country and listen to thousands of Americans talk about our health care system. I will never forget the pained voice of a woman I met in New Orleans who had worked her whole life but could not afford a

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This is an economic problem that we must face collectively. It is also a human problem. So when people ask me whether we should give up on reform, my answer is: We should never give up on Americans. And we should never give up on America.

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[001]

SCHEDULE OF THE PRESIDENT

FOR

TUESDAY, NOVEMBER 8, 1994

ELECTION DAY

FINAL

APPOINTMENT SCHEDULER: STEPHANIE STREETT
P6/b(6)
OFFICE: 202-456-7560
WHCA PAGER: 4033
P6/b(6)

PRESS DESK: ANNE EDWARDS
P6/b(6)
OFFICE: 202-456-7560
WHCA PAGER: 4208

WEATHER: Washington, DC
Partly cloudy. Wind northwest to northeast at 5 to 10 knots.
Low 52 to 57. High 65 to 70.

SCHEDULE OF THE PRESIDENT
FOR
TUESDAY, NOVEMBER 8, 1994
ELECTION DAY
FINAL

tba — **MORNING RUN**

7:00 am-
10:00 am — **RADIO INTERVIEWS**
OVAL OFFICE
Staff Contact: Richard Strauss

10:00 am-
10:15 am — **BRIEFING**
OVAL OFFICE
Staff Contact: Tony Lake

10:15 am-
10:45 am — **MEETING WITH PRESIDENT AHTISAARI OF FINLAND**
OVAL OFFICE
Staff Contact: Tony Lake
WHITE HOUSE PHOTO

10:45 am-
12:15 pm — **STRATEGY MEETING**
CABINET ROOM
Staff Contact: Leon Panetta

12:15 pm-
12:45 pm — **MEETING**
OVAL OFFICE
Staff Contact: Bob Rubin

12:45 pm-
3:00 pm — **PHONE AND OFFICE TIME**
OVAL OFFICE

3:00 pm-
3:30 pm — **VOLUNTEER EVENT**
SOUTH LAWN
Event Coordinator: Sarah Farnsworth
Staff Contact: Jim Dorskind, Robyn Dickey
CLOSED PRESS

-- **The President**, the First Lady, Vice President Gore, Mrs. Gore and Jim Dorskind are announced from the Diplomatic Reception Room and proceed to stage on the South Lawn.

-- Jim Dorskind makes welcoming remarks and introduces the First Lady.

-- The First Lady makes brief remarks and introduces Mrs. Gore.

-- Mrs. Gore makes brief remarks and introduces Vice President Gore.

-- Vice President Gore makes brief remarks and introduces **the President.**

-- **The President** makes remarks.

-- **The President**, the First Lady, Vice President Gore and Mrs. Gore exit stage, work ropeline and depart.

3:40 pm-
3:45 pm

PHOTO WITH HEROES (WH shooting)
OVAL OFFICE
Staff Contact: Dave Leavy
WHITE HOUSE PHOTO

3:45 pm-
5:00 pm

SPEECH PREP FOR GEORGETOWN SPEECH
CABINET ROOM
Staff Contact: Don Baer

5:00 pm-
6:00 pm

OPTION

RADIO INTERVIEWS
OVAL OFFICE
Staff Contact: Richard Strauss

6:00 pm-
7:00 pm

DNC ELECTION NIGHT RECEPTION
STATE FLOOR
Remarks: Tara Burns
Event Coordinator: Sarah Farnsworth
Staff Contact: Ann Stock, Joan Baggett
CLOSED PRESS

-- **The President**, the First Lady, Vice President Gore and Mrs. Gore are announced from the Green Room into the East Room.

-- The First Lady makes welcoming remarks and introduces Mrs. Gore.

-- Mrs. Gore makes brief remarks and introduces Vice President Gore.

-- Vice President Gore makes brief remarks and introduces **the President.**

-- **The President** makes remarks.

-- **The President**, the First Lady, Vice President Gore and Mrs. Gore exit the East Room and proceed to the Blue Room for receiving line.

-- Upon conclusion of the receiving line, **the President**, the First Lady, Vice President Gore and Mrs. Gore depart.

7:00 pm- 9:00 pm OPTION **RADIO INTERVIEWS**
OVAL OFFICE
Staff Contact: Richard Strauss

BC AND HRC RON **WHITE HOUSE**

NOTES / NYT OP-ED

Jamieson /

An hour on PBS tonight w/ Bill Moyers
The Pres + I were coerced abt 2
Coverge + cost
This is where
Redefine as an effort to solve a problem
WH got lost in what problem was
Talking is straightfwd —
Presuppose a Consensus
Doc # of children ✓ + adults 10/40 m
Talk abt cost as a v. real question
Stay away from abstractions
Global competitiveness
show we produce jobs

when 14% → to h.c. —
add to costs / gds + servs
but not adding to value / product
per product (mortality rate)
Our mortality rate is embarrassing
Our longevity rate not that great
given expenditures
Social goods could be

This is why we attempted to solve a problem.
[redacted] Establish our goodwill
(2) We learned some tips abt other actors + our pla
Can't solve this piecemeal

NYT (2)

Jamieson

We know some things abt consequences & alternatives

Next by we can come back & discuss ways but can't let probs go

Recog. altern

Debate ongoing

Key ! is can we find a way to solve problems.

go back to the good motivations - not to flaw

Nature of the problem

Don't talk abt bcg govt etc

Responding to "myths" is defensive

Point is to make her "good will"

Can't win from a rebuttal posture + inoculation won't win at this stage

Restate: can't solve budget deficit

1/7 of econ → h.c. 1/5 by 2004

37 m when debate started - now 40 m:

almost 10 m children

HEALTH CARE NOTES / NYT OP-ED

Way to charact what need – in terms of beneficial to us
way that pple understand

Pitch it >
Most effect argument against us
Social engineers
Wash knows best imposing h.c. syst
on pple
Nothing cld be farther from what we words intended

Myths & realities
Lessons learned to be applied to future –

We intended to provide a context for
medic. decisions that prov a
floor & security for people

Trying to create decisions to empower pple
to make conditions

By end of debate didn't recognize myself

We lost track of our audience
worried their coverage

What ~~can~~ HRC say now to open people's minds

up now

New York Democrats Mourn Health Care Reform. (Whew!)

IF many in Congress breathed sighs of relief last week at the collapse of health care reform, members of the New York delegation exhaled more deeply than most. For them, it meant being spared an especially painful dilemma.

Here is the paradox: New York is home to some of the poorest, sickest people in the country, and it is a liberal redoubt where President Clinton remains more popular than he is almost anywhere else. But his plan for reshaping the nation's health care system, and virtually every alternative proposal, would have left New York a net loser, at least in the short term.

That is partly because many of the problems reform aimed to solve — access to doctors and care and insurance — are less acute in New York, with its long tradition of public hospitals and rich social service benefits, and partly because various bills sought to solve such problems by curbing the number of medical specialists who are the pride of New York's world-class teaching hospitals, which train about 15 percent of the nation's medical residents.

"The type of concept that pushed these bills was directed at bringing New York down a few notches and other states up a few notches," said Representative Charles E. Schumer of Brooklyn. "Many of us wanted some form of national health care, but every single plan that came down the pike would have hurt New York, and it would have been an awful choice."

The Health Care Association of New York State, a trade group of 400 nonprofit hospitals and nursing homes, calculated that the House Democratic leadership's bill would have cost New York $2.4 billion annually in 2001, while the best proposal for the state — one that included Senator Daniel Patrick Moynihan's plan for a trust fund for graduate medical education — might have eventually provided a $90 million annual boon.

Those numbers made the politics tricky. No bill came to a vote on the floor of either House, but New York's 31-member House delegation was pledged to vote against anything that hurt the state. That left Mr. Moynihan, chairman of the Senate Finance Committee, and Representative Charles B. Rangel of Manhattan, a senior member of the Ways and Means Committee, in awkward spots. "Closing off specialists is the equivalent of closing off science — good God!" Mr. Moynihan said last week. "Most of the health care bills that piled up in the 103d Congress had too many such ideas in them. They presumed too much and confused too many." *TODD S. PURDUM*

Psst. Spies Aren't Always Smart.

WASHINGTON

HANNAH ARENDT, the political historian and social philosopher, sat through the trial of the Nazi Adolph Eichmann. She found him terrifyingly normal, monstrous because he was an ordinary man yet capable of mass murder. Her phrase for this unsettling quality — "the banality of evil" — still reverberates.

Aldrich H. Ames, the mole for Moscow inside the Central Intelligence Agency, fits that mold: a mediocre officer in his country's clandestine service and the most destructive traitor in modern American history.

But the story of the C.I.A.'s conduct in the Ames case is something else again: a lesson in the evil of banality.

The agency's inspector general had the unpleasant duty to report last week that Rick Ames — arrogant, drunken, shiftless, hopelessly sloppy — was an unremarkable member of the C.I.A.'s operations directorate. As his dereliction's and his flouting of all the rules gradually mutated into a murderous series of betrayals, leaving 10 double agents who worked for the United States dead, the C.I.A. kept promoting him, studiously ignoring evidence that fairly screamed that he was its worst nightmare.

For almost seven years after the F.B.I. reported that he was strutting into the Soviet Embassy in Washington in 1986 without notifying his bosses, the C.I.A. did nothing. It pursued the course of least resistance, pretending nothing was wrong, giving good old Rick, that scoundrel, yet another coveted position, just as long as it was far enough down the hall that he was out of sight.

And last week in its final judgment on the case the agency decided everyone was responsible but no one was. No was fired or demoted. No heads rolled.

The C.I.A. behaved, in short, like a bureaucracy. And this may be one of its darkest secrets: that out among the lovely trees in Langley, Va., lurks an ordinary Government shop, with ordinary pastel offices filled with ordinary men and women who have mid-life crises, drinking problems, self-doubts, an understandable desire to hide their mistakes and a crystal ball no clearer than the rest of the foreign-policy establishment of the United States. *TIM WEINER*

Ills of Health System Outlive Debate on Care

By ROBIN TONER

WASHINGTON

REALITY often seemed to be just another subject for debate in the health care struggle, but it has a way of reasserting itself when the shouting is over. As Congress and the White House move on to lobbying reform and trade issues, a variety of experts are quietly noting that the problems that prompted the health care struggle are still, ahem, very much here.

The debate of the past 18 months was often as stylized as a Kabuki play, with as little to do with the real world: Conservatives talked of a country that was, by and large, happily ensconced in a fee-for-service system with full freedom of choice over which doctors people see, and full access to the wonders of modern technology. Liberals countered with a portrait of middle-income Americans teetering on the brink of medical and financial catastrophe.

The "no-crisis" minimalists won, of course, to an extent that almost no one would have predicted six months ago; a weary Congress seems eager to move on. But many experts agree with Drew Altman, president of the Kaiser Family Foundation, a health care think tank based in California, who argued: "When it comes to health care reform, you can run but you can't hide. The problems that put this on the agenda are going to get worse."

> The problems won't go away. As a matter of fact, they'll get worse.

In fact, many experts agree, middle class Americans with insurance will not revert to a halcyon status quo, with generous coverage and an array of Marcus Welbys from whom to choose; they will get their health care in a radically changing marketplace shaped by the need to control costs. The choice never was between change and the status quo, but over who will make the changes, and how, and with what kind of regulation, if any.

If the Federal Government does not restructure the health care system this year, these experts say, it only means that the system will continue to be restructured piecemeal by employers and massive insurance companies and managed care networks. If Congress cannot reach a consensus on how to regulate these changes, and deal with some of the problems of cost and coverage, it only means that the pressure will grow on the states to do so, piecemeal — which means the chorus may rise once again for uniform Federal laws. In short, the whole noisy, confusing, troubling, expensive health care struggle will almost certainly end up back in Washington.

Not immediately, of course, and not on the scale of 1994, at least for a while; it is universally acknowledged in Washington that the Congress of 1995 — almost assuredly a more conservative Congress — will have the appetite only for bite-size reform. And there are some who worry about even that being accomplished; the new Congress is expected to be exceedingly deficit-conscious, and Medicare savings once expected to finance health care reform may, instead, end up being grabbed for the deficit.

But the pressures to act will mount. "The middle class problems and fears that put this on the agenda will only get worse," asserts Mr. Altman, "as more and more find their benefits cut, or their choice of physician constrained, or their employers sticking them with more and more of the bill." Uwe Reinhardt, a health economist at Princeton, argues that the country is inexorably moving toward a three-tier medical system, as more and more Americans are driven into health maintenance organizations and managed care, by employers trying to control costs.

A Three-Tiered System

Poor people and the uninsured will be treated by public hospitals and clinics, Mr. Reinhardt said; middle class people in H.M.O.'s and other such networks, and only the affluent in full-choice, fee-for-service medicine. Many Americans, of course, prefer health maintenance organizations and similar health plans, but the change is nevertheless sweeping. And it may seem jarring to a population that has recently heard its right to choose their own physician passionately — and somewhat surreally — defended by politicians of every stripe.

The message from one side during much of this debate was simple: The evil social engineers want to take away your freedom to get — and be reimbursed for — top quality medicine from the doctors of your choice. In fact, that posited an egalitarian ideal that many experts say simply does not exist in American medicine.

Whatever the flaws of the Clinton plan, one critique of it was fundamentally off-base, Mr. Reinhardt argues. "No one understood this, but the average American patient would have had more choice under the Clinton plan than they now will. If you work for a particular company, your choice of H.M.O.'s is whatever that company offers you."

There is already a backlash to managed care among doctors, many of whom feel themselves at the suffrance of cost-conscious health plans, deciding which doctors to carry and which doctors to drop. "I predict that before this decade is out, American physicians will be on their knees, at the state and federal level, begging for protection," Mr. Reinhardt said. Doctors' groups are already lobbying hard in state legislatures and on Capitol Hill for laws to make it harder for insurance companies and H.M.O.'s to exclude doctors from their networks.

But the catalyst for many of these changes — rising health costs — is powerful. The rate of increase in medical costs has slowed of late, but there is considerable debate over how long this will last.

Part of it is believed to be due to the threat of health care legislation, and part of it to longer term trends, like the movement toward managed care. Regardless, said Richard Ostuw, chief actuary for Towers Perrin, a benefits consulting firm, "most employers will still be dissatisfied with the rate of increase in health care costs" in the future.

Once the passions of the current struggle die down, many Americans may also wonder whatever happened to the insurance reforms they were promised — the rules intended to keep insurance companies from denying coverage on grounds like "pre-existing conditions." They may begin to worry again about having "portability" of health care plans when they change jobs.

If the economy goes into a downturn, they may start to worry about joining the ranks of the uninsured, now estimated at 39 million, a number that has risen steadily in recent years. They may become more receptive to the campaign, expected to begin in full force next year, to try, at least, to extend coverage to children.

Some 8 to 10 million of the uninsured are children, many of them with untreated or only sporadically treated conditions like repeated ear infections or asthma, said Dr. Irwin Redlener, president of the Children's Health Fund and chief of community pediatrics at the Montefiore Medical Center in the Bronx. Not providing for these children, he argues, "ends up costing the health care system in very substantial ways, and really impacts on these kids' ability to function."

Down the road, there will be other health-related pressures bubbling up among the middle class: "Over the next five to seven years, all the parents of the baby boom generation will become elderly, and many of them will become very elderly and start needing long-term-care services," said Joshua Wiener, a senior fellow at the Brookings Institution, and an expert on long-term care. "And they'll start turning to their baby boom children for care and help and in some cases financing for these services. How we're going to take care of Mom will become a major political and social issue in the very near term."

False Impressions?

Such realities linger. "As the debate went on and on, there was a kind of lulling, that the problems weren't so bad," said Stuart Altman, a health analyst at Brandeis, who advised the Clintons during the transition. "You in the press went from pumping up the problems to pumping up the problems of the solutions."

Some people, of course, never engaged in the expectations game. Dr. Gwen Wurm, director of community pediatrics at the University of Miami, spent substantial time with the uninsured in August, when she and her staff did free back-to-school physicals in a mobile clinic. They did not seem to think help was on its way from Washington, she said, now or any time soon. "People who are working poor, they're very realistic about what their chances are of getting help from any sector," she said.

But the middle class does not usually struggle in silence.

THE NEW YORK TIMES, SUNDAY, OCTOBER 2, 1994

10.25.94

The Miami Herald

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Health care gets a hand

UNBANNED IN BOSTON

Boston federal court says some conditions qualify under the Americans With Disabilities Act.

Americans who lose their health insurance after an accident or the onset of a chronic illness, or who find their benefits suddenly changing, surely will cheer a federal appeals court ruling that they are now covered under the Americans With Disabilities Act's anti-discrimination clauses. Boston's First U.S. Circuit Court of Appeals decision opens the courthouse door for discrimination suits against health insurers — at least in New England. (Any federal appellate court ruling is law only within the circuit in which it was rendered.)

The ruling also points out a basic flaw of the U.S. health insurance system: Nobody can predict who gets treated, for what, and for how long. Most Americans have health insurance, typically subsidized by employers or offered through unions or trade associations. The insured have little say about their benefits, much less about changes in them.

So it was for Ronald Senter, an auto parts distributor in New Hampshire. He was insured for nine years through the Automotive Wholesaler's Association of New England group plan before being diagnosed with HIV, the virus that causes AIDS. In 1989 he began filing claims for AIDS-related illnesses. In 1990 his insurer capped AIDS benefits at $25,000 while keeping its lifetime benefits for other conditions at $1 million. Mr. Senter sued his plan, alleging discrimination under the ADA. He developed AIDS in 1991 and died in 1993. His family and firm continued the case.

A New Hampshire district judge dismissed the case, holding that insurers are not bound by the ADA. The appeals court flatly disagreed. It held insurers liable under the ADA's anti-discrimination clauses *if* the insurer is so entwined with an employer as to control substantial aspects of employment or has been effectually designated as the employer's agent. Mr. Senter's family now gets to go back to court to try to prove that such conditions existed.

The serious public policy question is: Why should any American family be in court over medical bills? Why isn't health care in America — as elsewhere in the developed world — a right, universally available, when needed?

The U.S. health care system is fundamentally good — for those with access to it. It is a nightmare for the uninsured, the chronically ill, the uninsurable, or the insured who don't "choose" the right plan, or who can't collect on the one that they or their employer *did* choose. It is unfair, arbitrary, rationed.

Despite President Clinton's prodding, the 103rd Congress did nothing — *nothing* — to reform the delivery of health care. Some members of Congress are proud of that. Of course: All 535 of them have cheap, full, copious medical insurance. But what of the 39 million Americans who have none, and the majority who don't know what coverage they'll have, for how much, or for how long?

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Employee Health Benefits May Be Fine, But Look at What Some Executives Get

By George Anders
Staff Reporter of The Wall Street Journal

Does the boss deserve extra medical insurance?

Labor unions say no. Some bigger companies are retreating from the use of such perks. And if certain congressional Democrats had their way, they would ban two-tier health plans that provide special benefits for the corporate brass.

But many small and midsize businesses are pushing ahead anyway. "Executive health plans" are catching on at restaurant chains, supermarket companies and a host of other companies. With the collapse of federal health-reform efforts, these companies are pursuing their own notion of reform: better benefits for top management.

Such deluxe health plans, which have existed in some form for at least 15 years, amount to an escape from the copayments, deductibles and limits on physician choice that rank-and-file employees frequently face. The handful of executives who get this extra coverage can see any doctor they want and get reimbursed for every dollar of most medical bills.

"This area has really taken off," says Fred Thurston, director of specialty markets for Boston Mutual Life Insurance Co. His company began selling executive health plans just two years ago but already has more than 920 corporate customers, chiefly smaller businesses. Part of the reason: Cutbacks have made regular corporate health plans too spartan for some top managers' tastes.

Booking even more business is Guarantee Mutual Life Co. of Omaha, Neb., which has offered executive health plans since 1980. The insurer says its deluxe product, Exec-U-Care, provides extra health coverage for top managers at some 2,500 companies. "We get new companies every week," says Exec-U-Care sales representative Kelly Yoder.

Unlike most medical-insurance packages, executive health plans set out to cover only a small fraction of the work force. Exec-U-Care promotes its service under the slogan: "For you and your executives who deserve more."

HEALTH

Such elitism galls union officials. "I don't think management ought to get a better health-care package," says John Zalusky, a top economist at the AFL-CIO. "I don't think their health is any more valuable than the health of a worker. We in the labor movement are expected to make concessions on our health-care benefits. To the extent that top management gets an additional benefit, that's very offensive."

But companies opting for executive health plans say that, in some fashion, the boss's health does matter more. "Our executives are very busy people," says Tom Gathers, vice president for human resources at Uno Restaurant Corp., an operator of pizza restaurants based in West Roxbury, Mass. "They've tended to ignore their own health. Obviously, for continuity and for good business, you want people to be healthy."

Milan Trenc

Mr. Gathers says Uno cares about all its employees' health. But it does the most for the top brass. Most Uno employees choose a preferred-provider health plan, which lets them see certain doctors at very low cost but requires them to pay extra if they want to go outside that network. Senior managers pay nothing for doctors' visits, regardless of whom they see.

At Food Lion Inc., an executive health plan "helps us in recruiting and retaining senior management," says Ronnie Smith, head of employee benefits. In particular, he says, it makes it easier for the Salisbury, N.C., grocery-store chain to attract executives from other industries.

Food Lion's executive health plan covers 65 vice presidents and other top executives, as well as their family members. The Food Lion plan pays as much as $750 per person for what would otherwise be out-of-pocket medical expenses; rank-and-file employees choosing a standard indemnity plan must pay a $200 deductible on their medical claims and 20% of additional costs, up to a $1,500 maximum.

A Food Lion spokesman says the company's basic health plan is "one of the best, most competitive benefits packages in the industry." He adds that the extra executive plan is "what's necessary to remain competitive."

The largest U.S. companies, meanwhile, frequently pay for annual physical exams of top managers but otherwise appear to be cutting back their use of executive health plans. In a survey this year of large companies, the benefits-consulting firm of William M. Mercer Inc. found that 65% offer executive physicals—a rate that essentially has held steady since 1990.

And in its latest survey of 1,385 companies, Mercer found that just 17% offered completely reimbursable health insurance to top management. That's down from 21% in 1989.

Walt Disney Co., which has offered an executive health plan since 1976, now finds that the program is a sore spot in labor talks. The entertainment company is seeking to trim medical costs for workers at its Florida parks; the Service Employees International Union, which represents Disney workers, is protesting.

One target of union ire is Disney Chairman Michael Eisner, who gets extra health benefits and has been among the top-paid U.S. executives in recent years. "He made enough money to pay for health insurance for all of Walt Disney employees world-wide," asserts Michael Duffy, deputy director of Local 362 of the SEIU.

A Disney spokesman responds that the standard Disney health package is "an excellent program." He adds that the executive health plan "frees people from the administrative duties of selecting from a menu of insurance choices. That's time that they don't have to be distracted from the job."

Because of situations such as Disney, benefits consultants say executive health plans aren't attracting as much interest among giant corporations. "When companies are asking their workers to shoulder more of the burden of health care, there's a perception that it isn't fair if everyone doesn't join in," says Eric Scoones, a Mercer consultant.

Such thinking, in fact, helped shape provisions of various Democrat-sponsored health bills, including a bill introduced last summer by House Majority Leader Richard Gephardt. That bill, which never came to a vote, would have required employers to offer the same cost-sharing arrangements to all workers.

But insurers still see bright sales prospects with smaller companies – at which top management usually faces less public scrutiny. "As long as the rules don't change, we should be in good shape," says Boston Mutual's Mr. Thurston.

TUESDAY, OCTOBER 25, 1994

THE WALL STREET JOURNAL.

Research Grants Given to 42 Firms By the Government

By Helene Cooper
Staff Reporter of The Wall Street Journal

WASHINGTON – Forty-two companies will share $170 million in research-and-development money as part of a government program to encourage technology research.

The awards were hailed by the Commerce Department as the Clinton administration's "most important civilian technology initiative to stimulate economic growth and job creation through the development of new industries." They went to companies involved in health care, software systems and computer integrated manufacturing for the electronics industry.

Companies receiving the government funds must put up matching funds of their own to develop technology that can form the basis for new products and manufacturing processes. Commerce Secretary Ron Brown said. The government has been making such grants since 1990.

Mr. Brown, like other cabinet secretaries yesterday, used the press briefing on the technology awards to hype what the administration is calling its economic-success story: deficit reduction. Pointing to a chart that he said showed that the budget deficit under President Clinton has showed the largest two-year drop in American history, Mr. Brown said, "The fact is, the economy is back on track."

The Commerce Department received about 130 proposals from companies for the awards, a spokesman said. Arati Prabhakar, director of the department's National Institute of Standards and Technology, said a new batch of awards will be announced soon.

The largest award – $31.5 million – went to a joint venture between Affymetrix Inc. and Molecular Dynamics Inc., both of Santa Clara, Calif., which are developing a device that will diagnose diseases by analyzing a patient's DNA on the surface of a silicon microchip that is read by a laser scanner. The C. Everett Koop Institute received $14.7 million for a project to help the health-care industry re-engineer itself to best take advantage of the information superhighway.

A New Rice Could Raise Yields 20%

Scientists See Plant Available in 5 Years

By KEITH SCHNEIDER

After five years of work, plant scientists from the International Rice Research Institute in the Philippines said yesterday that they had developed a new type of rice that would increase harvests 20 to 25 percent.

After the new variety is commercially available, probably in five years, it will eventually yield enough to feed 500 million more people than current rice yields, said Dr. Ken S. Fischer, the institute's director of research.

The world's population, now estimated at 5.5 billion, is expected to reach 8.3 billion by 2025, according to the World Bank.

But an American rice breeder cautioned that the results were preliminary and that it would be years before the new plant would be introduced widely.

The announcement of the development of a new high-yielding rice plant was made at an international agricultural research meeting at the World Bank in Washington.

Lester R. Brown, president of the Worldwatch Institute in Washington and an authority on world grain production, said the demand for rice in Asia in the next 35 years would double as the population soared. In the same period, though, the amount of land devoted to growing rice is likely to shrink considerably, he said.

From 1990 to 1994, he said, the area cultivated for rice in China decreased 2 percent as paddies were drained for new factories and other buildings.

"The thing to keep in mind is that as acreage declined 2 percent, yields only increased 2 percent," Mr. Brown said. "So you have a wash in China. Production has been unchanged for the last four years. That is why any advance in yields of 20 to 25 percent is so exciting."

But several American plant breeders were more cautious. "There may be a little bit of hype associated with this," said Dr. Kent McKenzie, a plant breeder with the Rice Experiment Station, a farmer-supported research center in Biggs, Calif. "It's a huge yield increase, but there are all kinds of ways to get those statistics. I would be a little guarded in my evaluation of that increase."

The new variety was developed by a team headed by Gurdev S. Khush, a plant breeder who has helped produce more than 300 varieties of rice during his 27-year career at the International Rice Research Center, the world's leading rice breeding center, in Los Banos, about 45 miles southeast of Manila. Mr. Khush joined computer technology with classical plant breeding and designed an entirely new kind of rice plant, Dr. Fischer said.

Rice is a willowy, graceful plant almost like a bouquet of long grasses. Most modern rice plants have roughly 25 stems, called tillers. Only about 15 of the tillers produce the seed-bearing flowers, known as panicles, and the number of rice grains in each panicle is generally about 100.

Mr. Khush's team studied rice plants on computers. The team determined that the best way to produce more grain was to direct most of the plant's energy to developing panicles by reducing the energy devoted to producing tillers. Mr. Khush searched the institute's collection of rice and selected plants that had fewer tillers, more grains in their panicles and stronger roots.

He crossed the varieties and stabilized the traits he wanted to keep. Last spring enough seeds were available to test the new plant, called "super rice" by the research center, in small plots. Mr. Fischer said the tests were a success. The new variety has about eight tillers, each of which produces a panicle that is filled with almost 200 grains.

The increased yield is a result of being able to put more of the new plants on the same amount of land.

Mr. Fischer said it would probably take five more years for Mr. Khush's team to breed into the new variety other valuable commercial traits like natural defenses against diseases and insects. Sometime around the turn of the century the "super rice" will be ready to introduce to Asian farmers, he said.

In Asia, rice is the most important food crop. According to the Department of Agriculture, the world's farmers will harvest 521 million metric tons of rice this year, double what was harvested in 1966. China, with 1.2 billion people, is expected to harvest 174 million metric tons and is the world's largest producer.

The institute's work is unlikely to affect the American harvest very much, said J. Neil Rutger, a rice geneticist with the Department of Agriculture's research station in Stuttgart, Ark. The United States will harvest 8.7 million metric tons of rice this year. Most of it is intended for export or aimed at American consumers who prefer fluffier varieties than those grown in Asia.

Social Health Is Improving, A Study Says

Slight Gain Is Found After a 3-Year Drop

After three consecutive years of decline, the nation's social health is improving again, social scientists at Fordham University announced today in an annual report.

But the researchers report that the social well-being of the nation is still at one of its lowest points in 23 years.

The report, titled "The Index of Social Health," seeks to measure the nation's progress in addressing major social problems by analyzing 16 social issues ranging from infant mortality to out-of-pocket health costs for the elderly.

Researchers used a computer model and data gleaned from various Federal agencies, including the Census Bureau, to reduce the nation's social health to a single figure ranging from 0 to 100, which they call the social health index.

The first report, published in 1986, measured social health retrospectively for the year 1970 and gave it a ranking of 73.6. As of 1992, the latest year for which data were available, Fordham's index stood at 40.6.

While that is 45 percent lower than the 1970 figure, it represents an improvement over the 1990 and 1991 rankings, which were 39.4 and 38.8.

It's too early to ... upswing, but an increase is certainly better than a decline," said Dr. Marc L. Miringoff, the author of the study and the director of the Fordham Institute for Innovation in Social Policy in Tarrytown, N.Y. "Now the question is, will it continue?"

The latest report was the first since 1987 to find 7 of the 16 individual indicator problems improving in a single year: infant mortality, teenage suicide, high school dropout rates, drug abuse, homicide, food stamp coverage and access to affordable housing.

The problems that worsened were child abuse, unemployment, health insurance coverage, average weekly earnings, poverty among the elderly, health costs for the elderly and the gap between the rich and the poor.

Two problems remained the same: traffic deaths and the number of children being raised in poverty.

Dr. Miringoff offered two explanations for the improved index. For the first time since 1970, three teen-age social problems — high school dropout rates, suicide and drug abuse — all improved.

In addition, he said, the social index often rises during Presidential election years.

"We've only had an upswing eight times, and five were in election years," Dr. Miringoff said. "In an election year there is an increase in funding, which seems to confirm the fact that spending does make a difference."

This year the report included a special section that took a closer look at poverty trends among children and the elderly.

Poverty among children has worsened significantly since 1970, with 21 percent of the nation's children living under the poverty line in 1992, the highest level in nine years.

Among the elderly, the trend is more encouraging, with 13 percent of those over the age of 65 living in poverty, a drop of nearly 50 percent since 1970, when the rate was 25 percent.

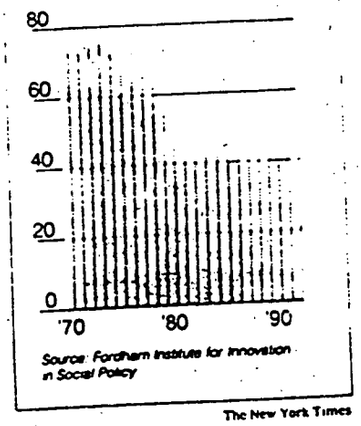
Dr. Miringoff said the report was the social equivalent to economic indicators like the Consumer Price Index.

"We have nothing like that on the social sphere," he said. "In other words, bells don't go off when the children living below the poverty level goes above 20 percent, which it is. But we really pay a lot of attention when housing starts increase 1 percent."

HEALTH

Social Health Index

The social health of the nation has risen slightly from 1991 to 1992, but is still relatively low compared to the 1970's. The index gauges the nation's performance in addressing 16 social problems, including those in poverty.



The New York Times

THE NEW YORK TIMES, MONDAY, OCTOBER 24, 1994

Federal Officials React Cautiously To State Pleas for Medicaid Relief

Concern About Budget Deficit Tempers Impulse to Be Generous

By Dan Morgan
Washington Post Staff Writer

On a trip to New York Wednesday, President Clinton tried to give Gov. Mario M. Cuomo (D) a political boost by promising to work with him to ease the "unfair" formula for allocating federal Medicaid funds to the state.

At almost the same time, officials at the Department of Health and Human Services in Washington were taking a harder line with representatives from California, who had flown across the country to plead for the release of $315 million in disputed federal payments.

The events illustrated the conflicting political and fiscal forces on the Clinton administration as it responds to powerful pressures welling up from the states for federal relief from the skyrocketing costs of Medicaid.

As Medicaid's share of state budgets has risen—from 9 percent in 1980 to 18.4 percent in 1993—governors around the nation have been clamoring for help, often taking their case directly to the White House.

President Clinton, who while governor of Arkansas often clashed with the Medicaid bureaucracy in Washington, has given instructions for his administration to do what it can to relieve the burden on the states of the $140 billion-a-year health program for the poor. Under the often-ambiguous Medicaid regulations, the president has considerable leeway to make concessions.

But any impulse for generosity is offset by constraints imposed by the federal budget deficit. Officials in the Office of Management and Budget scrutinize every change in Medicaid, and the administration is drafting a 1996 budget that includes proposals for savings in the rapidly growing program.

Concerns about the deficit have caused administration officials to move cautiously on a flurry of requests from states to use the Medicaid program as the main building block of comprehensive health care reform, according to federal and state sources.

Ohio, South Carolina, Massachusetts, Missouri, New Hampshire, Minnesota, Delaware and Illinois have applied to the Clinton administration for five-year waivers of Medicaid law allowing them to proceed in this way. Additional applications are expected soon from Utah, Washington, Texas, Oklahoma, Georgia and Louisiana, officials said.

Most of these proposals call for managed care companies to take over statewide medical assistance programs for the poor—and, in some cases, the elderly. The anticipated savings would be used to subsidize health insurance policies for hundreds of thousands of residents not currently covered by Medicaid.

In effect, the Clinton administration, using Medicaid, can approve what amounts to sweeping health reform without asking permission from Congress. But federal officials have insisted that they will approve these state plans only if they cost the federal government no more than it would spend under the traditional Medicaid program.

The federal government pays about 57 percent of the total costs of Medicaid, with the states paying the rest. Therefore, the federal government could be liable if there are cost overruns.

In closed-door negotiations, federal analysts reportedly have challenged the "budget neutrality" of some state proposals.

In September, the administration gave a green light to Florida Gov. Lawton Chiles (D) to launch a Medicaid experiment aimed at securing health coverage for 1.1 million of the state's uninsured. Although the experiment is part of a broad health reform, it is also considered essential for getting Florida's health care budget under control.

But during the last few weeks, Ohio Gov. George V. Voinovich, a Republican, has complained to Health and Human Services Secretary Donna E. Shalala and Carol Rasco, top White House domestic policy adviser, that the administration has been dragging its feet on his request for a similar authorization. The plan would extend health insurance coverage to some 400,000 Ohioans who now have none, and would put limits on the growth of state Medicaid expenditures.

State officials acknowledged yesterday that the "budget neutrality" of the Ohio plan had been one snag in the negotiations, and said that the delays appeared to be more bureaucratic and technical than political.

There are also questions about the budgetary impact of Clinton's proposal for helping New York state. A 1993 study by the General Accounting Office concluded that it could cost the federal government up to $900 million a year to provide New York state with the relief it wants.

A state's share of its total Medicaid costs can range from 20 percent to 50 percent of the total costs, depending on its average per capita income. New York—along with the District of Columbia, Maryland and Virginia and a handful of other jurisdictions—pays 50 percent of its Medicaid costs. Louisiana, Mississippi and Arkansas pay less than 30 percent.

New York officials argue that the formula is unfair because it does not reflect the state's disproportionately high percentage of poor residents, or the high taxes it levies to finance generous social benefits.

On a campaign foray into New York Wednesday, Clinton declared: "I am convinced now that the Medicaid formula is unfair to you. I will work with Gov. Cuomo, Mayor Rudy Giuliani (R) and others. We will work through this. It's not going to be easy."

However, Congress would have to approve a change in the present formula. That seems unlikely unless states scheduled to lose out under a new formula were protected. If a few states got more federal money, but none got less, it could cost the U.S. Treasury an additional $2 billion a year, according to GAO.

California's attempt to draw more federal Medicaid dollars centers on recent claims that Health Care Financing Administration officials contend inflate the state and local administrative costs of running the program, of which Washington pays half.

In an Oct. 7 letter to state officials, the acting HCFA administrator in San Francisco said that Los Angeles County had included outreach work with drug offenders by Los Angeles County juvenile probation officers and deputy sheriffs as administrative costs of the local Medicaid program.

The letter also cited possible "duplicate" claims, involving administrative costs that were supposed to be covered in the fees paid by Medicaid for clinical services. HCFA said California must provide better documentation.

John Rodriguez, a senior state health official, stood by the claim. He said Los Angeles County health officials told HCFA administrator Bruce Vladeck last week that denial of the funds could result in the closing of one or more public hospitals.

"We think these charges are legitimate and we're prepared to document them," Rodriguez said.

THE WASHINGTON POST
SUNDAY, OCTOBER 23, 1994

Defying Omens, Health Care Drops From Campaign Stage

By ADAM CLYMER
Special to The New York Times

WASHINGTON, Oct. 21 — Health care legislation, which dominated Capitol Hill for most of the year, is playing only a tiny role in this year's Congressional elections.

A few candidates discuss the issue in campaign appearances, usually if they played major roles in the unsuccessful effort to get a bill passed, and occasionally if their opponents did.

But right now there appears to be only one television advertisement on the air committing a candidate to fight for national health insurance legislation next year. And that comes from Senator Edward M. Kennedy, Democrat of Massachusetts, who has been fighting for such legislation since 1970.

The issue had loomed as potentially decisive in this year's elections. But just as it proved too complicated for Congress to vote on, political consultants seem to think it is too complex for the electorate to measure. With other issues dominating the airwaves because they seem easier to draw contrasts with, it does not seem that either Democrats or Republicans are being blamed for legislative failure on health care.

Representative Vic Fazio of California, the chairman of the Democratic Congressional Campaign Committee, told his colleagues in June that health care is the make-or-break issue, the centerpiece of Congressional activity," and a vital tool for the election. But Mr. Fazio conceded this week that he had been proved wrong, that health care was not crucial this fall because "we never got the message out."

The Democratic hope was that passing health care legislation would be popular with voters, and that even if legislation was defeated or filibustered, the party could attack Republicans as obstructionists. But Democrats never united behind a plan of their own and could not force a confrontation.

William Kristol, the Republican analyst who spent the spring and summer telling Republicans not to worry about appearing as "obstructionists," said "the issue is so far off the map that our guys are not being pressed on what they are for." While the public used to prefer Democrats over Republicans on health care by a wide margin, Mr. Kristol said the Clinton plan had failed so badly that it "took off the table probably the Democrats' best issue."

Richard B. Wirthlin, a Republican pollster, said today that his surveys showed that health care legislation remained a salient issue, cited as the most important problem by 11 percent of the public. But he said it was not being talked about much in this campaign.

"Politics is a game of differentiating yourself from your opponent," Mr. Wirthlin said. "The issue became so convoluted and mixed in the closing days of Congress that it's hard to draw a clear-cut line" between candidates.

For a few members of Congress, that line is clear. Senator Harris Wofford, the Pennsylvania Democrat who brought the issue to political center stage when he won a special election in 1991, has used a television advertisement that said: "Harris Wofford forced health care to the top of the nation's agenda. It is not being ignored any more."

And while Mr. Wofford's Republican opponent, Representative Rick Santorum, labels him a failure for supporting a flawed and unsuccessful Clinton proposal, Mr. Wofford hits back by saying Mr. Santorum wants to cut Medicare and offer the elderly nothing in return.

One of the few Republican candidates who brings up this year's health care experience in a positive way is Senator John H. Chafee of Rhode Island. He headed a bipartisan group of moderates who tried to forge a compromise bill that would have used subsidies and changes in insurance law to expand coverage without actually requiring individuals or employers to buy it.

The effort stalled in the face of a threatened Republican filibuster, but Mr. Chafee tells voters that it was "an example of the Senate working at its best, a bipartisan coalition working hard to find common ground."

Senator Dianne Feinstein, the California Democrat in a close race for re-election, also cites her work in that coalition, stressing its thwarted hopes for cooperation. But William A. Carrick, the Los Angeles consultant who is producing Ms. Feinstein's television commercials, said he did not use the issue on the air because the combination of "crime, the economy and immigration suffocates everything else."

The fact that neither the House nor the Senate even voted on health care makes it harder to label an incumbent. But Representatives Pat Williams of Montana and Peter Hoagland of Nebraska, Democrats who supported variants of the Clinton legislation in House committees, are targets of similar advertisements accusing them of trying to "socialize our health care industry."

Mr. Kennedy's opponent, Mitt Romney, fired a comparable blast a few weeks ago, with an advertisement that maintained that he and the Senator both wanted every American to have insurance, but "I want to fix the existing system with specific reforms, not a big government takeover."

Mr. Romney, a venture capitalist, said the biggest difference between him and Mr. Kennedy was that "I don't want the Federal Government making decisions for my family and yours."

Mr. Kennedy's advertisement, which parallels the pledges he makes on the stump, promises, "If he is re-elected, he will lead the fight for health insurance for all." It criticizes Mr. Romney for not providing health insurance for his workers and opposing any requirement that employers buy coverage, and it concludes with a warning about Mr. Romney: "In the Senate, he would be one more vote for the Republicans trying to block health care."

Massachusetts is a state where politicians believe that voters care about health care legislation. For instance, Representative Peter I. Blute of Shrewsbury, one of the most endangered Republican freshmen in the country, has a radio spot that depicts him as an agent of change, "keeping the heat on Congress" to make "necessary improvements" in health care, but without sacrificing quality or choice.

As the Congressional debate on health care legislation ground to a halt last month, many Republicans urged delay. Senator Bob Dole of Kansas, the Republican leader, said "the American people will speak again on Nov. 8, and they will give us further guidance as to whether we should pursue health care reform that calls for more government control, or reform that preserves quality, choice and jobs, and addresses issues of choice."

But with health care hardly heard on the airwaves or the hustings, that guidance will probably amount to whatever the winners in November think it should say.

Most candidates are ignoring health care in their advertisements.

CLINTON STEPS INTO VIRGINIA RACE

President Clinton took a campaign jab at Oliver L. North, and later Mr. North's opponent, Senator Charles Robb, got the backing of his old rival L. Douglas Wilder. *Page 9.*

THE NEW YORK TIMES, SATURDAY, OCTOBER 22, 1994

The worst health care in the nation

By Merrill Matthews Jr.

The health care service we provide to America's veterans is a national disgrace. Our veterans deserve better, and we can provide better for them.

The Veterans Administration runs the biggest — and least efficient — hospital system in the country. In 1992 it spent $15 billion to serve 2.7 million patients in 171 hospitals and 128 nursing homes. That works out to about $5,556 per person, as compared to $1,675 per person in the private market, $3,790 per person on Medicare (Parts A and B) and $3,821 per person on Medicaid in that same year.

Are our veterans getting our money's worth? By all accounts, the answer is a resounding no.

In 1993, the General Accounting Office did a survey of VA outpatient care. The survey pointed out that:

- Veterans with non-urgent conditions frequently wait one to three hours or longer before seeing a physician.
- Veterans generally wait eight to nine weeks for appointments to specialty clinics.

The system is so bad that about 90 percent of the veterans who could access the VA system choose not to. Instead they rely on other sources for health insurance and health care. Moreover, of those who receive VA health care, only 45 percent actually have service-related medical conditions.

For the most part, those who haven't opted out of the system can't opt out. In most cases they are either too sick or too poor. When it is virtually free to the patient, even poor quality health care and waiting lines are better than no health care.

Why does this system continue?

Merrill Matthews Jr., is the health policy director of the National Center for Policy Analysis in Dallas.

Pork. The VA has 268,000 employees, not to mention 400 lawyers. Getting the VA to build a hospital in one's district is a sure vote-getter for a congressman. VA hospitals are about money and jobs — not quality health care.

Of course, while many in Congress have been working to expand the VA system, most recognize that the VA is in trouble. The Clinton administration, for example, proposed bringing competition into the system by making VA health care providers compete with other providers for veterans' health care needs. But huge, bureaucratic systems established to provide jobs are hopelessly uncompetitive. They cannot compete against health care systems that can restructure, remove employees and stress efficiency.

The system is so bad that about 90 percent of the veterans who could access the VA system choose not to. Instead they rely on other sources for health insurance and health care.

In another attempt at reform, Rep. Roy Rowland, Democrat of Georgia, the only physician in Congress, introduced the "Veterans Health Care Pilot Program Act of 1994" which would bring veterans under the wing of state reform plans.

The question we really need to be asking, however, is not what is best for the VA system, but what is best for our veterans?

When Congress decided to give veterans the opportunity for a government-subsidized education when they left the service, Congress did not create a VA college system that would compete with private and public colleges. Rather Congress created the GI Bill, which permitted veterans to choose the type of college or vocational school they wanted to attend. Our colleges are better for the competition the GI Bill created, and our veterans received a quality education with the same choices available to them that the rest of the country had.

What we need is not more VA hospitals, but a GI Health Care Bill. A GI Health Care Bill would provide veterans with a voucher that could be used to purchase a traditional health insurance policy, a high deductible policy or membership in a health maintenance organization (HMO). This provision would give veterans the same choices that those with private health insurance have.

If veterans choose the high-deductible option, they should have the opportunity to put the premium savings into a Medical Savings Account (MSA), a personal tax-free account that would, if passed by Congress, permit people to set aside money for smaller health care expenditures not used on health insurance premiums.

Those veterans who have medical conditions that would preclude them from standard health insurance could be enrolled in a state high risk pool or allowed to join the Federal Employees Health Benefits Program (FEHBP), the health insurance plan that covers some 9 million federal employees (including all members of Congress) and their dependents. The federal government could, in fact, pay the entire premium for these veterans for a whole lot less than the $5,500 per person it currently spends.

With these options, American veterans would have the same choices as everyone else with standard health insurance. Our politicians would have one less pork barrel to empty. And, best of all, our veterans would not be forced to accept sub-standard health care. For having served our country so well, they deserve better.

Health care next time

Donna Shalala went off-message yesterday, undermining the Democrats' theme that public dissatisfaction with Washington should be blamed on rabid conservative radio talk-show hosts poisoning the airwaves.

Travelling around the country, Miss Shalala said she discovered why the president's health care legislation collapsed: "a very anti-government feeling that government can't get anything right." The secretary of Health and Human Services admitted that public anger was based on real experiences with government, federal, state and local, and not just "something that some talk-show host had fed" them. "With all of our good intentions," Miss Shalala said, "we walked right into that with health care reform."

Kudos to Miss Shalala for having the rare courage to state the obvious. But the kudos do not extend to the secretary's comments on the future of ClintonCare. Even though Miss Shalala claimed to recognize the valid animosity of an electorate scared off by socialized medicine, she did not back away from the fundamental details of the Clinton approach. "We have to lay out for the president some options that will get where he wants to get, but not necessarily with the same road map that we used before," Miss Shalala said.

Where the president wants to get is to a system that has expanded coverage for the poor. To do this, Miss Shalala suggests a less radical approach than a wholesale federal takeover of medicine, such as "using cigarette tax money and anything else you can scare up to extend the Medicaid program."

"We're going to try to be shrewder and more strategic about what things need to be done first," said Miss Shalala. Instead of Hillary Clinton's secretive task force with its monumental, 1,342-page celebration of government control, the secretary said the public "would like [health reform] to be in stages and see what the implications are of each piece as we move along."

The secretary's nascent strategy reveals that Miss Shalala may not have learned as much as she thinks from her travels. The problem with the Clinton plan was not just the way it was presented: The president's troubles were fundamentally about the substance of his plan. Repackaging the same tired and rejected ideas about health reform won't do the trick. The public doesn't want ClintonCare in bits and pieces. It just doesn't want ClintonCare.

President Clinton succeeded in appealing to middle-class voters during the 1992 campaign in part by promising that health care reform would keep their insurance costs down and protect them against insurance cancellation. But once in office, the idea of savings for the middle class evaporated in the rush to find financing for the great expansion of benefits envisioned by Hillary Clinton and Ira Magaziner. Even if a new reform plan is wrapped in soothing incrementalism, the public will be loath to embrace it as long as it entails higher costs and burgeoning welfare spending.

Washington has long thought that voters are like dogs and children — that they will swallow any unpleasant pill that has been hidden in the middle of some tasty snack. Voters don't like to be treated like children, which is one reason their mood has turned so surly. Finding new confections to hide the medicine in will not put smiles on the electorate's faces. They have figured out that the doctor is a quack, and his prescriptions are worse than the disease.

FRIDAY, OCTOBER 21, 1994 **The Washington Times**

F. Carter Smith for The New York Times

Presidential Ground Breaking

Former Presidents George Bush, left, and Gerald R. Ford, right, helped James A. Baker 3d break ground yesterday for the James A. Baker 3d Institute for Public Policy at Rice University in Houston. Mr. Baker was Mr. Bush's Treasury Secretary and chief of staff.

Study Says 1 in 5 Americans Suffers From Chronic Pain

By GINA KOLATA

Nearly one in five American adults suffers from pain that has lasted at least six months and led them to seek a doctor's help, a new study shows. In many cases, despite the doctor's care, the pain remained.

The findings are part of a national pain survey, conducted by Louis Harris & Associates and released yesterday by the American Medical Association.

In the survey, randomly selected adult Americans were asked about chronic pain. The interviewers questioned people until they had found 1,000 who had suffered for at least six months from migraine headaches, arthritis pain, lower back pain or nerve pain and who had visited a doctor seeking relief. To find those 1,000 people, the interviewers had to survey nearly 5,000, leading them to estimate that 17 percent of Americans, or 34 million people, have chronic pain.

People in pain reported that they were often unable to sleep, that they were less effective at work and that their relationships with friends and family suffered. Forty-four percent also said their doctors were unable to help.

The investigators questioned 400 doctors about how they treated chronic pain and found that most were dissatisfied with the drugs available to pain sufferers.

The medical association sought comment on the findings from David E. Joranson, a director of the World Health Organization Collaborating Center for Symptom Evaluation in Cancer Care, at the University of Wisconsin. He said in a telephone interview that it was "startling to learn that chronic pain is suffered by so many with such devastating effects."

"It is tragic that almost half are not getting good pain relief," Mr. Joranson said. "This should lead us into looking seriously why this is occurring."

Experts who spoke at the medical association's briefing yesterday said doctors often treated diseases but ignored pain, being reluctant to look into the psychological as well as physical reasons many complain of all-consuming pain.

Yet while doctors are quick to give prescription drugs for diseases, these experts said, they too often hold back on providing pain relief medication that patients may need. And patients often are afraid to take such drugs, even if their doctors suggest them.

The survey showed that doctors and patients worried about side effects of aspirin-like drugs, which could cause gastrointestinal bleeding. Even more frightening to most doctors and patients were narcotics, including drugs with codeine, which many feared would lead to addiction.

The result, Mr. Joranson said, is that patients are in "an analgesic dilemma, caught between a desire for better pain relief and concern about side effects."

But Mr. Joranson and others say that concerns about becoming addicted to narcotics are unfounded. People who take narcotics may become physically dependent on them, he said, but that is not the same as addiction. Addiction "is a behavioral disorder characterized by the non-

Doctors treat disease but may be reluctant to treat pain.

medical uses of drugs," Mr. Joranson said. "It has to do with the compulsive seeking of drugs for nonmedical effects."

Dr. John D. Loeser, who directs the multidisciplinary pain center at the University of Washington. stressed that narcotics were only a partial answer to the difficult problem of treating chronic pain. The real issue is whether you can "make people better," he said. "Can you get them to say, 'My pain is gone. I'm going back to work?' "

Very few, probably no more than 10 percent, will respond this way. Many still complain of being disabled by pain and "continue to go doctor shopping," Dr. Loeser said.

Dr. Peter Vicente, a psychologist at Good Samaritan Hospital in Cincinnati, said there was a confusion between pain and suffering and that suffering could result from depression, stress and personal losses. "For most chronic pain sufferers, 'pain' is, in fact, mislabeled suffering," he said.

Dr. Loeser added, "The question you always have to ask is, 'Is the unhappiness due to the message coming from their body, or are they listening to their body too much because of their unhappiness with the world around them?' "

LABOR UNIONS

2d Thoughts On the Backers Of Trade Bill

By RICHARD L. BERKE
Special to The New York Times

WASHINGTON, Oct. 20 — Only a year ago, labor leaders were threatening retribution against lawmakers who voted for the North American Free Trade Agreement. At the very least, they vowed to withhold support in this year's elections.

But the closeness of many campaigns has brought a change of heart: Unions are supporting candidates who opposed them on one of the most important labor-related votes before Congress in years.

Lane Kirkland, the president of the A.F.L.-C.I.O., said today that his organization, the largest labor confederation, had endorsed 59 House incumbents and 5 Senators who voted for the agreement.

In a meeting with reporters, Mr. Kirkland said that while the trade vote was crucial, it was not in labor's interest to reject candidates who were foes on a single issue.

"Writing somebody off and consigning him to outer darkness — even though his total record is pretty good — just because of one vote — does not strike me as prudent," Mr. Kirkland said. He insisted that the trade vote would remain "a negative mark" for lawmakers who backed the agreement, but that "it is capable of being outweighed by their positives."

Mr. Kirkland's position reflects the political climate: labor leaders are so worried about Democratic losses that they cannot afford to punish the party.

The five Senators who voted for the trade pact and were endorsed by the labor group, all Democrats, are Joseph I. Lieberman of Connecticut, Edward M. Kennedy of Massachusetts, Charles S. Robb of Virginia, Bob Kerrey of Nebraska and Jeff Bingaman of New Mexico.

Of the 59 House members who voted for the pact and were endorsed, all but three are Democrats. In all, the A.F.L.-C.I.O. endorsed 328 House candidates, 33 Senate candidates and 32 candidates for Governor. Of those, all but 10 are Democrats, reflecting what Mr. Kirkland said was an increasingly trend of the organization away from backing Republicans.

Republicans, he said, have been "moving further and further to the right" and "there are more ultraconservative candidates emerging in these races." He also expressed concern about "the role of the militant religious right."

Hospitals are fast becoming the last place to be if you want to get well

ASSOCIATED PRESS

NEW YORK — The quiet of the intensive care unit is disturbed only by the soft chatter of the staff and the hum of machines keeping people alive.

Some patients are on respirators, many barely able to move under the tangle of tubes and intravenous lines.

In this unit, at Columbia Presbyterian Medical Center, the patients are getting the best treatment medicine has to offer.

But they also could be facing risks. Hospitals are the cradle of the growing threat of bacteria resistant to antibiotics, and the sickest of patients now are the most vulnerable.

Five percent to 10 percent of all people get infections when they are hospitalized. Each surgical cut is a breach in the body's most important defense, the skin, and the sicker the patient, the more vulnerable the person is to infection.

Hospital-borne disease is a major contributing factor in 60,000 deaths each year, according to the federal Centers for Disease Control and Prevention. In many cases, bacteria and infection are the last push to death.

Bacteria lurk everywhere — on clothing, walls, blankets, medical equipment. Hospital workers can pass them on by hand. Some bacteria cling to plastic and travel up tubes inserted into the body.

So, doctors say, in the quest to treat cancer and AIDS and debilitating diseases, the weakest patients also are facing greater risks with the emergence of resistant bacteria in hospitals.

"The level of infection now is unacceptable," said Dr. Alexander Tomasz of New York's Rockefeller University. "We must have enforcement of infection control: nurses washing hands between patients, wearing and changing gloves.

"There are strict rules now, but the suspicion is they are not being followed."

Dr. Tomasz and Dr. Richard Roberts, chief of infectious diseases at New York Hospital-Cornell Medical Center, helped found the Bacterial Antibiotic Resistance Group.

The group wants the city's hospitals to help it track strains of bacteria that have developed resistance to at least some antibiotics — enterococcus, staphylcoccus and pneumococcus.

The group has the support of the city's Health Department, but its surveillance program is voluntary, and it's too soon to say if it will be successful.

Dr. Tomasz acknowledges that some hospitals may be reluctant to participate because disclosing problems with resistant bacteria could jeopardize their reputations.

In the Washington area, four hospitals asked about the problem also declined comment on how or whether they are coping with resistant bacteria.

But Dr. John Bartlett, chief of infectious diseases at the Johns Hopkins Medical Institutions in Baltimore, said the answer lies in "infection control policies," such as "more hand-washing" and "wearing gloves and gowns" when treating patients with such infections.

He said it's also important that medical devices used on patients infected with drug-resistant bacteria not be used on other patients until they've been sterilized. "For example, if you use a stethoscope, you should leave the stethoscope in that room and not take it with you," Dr. Bartlett said.

Such techniques, he said, are "very successful" in controlling the spread of such bacteria in hospital settings.

Dr. Tomasz and Dr. Roberts agree that what is needed in large part is a rededication to practices pioneered by Florence Nightingale: good hygiene and monitoring infectious diseases in hospitals.

"We must encourage people to wash their hands between patients. It's not done as well as it should be," Dr. Roberts said.

Hospitals also are trying to isolate patients with resistant bacteria by putting them in rooms by themselves, placing a tremendous strain on some facilities.

AP

Surgeons take every precaution against spreading bacteria. Hospital-borne disease is a factor in the deaths of 60,000 Americans annually.

"My understanding is that resistance is so prevalent in some places that they don't have enough rooms for these patients," Dr. Roberts said.

Kathleen Jakob, an infection-control specialist, instructs Columbia Presbyterian's staff about problems with resistant bacteria.

"This is an emerging problem that doctors and nurses didn't learn about in school," she said.

Her department examines bacteria from the lab to identify any patients with resistant bacteria. Nurses and doctors wear gowns, gloves and masks when treating a patient, then take off the gear before moving on. Medical equipment is specially cleaned and, in some cases, the hospital will limit the staff members allowed to treat the patient.

"In the future, somebody is going to find out that a hospital has a problem and sue," said Dr. Stuart B. Levy of Tufts University and the author of "The Antibiotic Paradox: How Miracle Drugs are Destroying the Miracle."

"I know hospitals that have problems, but I'm not going to identify them," he said. "The sooner somebody can get out of the hospital, the better. There are times when home is safer."

Until the 1920s, hospitals were known as crowded poorhouses of rampant disease and infection. Indeed, the middle class and wealthy were treated at home.

Resistant bacteria could give hospitals a bad name again and eventually make choosing a hospital a consumer issue — especially if superstrains of enterococcus, which are resistant to the typical last-resort antibiotic, vancomycin, share their DNA with other microbes. Bacteria are capable of this, and many doctors think it only a matter of time before staphylcoccus or pneumococcus pick up this shield.

Oct 20 1994 Thursday

JUDY MANN

Going for the Women's Vote

America's working women want health care for all and improved pay and benefits. Those were the top two concerns that came out of the U.S. Department of Labor's "Working Women Count" survey, which elicited pointed and often poignant responses from more than 250,000 women.

Stressed out? You're not alone. Feeling underappreciated and overworked? Join the crowd. There is, of course, nothing new in this. What's new is that a lot of busy women took the time to tell their government about their personal travails and the changes needed to alleviate them.

Most women said they liked their jobs. But many offered glimpses into lives filled with extraordinary stress. "Women have to work twice as hard to be recognized but still don't receive the same pay," wrote a 37-year-old woman from New Mexico who works 60 hours a week as a "manager."

"As the mother of two pre-schoolers, I'm the one that has to call in sick to work to take care of them. I have to lie and tell work that I'm sick. I think that's awful," wrote a 38-year-old professional from Massachusetts who works two jobs.

Half of the respondents cited the need for paid leave to take care of family illnesses as a top priority for change, rather than the unpaid leave that is mandated under the Family and Medical Leave Act. "Women are telling us that it is so hard to do this on our own, without any outside resources," says Karen Nussbaum, director of the Women's Bureau, which conducted the survey. One woman said her life is like trying to squeeze her feet into shoes that are two sizes too small.

Nussbaum noted that Labor Secretary Robert B. Reich has been warning employers that they can no longer afford to view workers as disposable, wringing them out and then replacing them. "This is what women are telling us in this survey as well."

President Clinton has directed Reich and Nussbaum to develop an initiative for addressing these concerns nationally by March 15. He has instructed the Office of Personnel Management to report on its efforts to make the federal government a family-friendly workplace by Jan. 15. Nussbaum said the administration will be reaching out to Congress and to the business community "to make sure solutions to these problems come from many quarters."

The fact that so many women responded to the questionnaire shows that there are still voters who believe the government can do something for them. On this point, the Australian Labor Party's experience ought to be instructive. Prime Minister Paul Keating was trailing more than 10 points among women 11 months before he stood for re-election in March 1993. He called on Anne Summers, a leading Australian journalist and feminist and former editor of Ms. Magazine, as a key political consultant to advise him on how to work with women. "The election was called unwinable," says Summers. But Keating was smart enough to listen to her, and to learn.

She asked focus groups of women what government had done for them, and their answer was "not much." Then she asked them what they were concerned about. "The response was overwhelming and completely unambiguous," she said. "The three top issues were child care, women's health and violence against women."

Keating's response was pragmatic. He promised to meet all demand for child care by the end of the century. He promised to introduce a rebate on the cost of child care, which is now in effect. "Women appreciated some relief and some recognition," said Summers.

Perhaps most significantly, he announced these initiatives as part of a major economic statement, recognizing that working women are an integral part of the economy. Keating also promised to send judges back to school for gender equity training, which he has done.

Keating won and the Australian media have given Summers much of the credit for boosting his standing among women. He knows how to say thank you. This month the Labor Party voted to require that 35 percent of its parliamentary seats must be held by women by the year 2002, tripling the seats women currently hold.

"We adopted a policy response to a political problem," says Summers, "rather than kissing babies or doing gimmicks in shopping malls. We found out where women thought the government was falling short and tried to address that."

The Working Women Counts survey has given Clinton a clear message on what women need. As the administration prepares to face the electorate again, its response needs to be loud, unambiguous and pragmatic. In the world of electoral politics, working women do, indeed, count.

THE FEDERAL DIARY

Full-Price Benefits

By Mike Causey
Washington Post Staff Writer

Although they pay much more than federal workers and retirees, thousands of people employed outside the government are covered by the Federal Employees Health Benefits Program. Many other non-feds are eager to join.

President Clinton's original national health insurance plan would have abolished the FEHBP and rolled federal workers and retirees into regional health alliances. The White House said they would get more coverage and pay less. Critics said federal workers would get less and pay more.

Faced with the prospect of a change, those who had been lukewarm about their insurance suddenly learned to love it. A recent survey showed better than eight in 10 federal employees were happy with their coverage.

The program covers about half the people in the Washington area and is considered one of the nation's best. Participants pay less than 30 percent of the total premium, can switch plans yearly without regard to age or preexisting medical conditions and can keep full coverage in retirement.

But thousands of non-feds, mostly ex-spouses of federal workers or retirees, also are in the FEHBP. Depending on the terms of their divorce decrees, they can be covered anywhere from 36 months to life.

Children of federal workers or retirees can stay in the FEHBP for 36 months after their 22nd birthday (when they lose their status as dependents), and workers who quit the government can stay in the health program for 18 months.

All of the above members, however, must pay the full premium for the health plan. For many ex-feds, who are accustomed to the government paying an average of 72 percent of the total premium, that can be a financial jolt. But even when paying the full premium—the employee and government shares—the enrollees still get the benefit of the overall group rate, and in most cases they get better coverage at less cost than if they bought a nearly identical plan as an individual rather than as part of the federal family.

Federal workers who are enrolled in the Blue Cross-Blue Shield self-only single-option plan next year will pay $20.00 and the government will pay $61 every two weeks for coverage. Those workers in the family plan will pay $47.15 and the government will pay $134.18 every two weeks for their coverage. But individuals outside the federal government enrolled in the plan will have to pay both the employee and government shares.

Federal retirees in the popular GEHA plan, who pay their premiums monthly rather than biweekly, will pay only $51.81 a month for the single-option coverage; the government will pay $132.99. The ex-spouse, independent child or ex-employee buying the same plan will pay $184.80 a month.

Workers who choose health maintenance organizations because of their generally lower premiums and minimal paperwork also get a tremendous price break—thanks to the government contribution—that isn't available to former spouses, ex-employees and others who pay the full premium.

For example, the HealthPlus self-only standard plan next year will cost a worker only $14.96 biweekly (a decrease of $1.14), and the standard family plan will be $35.21 biweekly (a decrease of $2.67 from this year's premium). But those paying the full freight for those plans will pay $59.92 biweekly for the self-only coverage and $140.83 biweekly for the standard family plan.

$720 Transit Perk

Uncle Sam is now buying Metro Farecards or paying the bus or commuter train fare for thousands of government workers here. Some agencies give employees as much as $60 a month—tax free—to get to work. If your agency isn't doing it, one of the best ways to persuade it to get on the bandwagon is to point out how many federal agencies are doing it. For a list of those offering transit perks, check this space tomorrow.

WEDNESDAY, OCTOBER 19, 1994 THE WASHINGTON POST

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THE `HILLARY FACTOR' IN HEALTH CARE
By BARBARA PRESLEY NOBLE
c. 1994 N.Y. Times News Service

Has the suddenly elusive Hillary Rodham Clinton slunk off, as some would suggest, to contemplate the sin of pride, to wit, imagining that through intelligence, reason and Ira Magaziner, she and her husband could tame a gaggle of competing interests and reform the American health care system?

A new survey of health benefits indicates the First Lady would be perfectly justified in proclaiming herself the unslinkable HRC.

``Health Benefits in 1994,'' an annual report from the compensation and benefits consultants KMPG Peat Marwick, says a widespread fear in the insurance industry of the ``Hillary factor,'' or ``unwieldy and profit-eating health care reform legislation,'' has been a major brake on increases in the cost of employers' health care premiums.

After several years of double-digit increases, the rise in premiums slowed to 4.8 percent from the spring of 1993 to the spring of 1994 from 8 percent the year before. The rate, said KPMG, is the lowest since 1986.

Talk of reform is the Washington equivalent of thigh boots and a riding crop. ``The spotlight and scrutiny focused on health costs is paying off,'' said James E. Buckley, national partner in charge of health benefits consulting at KMPG in New York. ``The administration should take credit.''

That's - sort of - the good news. The bad news is that increases in costs are still running ahead of inflation and workers' earnings during the period analyzed. And while Peat Marwick's experts expect relief from major increases for at least one more year, after that - if Congress and the Clintons, or whoever succeeds them, cannot come to a meeting of the minds on reform - costs are likely to escalate sharply again.

Additionally, the price of controling costs appears to be controling choice. Almost half of the employers surveyed offer only one health plan.

KMPG has sponsored the survey of medium- and large-size companies, of more than 200 employees, since 1991. This year, KMPG's researchers found, nearly four-fifths of employees have some form of employer-sponsored health insurance, up 10 percentage points since 1992.

Forty-four percent of those covered make no contribution to premiums. Slightly more than half of employers offer traditional fee-for-service coverage, the most expensive form of coverage for individuals, at $181 a month.

At $477 a month, point-of-service plans, a type of managed care that allows consumers to go outside the network if they are willing to pay extra, was the most expensive form of family care.

The cost of point-of-service plans, supposedly a choice-maintaining compromise between traditional care and the health maintenance organizations that many Americans disdain, had the highest average rate of increase, in part, Buckley theorizes, because they were priced too optimistically. ``The point-of-service plans probably need to be fine-tuned,'' he said.

The slowing of costs is almost entirely a function of pushing workers into managed care, whether they want it or not. The percentage of employees offered traditional fee-for-service plans dropped to 51 percent in 1994 from 65 percent a year earlier. Employees in HMO plans typically pay more toward their premium than employees with conventional coverage.

One of the biggest banes of consumers of health benefits, the pre-existing condition limitation, is apparently poised to go the way of leeching. The Hillary factor played a role in its demise.

Reform-related news stories often highlighted the hardship caused by pre-existing condition clauses. Insurers were not happy with the exposure.

``The spotlight embarrassed them,'' Buckley said. And health policies in the states, where reform efforts are now concentrated, generally ban the clauses. The numbers indicate that insurers are bowing to the inevitable.

This year the portion of companies offering health insurance imposing such clauses dropped to 56 percent from 70 percent in 1993.

Time will run out eventually, though, on what can be done by threatening reform rather than by actually instituting it. Squeezing savings out of the current system by better management and limited access will inevitably reach a point of diminishing returns. And technology is an inexorable inflator of costs.

``A few years ago, there was a $200 round of tests to do. Now there's a $1,000 round of tests,'' Buckley said. ``Doctors don't say, `Is it cost-effective?' They say, `It's available, let's use it.' ''

He fears the political momentum for reform has been lost, though the need has not, and that in a couple of years the inherent tendency of technology to cost more will explode on the marketplace. That's a force of nature even more powerful than Hillary.

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Health Care Reform: The Collapse of a Q

Clinton's Top Domestic Priority Succumbed to Miscalculation, Aggressive Opposition and Partisansh

By Dana Priest and Michael Weisskopf
Washington Post Staff Writers

The raucous, once-consuming quest to reform the nation's health care system ended on Sept. 22 in a subdued conversation between two understated northeastern senators.

Rhode Island Republican John H. Chafee, drenched from a rainstorm and behind schedule for a dinner on Capitol Hill, was dashing into his McLean home when his wife, Virginia, told him Senate Majority Leader George J. Mitchell (D-Maine) had called. When Chafee called back, the conversation was short. Mitchell said the votes weren't there for the last-ditch deal the two had worked out to try to salvage the mess the White House and its opponents had made of health care reform.

"I guess that ends health care for this year," Chafee told his wife.

It was an anticlimactic finale to 21 months of national debate over whether Americans should exchange the present health care system with all its flaws for a new, unpredictable one that President Clinton and First Lady Hillary Rodham Clinton promised would be better.

After hundreds of town hall meetings, months of congressional hearings and markups by five committees, days of Senate consideration and an unprecedented lobbying campaign by special interest groups, neither the House nor Senate ever did vote on a health care bill. As the 103rd Congress adjourned, its unwillingness to act on what President Clinton described as his most important domestic priority stood as the most conspicuous symbol of Clinton's failure to implement the ambitious reform agenda.

It is hard to isolate a single reason for the demise of health care reform; it died of a thousand cuts. But the forces at work can be understood through a series of snapshots along the road that ultimately ended at John Chafee's home.

They focus for the most part on the Clinton White House, first on what in retrospect was the fatal miscalculation that the president brought into the health care campaign—a vision about government's role that does not fit with the high degree of skepticism with which the American public now views government solutions.

The White House turned out to be absolutely correct in its prediction that the health care industry and its allies would unleash an unprecedented attack on reform. But neither the administration nor its allies responded swiftly or effectively when it came. The attacks and the design of the bill undermined the support of a crucial ally, big business, and so weakened the bill that by the time it got to Congress even such politically adroit allies as House Energy and Commerce Committee Chairman John D. Dingell (D-Mich.) could do nothing to save it.

By then Clinton's presidency was on such shaky ground that he was advised to become invisible on the health care front instead of being the leader many in Congress knew they would need to carry such major legislation through. The whole notion of universal coverage was unceremoniously dropped for modest insurance market changes. Even that was torpedoed by the partisan stalemate that consumed the final days of the 103rd Congress.

A Cumbersome Process and Plan

When President Clinton announced the formation of the National Health Care Reform Task Force on Jan. 25, 1993, with Hillary Rodham Clinton as the head and Ira Magaziner, the bookish business consultant and former Rhodes scholar from Rhode Island, to direct its operations, he set up a process that was as cumbersome and unsuited to the Washington political world as the final bill turned out to be.

The task force was stacked with Capitol Hill technical staff, academics, medical practitioners and a couple of insurance industry figures. They did not think politically and even those who tried to apply their real-world experience were often rebuffed for doing so.

Task force members were divided into 34 groups and their work had to pass the oral exams of seven "tollgates"—an exercise Magaziner imported from his consulting life. He once wrote Hillary Clinton outlining the 1,100 decisions that would have to be made.

The task force was a public relations disaster. White House officials refused to discuss the group's work or to release the names of participants until several publications had published them. Opponents of Clinton-style reform used the secrecy issue to cast the first real doubts on the effort.

They had plenty of targets. The evolving plan was full of newfangled mechanisms that became the grist for a huge new Washington health care press corps. One day it was purchasing alliances, the next a standard benefit package or price controls.

The task force was somewhat of a rogue operation at the White House, causing infighting and weakening the allegiance of key aides and Cabinet members. Magaziner's close relationship with the Clintons, especially Hillary, worked to the exclusion of other advisers with important political skills.

As the task force proceeded, lawmakers and others warned that the plan was becoming too big and complex. So did the task force's own legal review team. "There appears to be no precedent for the enactment and implementation of a national reform that alters so many existing statutory, administrative, contractual, private and moral arrangements as this reform would propose to do," the team wrote Magaziner.

But there is no indication that the Clintons ever seriously considered anything less.

In early September 1993, a 238-page draft was leaked to the news media by congressional sources. The premature disclosure forced administration officials, after months of refusing press interviews, to go on the record for the first time—not to elaborate on their plan, but to explain the unofficial preliminary draft. By then, industry groups, which had been warily watching the process unfold, were preparing to seize the moment.

'Harry and Louise' et al.

As the White House staff was writing the final 1,342-page bill that summer, pollsters hired by the Health Insurance Association of America (HIAA) were in Alexandria and Charlotte, N.C., testing a television commercial whose fictional characters would become more important to the debate than most members of Congress.

Former congressman Willis D. Gradison, president of the group of mid-sized insurance companies, thought health care was the kind of issue people would talk about around the kitchen table, so he hired actors whose real names were Harry and Louise to sit around one and express their fears about what Clinton had wrought.

The 30-second spot was the beginning of a $15 million HIAA ad campaign targeted at legislators, opinion makers and the news media—and spread far beyond its paid targets by news stories about the campaign and the president's denunciation of it. "Harry and Louise" were just the most visible side of the lobbying onslaught. Insurers paid for and packed forums in key congressional districts, giving the appearance of spontaneous town hall meetings with an anti-reform flavor. Hospitals organized their trustees and candy-stripers to fight Medicare cuts. Tobacco companies set up front groups to mobilize opposition to a cigarette tax hike.

In Washington, industry groups hired "Friends of Bill" to lobby the White House, and then hired every former lawmaker they could find to work the House and Senate floors.

The lobbyists and health and business interests poured a record $46.1 million into the health care fight, according to Federal Election Commission records compiled by Citizen Action, a liberal consumer group.

The administration was supposed to have its own cheerleaders to counter the industry lobbying. But the Democratic National Committee, charged with coordinating a coalition of labor unions, senior citizen advocates, consumer groups and medical professionals, was unable to pull it off.

A National Health Care Awareness Day, scheduled for Sept. 14 to be the kickoff event in a $30 million campaign to push the program, was canceled for lack of planning. Earlier, the DNC had created and then, under criticism, quickly disbanded a nonprofit organization that would have raised money for the campaign.

It would be months before proponents regrouped under the name Health Care Reform Project, only to launch a series of lukewarm ads and news conferences that never began to dominate the opposition.

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Big Business's Message

On a cold, crisp evening last February, members of the Business Roundtable, the men who run America's 100 biggest corporations, met in a ballroom at the Willard Hotel, two blocks from the White House. Their meeting would begin the crucial unification of the business community against Clinton-style reform.

White House officials once gloated about divisions in the business community, believing it would work to their advantage. Small business opposed the employer mandate—the proposal that firms provide coverage for employees—because many of them did not pay for their workers' insurance.

Big business was another matter. They typically paid for coverage for employees and often for their spouses and children. Their payments to hospitals and doctors were inflated to cover the cost of free care to the indigent. Many corporate executives believed reform would cut their health care bills.

The White House, told the Roundtable was likely to endorse a rival plan sponsored by Rep. Jim Cooper (D-Tenn.), had panicked in the days leading up to the meeting. Among other things, Cooper's bill did not guarantee universal coverage—Clinton's bottom line. The administration swung into action.

Vice President Gore, presidential economic adviser Robert E. Rubin and then-Deputy Treasury Secretary Roger C. Altman called dozens of chief executives. Dingell and House Ways and Means Committee Chairman Dan Rostenkowski (D-Ill.) were enlisted to pressure executives of companies with business before their committees. Hillary Clinton and Magaziner summoned a half-dozen Roundtable allies to the White House.

The decision-making process at the Roundtable had been dominated by the businesses that had the most to lose: insurance companies and fast-food chains that did not insure their employees. But as the Roundtable vote neared, health care turned into a referendum on the new administration.

Big business had backed the administration in its budget fight with Congress on the strength of White House promises of additional cuts in domestic spending. But the cuts never came. Many now believed the health plan would become an open-ended entitlement that would raise taxes and the federal deficit.

"The only things these guys in the White House understand is a sharp stick to the nose," one executive told another as the session broke up.

And a sharp stick it was. The Roundtable voted 60 to 20 to support the Cooper plan. In subsequent weeks, two other major business organizations, the National Association of Manufacturers and the U.S. Chamber of Commerce, came out against the Clinton plan.

The five congressional committees conducting hearings on health legislation watched anxiously, nowhere more closely than in Dingell's Energy and Commerce Committee, the House's bellwether on health care reform. Its members are considered most representative of the membership of the full House because of their eclectic philosophies and regional diversity.

"When the president failed to get the [Business Roundtable], there was a big shift in sentiment inside the committee," Dingell said recently. "That was a defining event."

Dingell's Defeat

The Energy and Commerce Committee, which sets the rules for a large swath of the U.S. economy, has a tradition of working through tough issues with the help of Republicans. But from the start, Dingell said, House Minority Whip Newt Gingrich (R-Ga.) secretly demanded that House Republicans oppose any Democratic bill, making it a test of party loyalty.

Members of Dingell's own party were divided. More than a third of the 27 Democrats came from districts where important constituents were antagonistic to Clinton's plan.

Dingell tried to co-opt industries with promises to work out their special problems. But the job was too big for a single committee chairman, he said. Only the president had the resources to put together a winning coalition and Dingell believed he was hindered by Clinton's fractured attention span.

Nevertheless, Dingell mowed down the sticking points, one by one. He pledged to foster new crops in tobacco country to ease the blow of higher cigarette taxes. He agreed to drop proposed price controls on drugs produced by biotechnology firms. Nearing the 23 votes needed for a majority, Dingell offered his best hand. He exempted family farmers from the employer mandate to win over rural Democrats and agreed to eliminate the mandate for merchants who the National Federation of Independent Business (NFIB) said were most vulnerable—those with fewer than 10 employees.

When he left town on the spring recess he was confident. But rival forces were at work too. Rep. Jim Slattery (D-Kan.), a Dingell protege, ran into an NFIB "emergency alert" sent to its 8,000 small business owner members in Kansas.

Slattery, who was running in the Democratic primary for governor, was the final vote Dingell needed. But on April 21, the Kansan received a critical four-hour visit from lobbyists for Hallmark Cards and the parent firm of Pizza Hut, two of his state's biggest employers. Both relied on large numbers of part-time, uninsured workers and vehemently opposed any mandated employer payments.

Later in the day, Slattery issued his own health care plan. It rejected any employer mandate. The stalemate was complete.

On the afternoon of June 28, Dingell told more than a dozen of his Democratic loyalists that he couldn't pry loose a single Republican vote or get enough of the committee Democrats to support a strong bill. He preferred to "pull the plug," he said, rather than pass a weak measure that would lower the threshold for reform.

No one dissented, and Dingell put on a positive face. But last week, he owned up to his fears. When Energy and Commerce folded, he said, "it told me the situation was not good from the standpoint of getting a bill" to the floor.

With Dingell out of the picture, health care reform fell to the Ways and Means and the Education and Labor committees—both more liberal and more loyal to the House Democratic leadership than the House as a whole. The House leadership then took the committee bills and created its own.

But when House Majority Leader Richard A. Gephardt (D-Mo.) finally put forth his proposal, many lawmakers believed it was too far-reaching to pass. Those who know Gephardt believed he must have done so expecting that the Senate's bill would be much more conservative. Eventually he hoped for a compromise in the middle.

But things did not go as planned in the Senate.

Moynihan and the 'Mainstream'

A week later the Senate Finance Committee became the last of five committees to finish work on a health care bill, in the process exacerbating the tense relationship between committee Chairman Daniel Patrick Moynihan (D-N.Y.) and the White House.

Moynihan, renowned for his intellect, seemed to his colleagues to be unengaged in health care. "I don't know about health care," he said on several occasions.

Once, in front of a roomful of senators, he ridiculed Hillary Clinton. "You just don't seem to get it, do you?" he said, according to attendees. He became enraged at White House slights and several times threatened to go public with harsh denunciations of Clinton's health care ideas.

To the dismay of Democrats, Moynihan helped give Republicans a platform in what had by then become a highly partisan fight. He sometimes let ranking minority member Bob Packwood (R-Ore.) chair private committee sessions and he later brought him to the White House to tell Clinton the votes weren't there for a universal coverage bill. Packwood would later gloat at how successful Republicans had been at killing reform.

As the clock ticked down on the committee's markup, Moynihan seemed to turn the process over to a bipartisan rump group of committee moderates who rewrote the bill in three days. That group, led by Chafee and Sen. John Breaux (D-La.), developed into what was called the "mainstream coalition" that worked through September to find common ground with Mitchell, the majority leader.

The mainstream compromise was closer to the minimalist proposal of Senate Minority Leader Robert J. Dole

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(R-Kan.) than it was to any of the Democratic leadership bills. But by then Republicans had made it clear they would not cooperate on any bill.

Dole and Gingrich told Clinton they would hold up legislation for the General Agreement on Tariffs and Trade (GATT) if the Democrats pushed health care onto the Senate floor. And many moderate and liberal Democrats said the mainstream bill was too incremental to take seriously, anyway.

"We were creating a bill that had no constituency," Breaux said.

On Monday, Sept. 19, Chafee had his final meeting with the mainstream group and at 11 a.m. he briefed Mitchell. By then U.S. troops were going into Haiti and Mitchell was called out frequently to deal with that. But Mitchell, who had given up a possible seat on the Supreme Court to help pass a health bill, was cutting deals up to the last minute.

The next day Chafee polled moderate Republicans. Only four said they would support a move to end debate and vote on the health bill. That evening at a meeting with Chafee and three other senators, Mitchell was pessimistic, especially in light of what he called the "atomic bomb" dropped by Gingrich in the form of a threat to hold up GATT.

It was two more days before Mitchell made his call to Chafee to acknowledge defeat. When he finally made his decision public the following week, he blamed Republicans and the insurance industry. Clinton issued his own statement condemning Republicans and lobbyists.

"We are going to keep up this fight and we will prevail," the statement said.

Staff writer Steven Pearlstein contributed to this report.

FROM HIGH HOPES TO AN ANTICLIMAX

Despite enormous efforts by the Clinton administration beginning with its inauguration in January 1993, efforts to reform health care have come to naught.

President Clinton sets goal

WINTER 1993

Jan. 25
Clinton names First Lady Hillary Rodham Clinton to head National Health Care Reform Task Force. The group has more than 500 members, including six Cabinet secretaries.


Bill Clinton

March 8
U.S. Chamber of Commerce endorses managed competition, signals potential endorsement of further provisions of Clinton plan.

Clinton unveils plan

SUMMER/FALL 1993

Sept. 8-10
White House shares preliminary plan with congressional staff, who leak it to press. Health Insurance Association of America launches "Harry and Louise" advertisements criticizing Clinton health plan.


Hillary Rodham Clinton

Sept. 22
Clinton unveils plan to Congress. Public approval peaks a month later.

Oct. 27
1,342-page Clinton Health Security Act delivered to Congress.

President's health plan

Universal coverage, at what cost?

WINTER 1994

Jan. 25
In his State of the Union Address, Clinton threatens to veto any health legislation that does not include universal coverage.

Feb. 2
Business Roundtable endorses rival health plan offered by Rep. Jim Cooper (D-Tenn.).

Feb. 8
Congressional Budget Office reports that Clinton plan would increase deficit in first five years of operation and that savings advertised by Clintons would not be realized until year 2000.

Congress weighs rival plans

SUMMER 1994

June
Five congressional committees wrestle with specifics of health care reform. At end of month, the key House Energy and Commerce Committee chaired by John D. Dingell (D-Mich.) gives up on issuing a bill.

July 20
At National Governors Association meeting, Clinton says employer mandate is negotiable and 95 percent coverage will meet his goal of "universal."

July 28
Democratic leaders send comprehensive health bill sponsored by House Majority Leader Richard A. Gephardt (D-Mo.) to House floor.

Aug. 2
Senate Majority Leader George J. Mitchell (D-Maine) unveils his health plan, which would cover 95 percent of the population and have no employer mandate. On **Aug. 15**, Mitchell threatens nonstop session on health care unless GOP agrees to vote.

Aug. 21-25
Both houses recess without acting on health care reform, return on **Sept. 12.**

Plan dies in Congress

FALL 1994

Sept. 26
Congress formally abandons health care reform efforts for 1994.

51%
October 1993*
APPROVE OF CLINTON HEALTH CARE PLAN

48%
January 1994*
APPROVE OF CLINTON HEALTH CARE PLAN


Richard A. Gephardt


George J. Mitchell

42%
September 1994*
APPROVE OF CLINTON HEALTH CARE PLAN

*Washington Post-ABC News Poll

THE WASHINGTON POST

BY MARILYN MOON

Health Reform And You

Q. *I'm 73 years old and I would like to know since I have no health insurance what is going to become of me? I have not worked since 1982 and I had to drop Blue Cross because I couldn't afford the premiums. I have many physical and emotional disabilities.*

A. It is not totally clear from your question whether you receive Medicare benefits and the Blue Cross/Blue Shield plan you mention was a supplemental policy or if it was the only insurance available to you. Most Americans over age 65 are covered by Medicare, since the only requirement to participate is that you are eligible for some type of Social Security benefit.

If you do not qualify for Medicare, you may still opt to purchase it on your own. That coverage would likely be your best option if you have enough resources to pay the premiums. In 1994, the cost of both parts of Medicare would be $286 per month (although some people would be eligible for a lower premium of $225 per month). If such premiums are beyond your means, you may qualify for coverage under the Medicaid program in your state. Eligibility depends upon your income, and these rules vary by state, so where you live will matter.

If you do have Medicare and the problem is affordability of supplemental coverage, you might qualify for special benefits through the Qualified Medicare Beneficiary (QMB) program that is run by your state Medicaid program. In that case, if your income is less than $614 per month this year, the QMB Program will pay for deductibles, cost sharing and premiums that Medicare normally requires its beneficiaries to pay.

Another way to reduce your out-of-pocket payments would be to join a health maintenance organization that takes Medicare patients. Often, for no additional cost or only a small additional premium, you could get more comprehensive coverage with an HMO as compared to traditional supplemental plans. However, these organizations require that you use their doctors and hospitals as a condition of participation.

If none of these options is open to you, public clinics and many hospital emergency rooms normally treat anyone who needs care. This is the less desirable way to get health services, however, because people like yourself with chronic problems are better served when they have a regular place to get care from a physician who knows their medical history.

Our complicated, patchwork system is hard to negotiate, but these are likely to be the only arrangements available, since further expansion of health coverage is unlikely in the foreseeable future. ■

Do you have questions about health care issues? Although Congress will not undertake legislation this year, the debate continues and many questions remain. The Washington Post free telephone information service can take your questions. Call POSTHASTE at 202-334-9000 on a touch-tone phone and enter category code 8500 (in Prince William County, 703-690-4110). Economist Marilyn Moon of the Urban Institute provides answers in this column. Questions cannot be answered individually.

BY ABIGAIL TRAFFORD

A Collective Case Of Compassion Fatigue?

Official Washington sank into a mood of nostalgia as it bade farewell to departing Sen. George Mitchell, the dapper Down East liberal who championed President Clinton's agenda, presiding like a grieving parent over the prolonged death of health care reform. His colleagues said he had the patience of Job. His resume reflected the American Dream of the immigrant son who became a quiet giant of Congress.

The same week, the nation said goodbye to another American favorite—Harriet Nelson, the perfect TV mom of the '50s. The real wife of Ozzie and costar of Hollywood's longest-running comedy, "The Adventures of Ozzie and Harriet," Harriet symbolized an era when family values were as common as Hula-Hoops and Yankee can-doism pervaded the suburban wonderland of Eisenhower's America.

Perhaps it was fitting for the politician of the '90s to be filled with some nostalgia for the Age of Ozzie and Harriet as he prepared to leave the citadel of politics for a private life. Not for social reasons: As he made clear last week to reporters at the National Press Club, he does not envision a reversal of the social and economic revolution that has brought mothers into the work force.

But what the Senate majority leader especially misses in this Era of Murphy Brown is the voters' confidence in the government that was prevalent in the Age of Ozzie and Harriet.

In the years when Harriet wore an apron and dished out cookies and common sense on TV, most Americans looked to the federal government to address the nation's problems. In 1958, according to research by the Roper Center for Public Opinion Research and by Robert J. Blendon at the Harvard School of Public Health, 75 percent of Americans trusted the government to do the right thing.

Today, public trust in the government has dropped to an all-time low of 19 percent.

This "trust deficit" has made "government program" a dirty word. In the past, said Mitchell, the government had been "a force for change," not to preserve the privileged but to protect the powerless. But now the government is seen as the snarling black dog of taxes and rules on everyone's back. "In recent years . . . it has become fashionable to sneer that government isn't the solution, it's the problem," he said. "What is new is that skepticism has become cynicism and the intensity of distrust [of government] has reached unprecedented levels."

Certainly the "trust deficit" helped kill Mitchell's legislative baby of a national health care plan. As the debate wore on, people became afraid that members of Congress were building a Trojan horse for the government to take over health care. Despite protests from the Clintons and Mitchell that legislation would build upon the private medical system, the whole idea of a national plan was increasingly seen as Big Government run amok.

While health care legislation foundered, people turned their rage against Washington. A survey published last month diagnosed the public as angry, self-absorbed, cynical and increasingly hostile toward the needs of the poor and minorities.

"Today, an anti-government mood pervades nearly all segments of the public and characterizes much of the public discourse on politics and policy," conclude the authors of a recent public opinion survey by the Times Mirror Center for the People and the Press.

It's as though the country has a collective case of compassion fatigue. Only 41 percent of Americans believe that the government should help more needy people even if it means the country goes deeper into debt. Two years ago, a hefty majority—nearly 70 percent—supported the idea.

"In the abstract, people do support programs aimed at the deserving poor," said Marc L. Berk, project director of Project Hope Center for Health Affairs. "Once you get beyond the abstract and hit people in their pocketbooks, support evaporates."

No wonder Mitchell and the other congressional gladiators who fell on their swords for health care legislation might long for the days of Ozzie and Harriet. In 1964—when the Nelsons completed the show's 14-year run—surveys showed that trust in government had risen to a high of 77 percent of the American people. The following year, Medicare was passed to provide health coverage to the elderly.

Until the mid-'70s, more than 50 percent of Americans continued to have faith in the federal government. But after the Vietnam War, the Watergate scandal and the resignation of President Nixon, people who trusted Washington to do the right thing became a new minority. When Bill Clinton was elected president in 1992, only 22 percent had faith in Washington. Since then, the administration has been unable to stem the growing trust deficit.

"It's a very anti-government period," commented polling expert Blendon. "In today's climate, we could not enact Medicare."

That's the final irony. No government health program enjoys so much support from beneficiaries, their families, the medical community—and virtually all members of Congress. Perhaps the program's secret is that Medicare doesn't feel like "socialized medicine" because most of the elderly can choose their private physician and hospital and in many instances their bills are handled by private insurance carriers.

In the final hours of the debate, a woman in the New Orleans airport ran up to Louisiana Democrat John Breaux and said: "Whatever you do, senator, don't let the federal government take over my Medicare!" The woman may have been confused about health care reform, but she captured the mood of the public.Now that this gridlocked session of Congress is over, a number of lawmakers would probably just like to watch reruns of Ozzie and Harriet and reminisce about a time when the voters trusted Washington to do the right thing. ■

Where New Health Reform Should Start

By Jane M. Orient

When challenged about a government takeover of the U.S. health care system, defenders of Clinton-style health reform would always respond, "We already *have* government-dominated health care. You don't want to do away with Medicare, do you?"

Perhaps eliminating Medicare is not going to be on the table anytime soon, but it is precisely with government domination of health care that the next reform effort should start. The focus should be on lightening the federal presence, not strengthening it, and Medicare price controls would be a pretty good place to start.

In 1965, Ernest Anthony, president of the Association of American Physicians and Surgeons, the organization I now lead, called Medicare a Trojan horse: "The ultimate objective was and continues to be to place control of health services in the hands of central government."

At first, Medicare seemed to be a boon for both patients and physicians. But doctors who scoffed at the dire prophecies of Medicare opponents nearly 30 years ago are beginning to say, "You were right." And elderly patients, still largely shielded from the soaring costs of the program by cost-shifting and other mechanisms, soon may join them in vocal dissatisfaction.

A government-run system requires universal, compulsory participation. If the exits are not sealed off, everyone who can escape the constraints of the system will do so. President Johnson understood this. After Medicare passed, he persuaded insurers to cancel the basic policies of everyone who had reached age 65. (About 56% of this population had hospitalization insurance at the time.) Overnight, all senior citizens became recipients of payroll-tax largess. Beneficiaries pay premiums only for the nonhospital portion (Part B), and even that part is 75% subsidized. Premiums bear no relationship to the beneficiary's risk or the extent of coverage.

As soon as Medicare was introduced, demand for services exploded—and so did costs. By 1980, Medicare expenditures had reached 10 times the projected level of $6.8 billion. In 1994, they are $179 billion. Total medical expenses for the elderly are projected to reach 14% of workers' payrolls by the year 2000 and 55% by 2050.

The government's response has been to impose price controls. Hospitals are paid by the diagnosis related group, or DRG, no matter what treatment the patient receives. For physicians, there is the relative value scale. All services with the same numerical code are treated as identical regardless of the complexity of the case or the skill of the physician.

In some cases, the hospital or physician collects more from the government than the service is worth in the free market. In others, the level of compensation is artificially low. Some elderly patients find it increasingly hard to find a physician willing to accept them. Many doctors and hospitals have resorted to a dual fee schedule. They collect the government-dictated amount for patients over 65, however wealthy, and extract an extra amount from younger patients and their insurers: Young people pay a sickness tax in addition to their payroll tax.

So far, elderly patients have been largely protected from the consequences of Medicare's price controls. But when the shift can no longer occur, either because the market will no longer bear it or because it is forbidden by law, rationing will become apparent.

The effects of price controls were well understood by members of President Clinton's Task Force on Health Care Reform. Queues, black markets, quality degradation, financial havoc for many providers, and decreased work by physicians are all mentioned in Working Group documents.

Already, certain devices (such as cochlear implants for the ear) are unavailable to Medicare patients because of price controls. Newer drugs, as well as improved versions of pacemakers, heart valves, hip prostheses, and interocular lenses are also likely to become unavailable. Some advances may be withheld even if they are less expensive—not because of economics, but because of fear.

More than 125 hospitals recently received subpoenas from the Office of the Inspector General of HHS, demanding 10 years of records on Medicare patients who had undergone cardiac procedures. The inspector general wanted to know everything, including the names of the operating room nurses. Hospitals could face criminal penalties for fraud and abuse if they used a device that had not been specifically approved for its precise application. The rationale is that Medicare doesn't pay for "investigational" procedures.

One cardiac surgeon stated that he would no longer use stents to keep coronary arteries open in Medicare patients. He is not willing to risk his career. Instead he will perform open-heart surgery on these patients, a much more invasive procedure.

The Medicare statute specifically provides that the government will never interfere in the practice of medicine. But its actions speak louder than its words. "All-payer" or "single-payer" proposals do not even make this false promise. In fact, they guarantee the opposite—pervasive controls at the discretion of a nonaccountable, all-powerful National Health Board.

Now that huge government-run health care proposals have been convincingly defeated in the political arena, it is time to think of reforms that would take things the other way. It will soon be evident to most Americans that Medicare, far from being a harbinger of a socialized medicine of the future, is a problem that still needs fixing.

Dr. Orient, a Tucson physician, heads the Association of American Physicians and Surgeons, whose lawsuit claims that the Working Groups of the president's Health Care Task Force violated the federal open meetings law.

THE WALL STREET JOURNAL, THURSDAY, OCTOBER 6, 1994

Robert J. Samuelson

Health Care: The 'Con' That Failed

The "con that failed" may seem a harsh verdict on why the Clintons' health "reform" didn't pass Congress. But it captures the essence of what happened and refutes the view that the plan was doomed by "special interests" and inept White House lobbying. These assessments, though partially true, miss the larger truth. The real undoing of "reform" was its utopianism. The Clintons tried to create a perfect health care system and, in the process, missed an opportunity to improve a system that is inevitably imperfect.

We would all prefer a system that provides "universal" insurance for every conceivable ailment (from diet disorders to long-term care), remains "affordable" and allows complete "choice" for patients and doctors alike. But such a system is a mirage. There are conflicts among all these goals, and somehow they will be resolved. What we call "the uninsured," or "soaring health costs" or "rationing" are just some of the ways it happens. Our ideal system is an impossibility, and the debate's crippling defect was its inability to recognize this basic limit.

For this, the Clintons bear a heavy responsibility. Their original proposal tried to be all things to all people. It tried to placate liberals and advocates of a Canadian-like "single payer" system by promising "universal coverage" with lavish benefits. It tried to placate big business by calling itself "managed competition," which had a private-enterprise aura. And it tried to seduce selected constituencies with new benefits: The elderly got drug coverage under Medicare; states were relieved of many Medicaid costs.

The "con" failed because too many people concluded that the plan wasn't credible. That is, it couldn't expand insurance coverage and control costs without (as the Clintons said) major tax increases or massive government meddling in medicine. The initial Clinton strategy aimed to build support on two levels. Public opinion would be won by preaching "universal coverage," which was heavily favored by the public as a way to protect people against insurance loss. On Capitol Hill, a coalition of big business, labor and the elderly would overwhelm opposition from small business (which disliked employer "mandates") and some insurance companies (which would lose under "managed competition").

In practice, the plan's complexities—reflecting its many promises—sabotaged the strategy. Public opinion was lost because the plan's bewildering details (health "alliances," "accountable health plans") fanned people's fears that government would disrupt their medical care. After Clinton's speech to Congress in September, 59 percent of the public supported his plan. By July this was 40 percent. The plan did the carnage, not hostile TV ads: in a Newsweek poll, 62 percent of respondents rated those ads as dishonest. The problem was not that the people grasped what the plan meant for them; it was that they couldn't.

Similar problems eroded interest-group support. For example, big companies initially backed employer "mandates" because they believed universal insurance would lower their costs. They would no longer have to bear, through premiums, the burden of the uninsured. But the Clinton plan also shifted costs to employers by putting many nonworkers into huge insurance pools, where some of their costs would have to be subsidized by companies. The consulting firm Lewin-VHI estimated these subsidies at $20 billion annually. This was one way Clinton minimized new taxes.

The term "con" implies that the Clintons recognized their plan's inconsistencies. In truth, I don't know whether this was so. They should have known, but perhaps they deceived themselves. Either way, the plan squandered support while generating huge expectations of what "reform" should achieve. All subsequent efforts to modify Clinton's plan started from a shaky political base while straining to satisfy sweeping and unrealistic goals. Republicans didn't kill health reform; it self-destructed.

Democrats ought to concede this, but Republicans should not gloat. They hypocritically complained about "too much government" and extolled "competition." What they ignored is that health care is already dominated by government. It pays two-fifths of all costs and subsidizes private insurance by excluding employer-paid benefits from income taxes. In 1995 the subsidy will cost about $56 billion. If Republicans truly wanted "competition," they'd end the subsidy (other taxes could be cut to offset the tax increase). No major GOP proposal did so.

In this sense, the "con" was bipartisan. Everyone evaded the nub of the problem, which is the insistent rise of spending. This squeezes government budgets and private pay and, as insurance becomes costlier, raises the number of uninsured. But there are no easy ways to curb spending. The two basic approaches are tough governmental controls or less generous private insurance, which channels people into "managed care" (giving them fewer choices) or makes them pay more of their own costs. All approaches pose risks. They could suffocate us in governmental or private bureaucracies; quality of care could suffer.

The debate failed in its function of illuminating important public choices and providing popular consent for some set of preferences. But just because the choices weren't faced doesn't mean they can be avoided. They will continue to be made in a largely random fashion—driven by companies' and states' desire to curb their health costs. Perhaps this is the best we can do; it's better than Clinton's system. But there's no guarantee that this haphazard process will sharply limit spending or that the number of uninsured won't continue to rise. Congressional inaction will not insulate Americans from change.

Sooner or later, there will be another health care debate. Broad agreement already exists on "insurance reform" (protecting people against the loss of coverage), and had the Clintons been willing to settle for less, Congress could have passed a bill. But grappling with the larger issues of costs and the uninsured will require more candor. Politicians can be blamed for only so much. Their "cons" reflect popular delusions. Americans have always been prone to utopianism. We want some grand solutions to our problems—and nothing less. We don't want to talk about modest improvements or messy choices. Politicians pander to our erratic expectations with either sweeping promises or prudent silences. In health care, neither will get us very far.

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The Toronto Star

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LENGTH: 987 words

HEADLINE: U.S. health care losers Now that Bill Clinton's reform plan is dead, even the opponents stand to suffer

BYLINE: BY CHRISTOPHER CONNELL ASSOCIATED PRESS

DATELINE: WASHINGTON

BODY:

The 39 million uninsured people in the United States aren't the only losers from the collapse of health reform.

The high hopes that many physicians, hospitals and even insurance companies had placed in a major overhaul also have been dashed.

"The three big problems that brought about this debate are only going to get worse," said Drew Altman, president of the Kaiser Family Foundation, a think tank that specializes in health policy. "The number of uninsured will increase. The middle class problems and fears about their insurance will get worse. And health-care spending will continue to grow to ever scarier numbers."

SMALL BUSINESSES

The American Medical Association had lobbied furiously for special protections to guarantee patients' right to choose their doctors and to prevent big insurance companies from arbitrarily cutting physicians out of their networks. For now, that battle is lost.

Small businesses dodged a bullet in helping to kill U.S. President Bill Clinton's proposal to make all employers help pay their workers' premiums. But they also lost a chance to join government-assisted purchasing pools to get a better price on the high premiums many small businesses now pay.

Even before the White House launched its crusade, teaching hospitals were worried that belt-tightening and the shift to managed care by big insurers and employers would cost them patients and revenues.

The academic health centres would have gotten billions of dollars each year in new, earmarked federal revenues. The demise of reform leaves them back at square one.

The most obvious losers are the 15 per cent of Americans with no health insurance and the millions more with inadequate coverage.

Some 81 million Americans - nearly a third of the population - are said to have health problems that make getting or keeping insurance a constant worry.

While Congress had retreated weeks ago from Clinton's goal of guaranteed coverage for every American, all of the health bills had promised to curb abusive insurance company practices and make it easier for Americans to stay insured when they changed jobs or got ill.

The National Federation of Independent Businesses, which helped galvanize the fierce small business opposition to any compulsory health insurance contributions by employers, said it felt both "disappointment and relief " at the outcome.

Jack Faris, the NFIB president, said the country was well rid of the employer mandate, but added, "We wanted market reforms because we know that many small-business owners are paying higher and higher premiums under the current system."

The Health Insurance Association of America, which mounted the $ 15 million "Harry and Louise" advertising campaign that helped torpedo Clinton's mandatory health alliances, said that all along it wanted universal coverage and required employer contributions.

"We're as sad as anybody else to see the process come to this end," said Chip Kahn, the HIAA's executive vice-president. But small- to medium-size insurers had no choice but to mount their opposition when the White House "turned off its hearing aid" to their concerns, Kahn said.

HOSPITAL LOBBY

The Blue Cross Blue Shield Association, whose 69 plans provide insurance for one in four Americans, had hoped that health reform would level the playing field and force all insurers to take bad risks.

"We are still the insurer of last resort in most states, where we have to take all comers, as opposed to our competitors who have made cherry-picking an art form," said Alixe Glen, a Blue Cross vice-president. "Strictly from a business standpoint, we wanted to see insurance reform pass very, very much."

Newsday

September 22, 1994, Thursday, HOME EDITION

SECTION: NEWS; Pg. 8
Other Edition: Nassau and Suffolk

LENGTH: 709 words

HEADLINE: Most LIers Happy With Health Care, But Problem Seen

BYLINE: By Stuart Vincent. STAFF WRITER

BODY:

Almost half the Long Islanders surveyed by a Newsday poll last week believe the national health-care problem has gotten worse over the past year. But three-quarters also said they were satisfied with their own level of health care.

"At the personal level, most people do not have a problem. Most people are satisfied with their health care," said David Moore, a vice president at The Gallup Organization, which conducted the poll. Asked about the national problem, however, "they're not talking about themselves. It's what they perceive to be the situation for other people," he said.

Some experts and those who responded to the survey agreed that the public's perception of the health-care crisis has been shaped by more than a year of debate over President Bill Clinton's proposed health-care reform.

The majority view that health care has worsened "is a reflection of the media coverage of the political debate that has focused on what needs to be fixed in our health-care system," said Peter Sullivan, executive vice president of the Nassau-Suffolk Hospital Council. "There is a strong consensus that there are things in our health-care system that need fixing, but that's within a recognition that we have an exceptionally good health-care system in the United States, especially on Long Island."

The poll surveyed 1,115 state residents, including 307 Long Islanders. The local survey, which also asked questions unrelated to health care, has a margin of error of six points.

In the survey, 48 percent said health care has gotten worse over the past year, and 45 percent said it has stayed the same. Only 4 percent thought it had improved. Respondents were then asked how satisfied they were with their own health care, and 77 percent said they were very or somewhat satisfied. Another 20 percent said they were not too or not at all satisfied.

Robert Mauro of Levittown, who is disabled and on Medicaid, thought the problem had worsened. "If you're disabled and you're on Medicaid, you basically can't work because if you work and have a pre-existing condition, there's a chance you may not be covered by health care, especially if you work for a small business," he said.

James Gallo, an administrator at Walt Whitman High School in Melville, thought health care remained about the same and said he was very satisfied with his own health care. "There are some people in my family who don't have health care at all from their employer," he said. "I'm just satisfied that I have it at all, and the level."

Karen Palacios of Bethpage thought health care in general has improved over the past year. Still, she said, "I'm satisfied with my health care, but I pay for it. I'm not satisfied with their fees . . . I'm a waitress, my husband's a cook, and neither one of us has any benefits, and we have three kids."

Lisa Minor of Westbury, a nurse at Long Island Jewish Medical Center in New Hyde Park, said she didn't believe that any one person or group was responsible for the failure to adopt a new health-care plan. The survey reflected that opinion, with 28 percent blaming the health insurance industry, 23 percent blaming Congress, 16 percent blamed Clinton and 14 percent blamed doctors.

Sixty percent believed the government should be responsible for guaranteeing health-care access for all Americans, but the question of whether it was more important for the goverment to reduce costs or to provide health-care insurance for all drew a more mixed response - 47 percent to 45 percent, respectively.

"The focus of the entire health care debate was on cost," said Stephen Villano, associate dean for public affairs at University Medical Center at Stony Brook. "Doctors and associations like the Association of Medical Colleges and the AMA [American Medical Association] tried to focus the public's attention on the quality of care. On the other side, you had the insurance lobby spending millions on ads that focus on costs."

THE DALLAS MORNING NEWS

September 25, 1994, Sunday, HOME FINAL EDITION

SECTION: TEXAS & SOUTHWEST; Pg. 45A

LENGTH: 520 words

HEADLINE: For haves, have-nots, health cost is key Woman stresses need for equal access to care

SERIES: TEXANS TALK

BYLINE: Arnold Hamilton, Staff Writer of The Dallas Morning News

DATELINE: RINGGOLD, Texas

BODY:

RINGGOLD, Texas - As far as Julie Campbell is concerned, Americans deserve access to affordable, quality health care.

After all, she is fortunate enough to have health insurance.

And so is her postmaster husband, Del. But she has seen firsthand the problems when someone doesn't, facing an increasingly costly medical system, unable to pay.

It's been enough to firmly plant health care reform at the top of her personal political agenda in 1994.

"We want them (federal officials) to do something, not just talk about it, not just fight about it," said Mrs. Campbell, who has lived in this tiny farming and ranching community southeast of Wichita Falls for about 42 years. "We need it."

Her awareness of the issue was heightened almost five years ago when one of her two daughters committed suicide after a long bout with depression.

Mrs. Campbell, 64, said the mental illness prevented her daughter, a graduate of Hardin-Simmons University in Abilene, from holding a job. And without a job, she had no insurance.

For a time, Mrs. Campbell said, she and her husband paid for their daughter's treatment at a privately owned medical facility.

But she said, "We're not rich," and later their daughter entered a publicly owned

hospital as an indigent.

Mrs. Campbell said there was a clear difference between the two facilities in the level of treatment: The private center provided more extensive and elaborate care.

But she said she could not be certain whether her daughter's death might have been prevented had she been able to remain at the first facility.

"People need to be treated more equally," Mrs. Campbell said as she sat at the kitchen table in her modest frame home on the main road in Ringgold. "Of course, money talks. I don't think poor people ought to take advantage of it, but if they need it (medical care), they ought to have it.

"There are so many people out of work. They have a good education, but they lose their jobs. They need help."

Mrs. Campbell, who describes herself as a Democrat, said another recent incident, involving the grandson of a family friend, strengthened her belief in the need to overhaul the American health care system.

She said the young man, 17, recently moved to Ringgold to live with his grandmother. He was hired by a rancher who could not afford to offer health insurance. Unfortunately, she said, the teen-ager had a ranch vehicle roll over on top of him, severely damaging his knee.

"He's on his own," Mrs. Campbell said. "His grandmother is taking care of him, but he needs an operation on his knee and they can't afford to pay for it. She asked me, What am I going to do?'

"I just don't know what people are going to do."

Although she has many questions about how the president and Congress will resolve such health care issues, Mrs. Campbell said she has faith that the government eventually will fix the problem.

"They are fighting one another on health care and neither side wants to give in," she said. "They're only interested in their parties."

But, she added, "I still have confidence. I feel things can be worked out."
GRAPHIC: PHOTO(S): Julie Campbell . . . "We want them (federal officials) to do something." CHART(S): The People's Agenda.

LANGUAGE: ENGLISH

LOAD-DATE-MDC: October 1, 1994

Los Angeles Times

September 25, 1994, Sunday, Valley Edition

SECTION: Metro; Part B; Page 17; Column 3

LENGTH: 940 words

HEADLINE: HOW CONGRESS SHOULD OPERATE ON HEALTH CARE SYSTEM; CENTRAL TO THE ISSUE IS THE SOARING RATE OF MEDICAL COSTS. WE MUST ACT BEFORE THESE PROBLEMS GET WORSE, BUT WE MUST MOVE CAREFULLY.

SERIES: POINTS OF VIEW: 24th District congressional candidates discuss the issues. One in an occasional series.

BYLINE: By ANTHONY C. BEILENSON, The Times has invited the two leading candidates in the hotly contested race for Congress in the 24th District, which includes the southwest San Fernando Valley, to write on several issues before the election. Incumbent Democrat Anthony Beilenson has been a congressman since 1977. Republican Rich Sybert was state director of planning and research from 1991 to 1993. For this article they were asked: Do we have a national crisis in health care that must be addressed by Congress? What are the elements of an ideal, affordable system?

BODY:

This year's debate over health care reform has demonstrated how enormously complex and difficult it will be to slow the growth of our dangerously high health care costs and to ensure that all Americans have access to the health care they need. But despite the impasse we have reached for the time being, the very fact that a full national debate over this very serious issue has begun in earnest -- and it will continue -- means that health care reform has at last received the priority it deserves.

Spending on health care has been rising at an unsustainable rate. As recently as 1965, we spent 6% of our gross domestic product on health care. We now spend 14%, and, if current trends continue, that figure will rise to 18% or 19% by the year 2000 -- only six years from now.

All of us feel these higher costs in the prices charged for insurance policies, in out-of-pocket deductibles and co-payments, in lower wages that result from companies' paying more for health benefits, and in federal, state and local taxes to support government-sponsored health insurance and health care programs.

The costs of Medicare and Medicaid (Medi-Cal), in particular, are growing at an

alarming rate. Since 1980, federal spending for Medicare and Medicaid has grown by 113% -- after adjusting for inflation. In 13 years, these two programs have risen from 16% of the federal government's domestic budget to 22% this year and, unless changes are made, will rise to an astounding 35% five years from now.

These increasing costs are the major obstacle to eliminating federal budget deficits, and to reordering federal spending priorities so that more funds are available for other critical national needs.

One reason our health care costs are rising so rapidly is that the proportion of Americans over age 65 -- those with the greatest need for health care -- is growing each year. Another is that more treatments have been made possible by medical and technological advances. A third is extremely high administrative costs, accounting for fully one-quarter of all U.S. health care costs.

In addition, we have too many hospital beds, a surplus of specialists and a shortage of primary-care physicians, a high rate of unnecessary procedures, high medical malpractice insurance costs, dependence on high-cost emergency room care by those who lack insurance and very high prices for many prescription drugs.

Most Americans have employer-provided health insurance. Almost everyone over 65 is covered by Medicare, and about half the poor are covered by Medicaid. But nearly 40 million Americans -- 85% of whom are workers or their dependents -- have no health insurance at all. They rarely see a physician, waiting until a problem becomes acute. Then they resort to emergency room services, the most expensive care. Since the uninsured often are unable to pay their medical bills, hospitals and doctors shift the cost to patients with insurance.

Even more worrisome, millions of additional Americans lose their insurance as they lose or change their jobs. And increasing numbers of workers avoid changing jobs, because of fear of losing valued health benefits. Even those who remain in their current jobs have no guarantee of continued coverage, and people who work for small businesses are especially at risk of losing their insurance. If only one employee of a small business becomes seriously ill, insurance companies usually raise rates to unaffordable levels or refuse to renew coverage. Even small businesses with low-risk employees often pay 30% to 40% more than large companies, which negotiate discounts for insurance, for identical coverage.

Not surprisingly, about two-thirds of workers without health insurance are employed by firms with fewer than 100 employees. Many of those firms would like to provide insurance for their employees but simply cannot afford to.

For those who do have insurance, benefit packages vary widely, and many are seriously underinsured. The most serious gap in coverage for those who are insured is for illnesses or disabilities that require long-term care, which is a special concern of older Americans since Medicare does not cover nursing or home care, and little

private insurance is available.

We must act before these problems get worse, but we must move carefully. All the alternatives to the present health care system raise serious questions. But costs are rising faster than our ability to meet them; large numbers of Americans are experiencing personal crises because they cannot pay for the health care they need. And our capacity to compete in the global economy is seriously threatened by health care costs that are far higher than those of other nations.

Although I am disappointed that we were not able to make more progress in solving these problems this year, I believe it would have been a mistake to have tried to develop and rush through Congress a major restructuring of our health care system in the waning days of this session. Congressional leaders have made the right decision to focus on passing, if anything, a bill which will serve as a modest first step in addressing the problems.

Because of this year's groundwork, Congress will return to the issue next year with a far better understanding than we had a year ago of how we might extend coverage and control costs, and how we can accomplish those goals without disrupting the health care of those who are satisfied with the benefits they currently receive. We will be able to respond more effectively to the needs and desires of Americans as individuals, as well as serve the best interests of our nation as a whole.

GRAPHIC: Photo, ANTHONY C. BEILENSON

LANGUAGE: ENGLISH

LOAD-DATE-MDC: September 26, 1994

Faulkner & Gray, Inc

Medicine & Health

September 26, 1994

SECTION: No. 38, Vol. 48; ISSN: 1047-8892

LENGTH: 2487 words

HEADLINE: Children's Health Care: Dim Prospects for a Bright Future

BODY:

Last week, a group of child health experts gathered in the office of Sen. Christopher Dodd (D-CT) to release a new report, four years in the making. Begun in the Bush Administration under the sponsorship of HHS, the "Bright Futures" report offers guidelines for infant, child, and adolescent health care. "This report is a blueprint in many ways for what needs to be done to provide adequate health care and to prevent problems children face today in our modern society," Dodd said. Among other things, the report recommends that children's health needs be addressed within the context of the child's environment. Since health, educational, and social problems are strongly interrelated, none can be viewed in isolation, and health professionals should act on that by doing things like asking families about their concerns. But if the experts were pleased that the guidelines were finally completed, they were frustrated that so many American children are still at risk of developing serious physical or psychological conditions. "More children are living in poverty today, more children are facing critical life transitions such as divorce, remarriage, or unemployment of a parent, and more children are falling through the cracks and need our help," said Morris Green, MD, chairman of the Bright Futures Project Board. Compounding the difficulties is the fact that the number of children who lack private health insurance is growing, as employers seek to cut health care costs by dropping coverage. According to HHS, one-third of the 66 million children in the U.S. do not have private health insurance. In 1992, about 9 million children in the U.S. were without any insurance, and the number of children who depend on Medicaid and other government programs for coverage reached an all-time high of 15.6 million. In a last-gasp effort to pass some health reform before Congress goes out of session, a group of Senators has been pushing a modest package of health reforms that would provide federal subsidies for uninsured children. Sponsored by Sen. Tom Harkin (D-IA) and designed to appeal to politicians of all stripes, the measure incorporates elements for which there is broad bipartisan support: insurance market reforms including a ban on preexisting condition restrictions and lifetime limits on benefits, fraud and abuse protections, a "capped" long term care benefit, and 100 percent tax deductibility for the self-employed. "I believe that there is a possibility, a

ray of light, a bit of hope that something very scaled down will get through," Harkin told reporters recently. He estimates that providing children with insurance subsidies would result in 90 percent of Americans being covered. "It's not comprehensive health care reform, but it certainly could do some very positive things for families," says Elizabeth Noyes, director of the Washington office of the American Academy of Pediatrics.

A Dubious Outlook

But there are so many forces working against the Harkin bill that some observers liken its chances of passage before Congress adjourns to those of the proverbial snowball in hell. First, there are only 10-15 days left in the legislative session, and Congress has other pressing business to complete, like the passage of trade legislation. Secondly, there are concerns about the package's financing. Would the costs of the program outstrip the available revenues, and what would Congress do then? Last but not least, there is politics. Over the past year, the momentum on reform in Congress has slowed from fast-forward to a cautious crawl. In an effort to avoid handing President Clinton a significant political victory in the final weeks before the November elections, House Minority Leader Newt Gingrich (R-GA) has urged party members to avoid coming to any compromise on health reform. And some liberals want to hold off on reform until next year or even 1996, in the hopes of winning bigger gains. At a Sept. 7 speech in Seattle, single payer leader Rep. Jim McDermott (D-WA) said he wants to come back next year and start over. In the meantime, the plight of some children is not likely to get better. At the Bright Futures press conference, Barry Zuckerman, MD, chief of pediatrics at Boston City Hospital, related a story, documented in the Journal of the American Medical Association, about a Boston infant who died of diarrhea because the baby's mother was unable to afford the oral rehydration therapy (water, sugar, and salt) that would have saved the baby's life. Diarrhea is the most common cause of death among infants in the developing world.

A Grim Picture

At the beginning of this century, infectious disease was the biggest killer of American children. But the revolution in public health (including improvements in sanitation, nutrition, immunizations, and pasteurization) slashed the childhood mortality rate. Since then, however, new economic, demographic, and social forces have created other risks to children's health - especially poor and minority children. The highly regarded Kids Count Data Book, produced by the Greenwich CT-based Annie E. Casey Foundation, documents high rates of child poverty and births to single teens, rising rates of teenage violence, and the failure of many teens to graduate from high school on time (see chart). * The death rate for children aged 1 to 14 has declined from 33.8 per 100,000 children in 1985, to 30.7 in 1991, an improvement of about 9 percent. The District of Columbia's rate of 55.4 percent was the highest in 1991, while New Hampshire's (18.9 percent) was the lowest. The

modest advancements are generally credited to improvements in trauma care, auto safety, and accident prevention. However, minorities continue to bear the greatest burden: In 1991, the death rate for black children was almost twice that for white children. * The percentage of children in poverty has improved only slightly from 20.8 percent in 1985, to 20 percent in 1991. In 18 states, however, the child poverty rate actually increased over those same years, and when viewed from a longer term vantage point, the small improvement in child poverty rates looks more like a plateau than a trend. In 1969, the child poverty rate was a much lower 13.8 percent. How does poverty affect a child's health? A study by the Kansas Health Dept. noted that poor children are five times as likely as nonpoor children to die from infections and parasitic disease, four times as likely to die from drowning or suffocation, three times as likely to die from all causes combined, and twice as likely to die from car accidents and fires. Poverty also contributes to learning problems. A study published by the U.S. Dept. of Education during the Reagan Administration found that every year spent in poverty adds 2 percentage points to the chances that a child will

fall behind in school. * The teen violent death rate (homicide, suicide, and accidents among youths aged 15 to 19) rose 13 percent, from nearly 63 per 100,000 youths in 1985, to 71 per 100,000 in 1991. The overall growth in this indicator is due almost entirely to the doubling in the number of teenage homicide victims since 1985. * The share of all births occurring to unwed teenage mothers rose from 7.5 percent in 1985 to 9 percent in 1991. Of the 50 states, only two - Maryland and New Jersey - experienced a decrease in that measure over the past six years. * The U.S. infant mortality rate declined from 10.6 per 1,000 births in 1985, to an all-time low of 8.9 in 1991. This encouraging progress is generally attributed to advances in neonatal medical care and improved public education efforts. The extent of progress, however, has not been uniform across all populations. Children born to poor families are much more likely to die in their first year of life than children in middle-class families. HHS notes that while the U.S. has greatly reduced its infant mortality rate since 1965, the nation still ranks lower than 22 other industrialized nations.

Shrinking Access

Concurrent with other trends affecting children's health is an increase in the number of children who lack private health insurance. Carol Regan, health director for the Children's Defense Fund (CDF), points out that access to primary and preventive health services is crucial to a child's development. According to prevailing myth, most uninsured kids are members of poor, minority, unemployed, and single-parent families. In fact, according to the CDF, if one could identify a "typical" uninsured American child, that child would be white, between the ages of 6 and 17, and living with married parents in a working family with a moderate but above-poverty income. However, minority children continue to be disproportionately uninsured - more than 13 percent of black children and more than one-quarter of Latino children were uninsured in 1992. Since 1977, the number of children covered by employment -related insurance has fallen by about one percent per year; today, fewer than 60 percent of all American children have employment-related insurance,

the CDF says. The advocacy group predicts that if no substantial health reform is enacted, by 2000, slightly more than half of U.S. children will be protected by employment-related health insurance, even though more than 90 percent will have at least one employed family member. William Custer, research director for the Employees Benefit Research Institute, says that if employers offer coverage, they nearly always include dependents because they want to attract a high-quality work force. In 1993, only 5 percent of all employees who got insurance through their workplace were not offered dependent coverage. But more and more small businesses are dropping coverage altogether. The percentage of employees covered by an employer-based policy has decreased from nearly 39 percent among firms of fewer than 10 workers in 1988, to 33 percent in 1993. Medicaid - which has expanded its coverage of pregnant women and children over the last decade largely through a series of mandates sponsored by Rep. Henry Waxman (D-CA) - has picked up some of the slack in private insurance coverage. States also are pitching in. A growing number are not only enacting long term care programs for the elderly and disabled, but are establishing programs that expand children's access to coverage. In Pennsylvania, for example, Gov. Robert Casey (R) in June 1993 launched a program to provide insurance to children up to 18 years of age whose income levels are too high to allow them to qualify for state medical assistance. Private HMOs, including Blue Cross plans, compete for state contracts to provide children with comprehensive primary care services,

including dental and mental health services, and prescription drugs, says Stephen Male, director of the bureau of health care financing in the Pennsylvania Dept. of Health. Three days of hospitalization is covered, after which the child becomes eligible for medical assistance. The program is paid for through a 2 percent cigarette tax. Currently, about 36,000 children are covered under the program, and the state plans to expand it soon by broadening eligibility standards, Male says.

A Down Payment on Reform

Backed by Sens. Harris Wofford (D-PA), Carl Levin (D-MI), and others, the Harkin plan would go into effect in 1996. The plan (which is not yet in bill form) has three main elements, costing an estimated $208 billion over 10 years. Allowing tax deductibility for the self-employed would cost an estimated $29 billion over 10 years; the limited home and community-based care program would cost $52 billion. At a cost of $127 billion over 10 years, the insurance program for children would be administered by states which would contract with private plans to provide insurance, a la Pennsylvania. If a state chose not to run its own program, it could provide coverage through the Federal Employees Health Benefits Program. The plan would offer full insurance subsidies to uninsured children in families with incomes up to 200 percent of the federal poverty level, and partial subsidies to families with incomes up to 300 percent of poverty. The program would provide a comprehensive set of benefits, with no copayments or deductibles for preventive care. To prevent cost shifting to the federal government, the plan would prohibit states from lowering their Medicaid eligibility levels, and businesses would not be allowed to drop

dependent coverage. Families that dropped dependent coverage would be ineligible for the program for six months. Harkin would pay for the bill by extending Medicare savings enacted in the 1993 budget law past the current expiration date of 1998 (raising $78 billion over 10 years); increasing Medicare Part B premiums for beneficiaries who earn more than $80,000 per year (raising $25 billion); and boosting cigarettes taxes by 75 cents per pack (raising $105 billion). If costs for the program increase past the $208 billion that would be raised through those means, Harkin says he might push to have the cigarette tax increased by another one or two cents. While Harkin has designed the bill to be non -controversial, it's likely that many of its elements would be contentious once they were introduced on the floor. Almost every policymaker is in favor of insurance market reforms, but there is little agreement on how those reforms should be designed. Nor is there agreement on eligibility levels for families, nor on a cigarette tax. The most difficult obstacle could prove to be that the comprehensive set of benefits includes family planning services - which would be sure to inflame abortion opponents in Congress. Harkin says there are a number of reasons why Congress should pass his bill. One is that "with kids, you get a lot of bang for the buck." Investments in health services for children produce "a lot of health care savings that you can't quantify." Statistics bolster his claim that children are inexpensive consumers of medical care. Children represent about half of all Medicaid recipients but consume less than one-quarter of total Medicaid spending. In fiscal 1992, Medicaid paid a total of $5,095 for each covered adult and only $1,285 for each child, according to a CDF analysis of HHS data. Also, Congress is likely to take up welfare reform next year, and Harkin says that can't be done without providing welfare recipients with an alternative source of coverage for their kids. Under the current system, mothers who leave welfare to go to work frequently lose Medicaid benefits for their children. Harkin says that even if the House Democratic Leadership tells

him it would be better to wait on reform until next year, he will introduce his bill this week. "There's tremendous support out there" for insuring children, Harkin says. For the 103rd Congress, however, it may be too late.-CK.

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Roll Call

September 26, 1994

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HEADLINE: 'Things Are Getting Worse'
Twelve Months After President Clinton Called on Congress to Fix the Health Care System, 'The Same Problems That Drew Us Into the Debate Continue to Plague Us,' Writes Shalala

BYLINE: By Donna E. Shalala

BODY:

One year ago, President Clinton went to Capitol Hill to talk to Members of Congress and to the American people about the need for health care reform.

In that Sept. 22 speech, the President called our current health care system "badly broken" and asked Congress to work with him to fix it. He described the current system as "too uncertain, too expensive, too bureaucratic, and too wasteful."

Today, 12 months later, the same problems that drew us into the debate continue to plague American consumers, business owners, and governments.

Then and now, there are 58 million Americans without health insurance during part of the year. There are 81 million Americans affected by insurance rules that discriminate against people with medical conditions. Another 133 million people have insurance policies with lifetime limits on their coverage.

Some would like to believe that things are getting better; unfortunately they are getting worse.

Let's look first at health care spending. In 1994, Americans are expected to spend a total of $982 billion on health care services, or about 14 percent of our gross domestic product (GDP). If we do nothing, that total will more than double to $2.1 trillion in 2003, or 20 percent of the GDP. In other words, one out of every five dollars that Americans will spend will go to health care.

But even with all of that money being spent, the number of Americans without insurance will also increase.

Today, 14.7 percent of people under the age of 65 have no health coverage. If we do not reform our system, that number will rise to 15.7 percent in 2003.

And the percentage of Americans with coverage from their employer will drop from 58.5 percent today to only 55.8 percent in 2003. That would reverse a 40-year trend of growth in employer-based coverage.

Privately insured Americans already pay a steep price for the lack of universal coverage. Because hospitals have to recoup the cost of caring for those without coverage, they shift those expenses to those of us with insurance. In 1980, for example, private insurers paid an average of 20 percent above the actual cost of hospital care. By 1992, that was up to 31 percent, and it

continues to rise. It is understandable, then, that some employers are feeling the need to drop health insurance benefits for their workers.

Much has been made of the recent slowing of growth in health care prices. While smaller increases are certainly welcome news, it's important to note that the gap between medical prices and overall prices continues to be 4 percent. In 1990, for example, medical prices rose 9 percent, compared with a 5.4 percent rise in overall prices. In 1993, medical prices were up 5.9 percent, compared with 3 percent for overall prices.

And while I would hope that the recent cooling of health care inflation might continue, history shows that medical prices have abated during periods of intense national debate over health care reform. In the past, the pace has picked right up as soon as the debate ended.

The President's economic plan successfully cut the deficit in half as a percentage of the GDP and keeps it at that level for the remainder of the century. Yet the one area of the federal budget that is still not under control and will eventually drive the deficit back up is the exploding growth rate of federal health care programs.

These are troubling trends as we move toward the 21st century.

That's not to say that there hasn't been some important progress this year. As a result of the national debate the President began last September, our country is more health care literate than at any other point in our history. The public and its elected officials have been engaged in a serious conversation about the virtues and the flaws in our health care system.

And the results of this conversation demonstrate how productive this debate has been. The President proposed to improve our health care system because he recognized the need to provide coverage for every American and to control health care costs.

The public continues to support these two goals overwhelmingly. The recent New York Times/CBS poll concluded that nearly 70 percent of Americans still support universal coverage. This public support is even more astounding because of the

massive spending by those opposed to change in our health care system.

The debate about how to accomplish these two goals is a legitimate but complex one. As a country, we face important choices about how to cover everyone and at the same time control costs.

The problems with our current health care system are not going to disappear. Neither are the special interest defenders of the status quo. As the 103rd Congress nears its conclusion, we must remember what brought us to this debate.

Let's remember the millions of Americans who remain uninsured and the millions more who have only a tenuous hold on their coverage. Let's remember the millions of business owners - large and small - who struggle to continue covering their workers, and the millions more who yearn to offer that security to their employees.

Finally, let's remember the words of one of my favorite political pundits, Mark Twain, who said: "Always do right. This will gratify some and astonish the rest."

Donna E. Shalala is Secretary of Health and Human Services.

LANGUAGE: ENGLISH

LOAD-DATE-MDC: September 26, 1994

lm draft 10/19/94

OP-ED PIECE

People frequently ask me about the future of health care reform, and each time I'm reminded of Aesop's fable about the crow and the pitcher.

Like the thirsty crow whose perseverance finally enabled her to drink water from the bottom of a pitcher, we must keep working toward health care reform even if the journey is longer and more arduous than we initially hoped.

We didn't make as much progress this year as we expected we could. Clearly we made some mistakes in our approach to reform. But in the course of the historic discussion that took place across the country, we also learned a lot. We learned that there are many good ideas out there about how to fix our health care system. And we learned that the majority of Americans still want something to be done.

Simply put, we have no alternative as a nation if we care about our economic future. When the President first proposed reform more than a year ago, his motivation was clear: sustaining a long-term economic recovery was impossible without controlling health care costs. And controlling health care costs was impossible until every American had health coverage.

Today, the economic imperative is even greater. Each year we delay, health care costs consume a greater portion of our national income. This year they account for one-seventh of our economy. In 2004, they will account for one-fifth. And if the trend continues, one can only imagine the economic peril we will face 20 or 30 years from now.

When the health care debate began, 37 million Americans were uninsured. Just this week, the xxxx reported that more than 39 million -- 15 percent of our population -- lack coverage, most of them working Americans. That means that in xxx months, two million more Americans were priced out of the insurance market for one reason or another.

The situation is even bleaker if one considers the health care outlook for children. Nearly 14 percent of children under 18 years old do not have insurance. Obviously this is a health catastrophe in the making -- and an economic one as well.

When 40 million men, women, and children who lack insurance get sick and need treatment, or are in an accident and are rushed to the emergency room, they usually receive care, at least

minimally. And someone pays for it. The hospital or doctor covers their own costs by charging other patients -- those with insurance -- more for services. Hence, the stories we have all heard about hospital patients paying $25 for a Tylenol.

As the cost of care goes up, so do the prices of insurance premiums. In turn, more and more employers decline to provide insurance for their workers. More workers find themselves without insurance through their workplace and unable to buy it on their own.

The vicious cycle of rising costs, uninsured patients, and economic consumption continues unabated. And every American feels the effects.

The more our nation spends on health care, the worse our competitive stature in the global economy. We pay more for clothes, food, cars, houses, and services. We have more difficulty producing jobs. Our deficit is harder to cut. And our investments in other programs we need -- crime, education, job training, environmental protection, economic development, and so on -- diminish.

Equally distressing is that, even as we spend more and more on health care, Americans remain less healthy than their counterparts in other industrialized nations. With health care available from cradle to grave [check this], men and women in Germany, England, Canada, and Japan all have longer life expectancies than men and women in the United States.

Unfortunately, this picture hasn't changed much in the last year.

What has changed is that discussions of our health care system became regular fare in town halls, hospitals, senior centers, offices, schools, and around the kitchen tables of America. Hopefully, those discussions will continue among family members and friends, colleagues at work, and also among lawmakers when the new session of Congress convenes in Washington.

While the economic repercussions of inaction should be paramount in our minds, I hope Americans also will remember the moral incentives for reform. Millions of our fellow citizens are living in fear today that they will not be able to afford health care when they most need it. Millions of children are being denied the most basic treatments that every child in this country deserves.

I've been fortunate enough to travel around the country and listen to thousands of Americans talk about our health care system. I will never forget the pained voice of a woman I met in New Orleans who had worked her whole life but could not afford a

biopsy when a lump was discovered in her breast. I will never forget the look of anguish I saw in the eyes of grandparents whose two grandchildren had meningitis -- one of whom lived and one of whom died, the only difference being that one had insurance and the other did not.

I'll never forget the despair I heard in the voice of a mother and father from Cleveland who were told by an insurance agent that no company would insure their chronically ill daughters because, "we don't insure burning houses."

This is not a vision of America that makes me proud. I believe we can be better than that.

Not long ago, I visited children's hospitals in Boston, Washington, and Memphis. In each one I saw babies recovering from all kinds of illnesses. I wondered what would happen to them. Today, I still wonder about them, and the 11,000 babies born each day across this country.

There are still too many babies who don't have access to preventive care, regular check-ups, and immunizations. There are still too many adults who don't have access to health care, except in emergency rooms. And there are still too many families paying far too much for the care they receive -- and worrying every day about whether they can afford the cost tomorrow.

This is an economic problem that we must face collectively. It is also a human problem. So when people ask me whether we should give up on reform, my answer is: We should never give up on Americans. And we should never give up on America.

Book of Virtues
William Bennett

7

Perseverance

"The noblest question in the world," observed Benjamin Franklin in *Poor Richard,* "is What good may I do in it?" "Hang in there!" is more than an expression of encouragement to someone experiencing hardship or difficulty; it is sound advice for anyone intent on doing good in the world. Whether by leading or prodding others, or improving oneself, or contributing in the thick of things to some larger cause, perseverance is often crucial to success.

Drawing on an ancient Chinese proverb, Harry Truman recounted in his *Memoirs* that being president "is like riding a tiger. A man has to keep on riding or be swallowed." He went on to explain that "a President either is constantly on top of events or, if he hesitates, events will soon be on top of him. I never felt that I could let up for a single moment." Perseverance is an essential quality of character in high-level leadership. Much good that might have been achieved in the world is lost through hesitation, faltering, wavering, vacillating, or just not sticking with it.

Perseverance is also essential to the watchdog's and gadfly's approaches to working for good in the world. Socrates, self-acknowledged gadfly of ancient Athens, was absolutely serious in proclaiming at his trial (as recounted in Plato's *Apology*) that "as long as I draw breath and am able, I shall not cease to practice philosophy, to exhort you and in my usual way to point out to any one of you whom I happen to meet: Good Sir, you are an Athenian, a citizen of the greatest city with the greatest reputation for both wisdom and power; are you not ashamed of your eagerness to possess as much wealth, reputation, and honors as possible, while you do not care for or give thought to wisdom or truth, or the best possible state of your soul?" Socrates' persistent exhortations proved too much for many Athenians, however, and he was condemned. But there are worse fates, as Socrates himself pointed out: while he had merely been condemned to *death,* his accusers had by that same act been condemned to *wickedness!*

"Slow and steady wins the race," runs the moral of Aesop's familiar fable of the tortoise and the hare. Plutarch in his *Life of Sertorius* recounts how this great Roman soldier, while serving as praetor in Spain in the first century B.C., contrived a demonstration for his troops to the same effect, following which he addressed them in this manner: "You see, fellow soldiers, that perseverance is more prevailing than violence, and that many things which cannot be overcome when they are together, yield themselves up when taken little by little. Assiduity and persistence are irresistible, and in time overthrow and destroy the greatest powers whatever, time being the favorable friend and assistant of those who use their judgment to await his occasions, and the destructive enemy of those who are unreasonably urging and pressing forward."

Like most other virtues, persistence and perseverance cannot operate for good in the world in isolation from practical intelligence. A person who is *merely* persistent may be a carping, pestering, irksome annoyance, having no salutary effect whatsoever. But given the right context, occurring in the right combination with other virtues, perseverance is an essential ingredient in human progress. Sam Adams saw it thus in the gestation period prior to our birth as a nation. "The necessity of the times," he proclaimed in 1771, "more than ever, calls for our utmost circumspection, deliberation, fortitude, and perseverance." And the same holds true today.

How do we encourage our children to persevere, to persist in their efforts to improve themselves, their own lot, and the lot of others? By standing by them, and with them and behind them; by being coaches and cheerleaders, and by the witness of our own example. Modern technology has made some of this much easier for us. Video and tape recordings are convincing evidence of the long-term progress that is sometimes hard to see in the short term.

Persevere

Stick-to-it-iveness has a lot to do with getting the right answers in math, English, history, and life, as young Americans of the turn of the twentieth century learned when they memorized this little verse from their *McGuffey's Reader*.

The fisher who draws in his net too soon,
  Won't have any fish to sell;
The child who shuts up his book too soon,
  Won't learn any lessons well.

If you would have your learning stay,
  Be patient—don't learn too fast;
The man who travels a mile each day,
  May get round the world at last.

The Tortoise and the Hare

Aesop

As Aesop knew, perseverance makes up for all sorts of disadvantages. Here is a case of virtue outdistancing undisciplined ability.

A hare once made fun of a tortoise. "What a slow way you have!" he said. "How you creep along!"

"Do I?" said the tortoise. "Try a race with me and I'll beat you."

"What a boaster you are," said the hare. "But come! I will race with you. Whom shall we ask to mark off the finish line and see that the race is fair?"

"Let us ask the fox," said the tortoise.

The fox was very wise and fair. He showed them where they were to start, and how far they were to run.

The tortoise lost no time. He started out at once and jogged straight on.

The hare leaped along swiftly for a few minutes till he had left the tortoise far behind. He knew he could reach the mark very quickly, so he lay down by the road under a shady tree and took a nap.

By and by he awoke and remembered the race. He sprang up and ran as fast as he could. But when he reached the mark the tortoise was already there!

"Slow and steady wins the race," said the fox.

The Little Steam Engine

The story of the little engine that said "I think I can!" has been entertaining children for generations. This version, which comes from an early-twentieth-century reader, offers a portrait of self-resolve as well as cooperation. It reminds us that we get through the hardest times and tasks by pushing and pulling together.

A little steam engine had a long train of cars to pull.

She went along very well till she came to a steep hill. But then, no matter how hard she tried, she could not move the long train of cars.

She pulled, and she pulled. She puffed, and she puffed. She backed and started off again. Choo! Choo! Choo! Choo!

But no! The cars would not go up the hill.

At last she left the train and started up the track alone. Do you think she had stopped working? No, indeed! She was going for help.

"Surely I can find someone to help me," she thought.

Over the hill and up the track went the little steam engine. Choo, choo! Choo, choo! Choo, choo! Choo, choo!

Pretty soon she saw a big steam engine standing on a side track. He looked very big and strong. Running alongside, she looked up and said,

"Will you help me over the hill with my train of cars? It is so long and so heavy that I can't get it over."

The big steam engine looked down at the little steam engine. Then he said,

"Don't you see that I am through my day's work? I have been all rubbed and scoured ready for my next run. No, I cannot help you."

The little steam engine was sorry, but she went on. Choo, choo! Choo, choo! Choo, choo! Choo, choo!

Soon she came to a second big steam engine standing on a side track. He was puffing and puffing, as if he were tired.

"He may help me," thought the little steam engine. She ran alongside and asked,

"Will you help me bring my train of cars over the hill? It is so long and so heavy that I can't get it over."

The second big steam engine answered,

"I have just come in from a long, long run. Don't you see how tired I am? Can't you get some other engine to help you this time?"

"I'll try," said the little steam engine, and off she went. Choo, choo! Choo, choo! Choo, choo! Choo, choo!

After a while she came to a little steam engine just like herself. She ran alongside and said,

"Will you help me over the hill with my train of cars? It is so long and so heavy that I can't get it over."

"Yes, indeed!" said the second little steam engine. "I'll be glad to help you, if I can."

So the little steam engines started back to where the train of cars had been standing all this time. One little steam engine went to the head of the train, and the other to the end of it.

Puff, puff! Chug, chug! Choo, choo! Off they started!

Slowly the cars began to move. Slowly they climbed the steep hill. As they climbed, each little steam engine began to sing,

"I—think—I—can! I—think—I—can! I—think—I—can! I—think—I—can! I—think—I—can! I—think—I—can! I think I can—I think I can—I think I can I think I can—"

And they did! Very soon, they were over the hill and going down the other side.

Now they were on the plain again, and the little steam engine could pull her train herself. So she thanked the little engine who had come to help her, and said goodbye.

And as she went merrily on her way, she sang to herself,

"I—thought—I—could! I—thought—I—could! I—thought—I—could! I—thought—I—could! I thought I could—I thought I could—I thought I could—I thought I could—I thought I could I thought I could—"

Try, Try Again

'Tis a lesson you should heed,
Try, try again;
If at first you don't succeed,
Try, try again;
Then your courage should appear,
For, if you will persevere,
You will conquer, never fear;
Try, try again.

The Crow and the Pitcher

Aesop

This is the famous fable from Aesop which tells us that where there's a will accompanied by practical intelligence, there's a way.

Once there was a thirsty crow. She had flown a long way looking for water to drink.

Suddenly she saw a pitcher. She flew down and saw it held a little water, but it was so low in the pitcher that she could not reach it.

"But I must have that water," she cried. "I am too weary to fly farther. What shall I do? I know! I'll tip the pitcher over."

She beat it with her wings, but it was too heavy. She could not move it.

Then she thought awhile. "I know now! I will break it! Then I will drink the water as it pours out. How good it will taste!"

With beak and claws and wings she threw herself against the pitcher. But it was too strong.

The poor crow stopped to rest. "What shall I do now? I cannot die of thirst with water close by. There must be a way, if I only had wit enough to find it out."

After a while the crow had a bright idea. There were many small stones lying about. She picked them up one by one and dropped them into the pitcher. Slowly the water rose, till at last she could drink it. How good it tasted!

"There is always a way out of hard places," said the crow, "if only you have the wit to find it."

The Little Hero of Holland

Adapted from Etta Austin Blaisdell and Mary Frances Blaisdell

Here is true fortitude: someone doing his duty despite pain and loneliness and danger, someone willing to hold on, hold fast, and hold out as long as it takes, someone whose resolution outweighs even the weight of the sea.

Holland is a country where much of the land lies below sea level. Only great walls called dikes keep the North Sea from rushing in and flooding the land. For centuries the people of Holland have worked to keep the walls strong so that their country will be safe and dry. Even the little children know the dikes must be watched every moment, and that a hole no larger than your finger can be a very dangerous thing.

lm draft 10/19/94

FIRST LADY HILLARY RODHAM CLINTON
OP-ED PIECE -- THE FUTURE OF HEALTH CARE REFORM

People frequently ask me about the future of health care reform, and each time I'm reminded of Aesop's fable about the crow and the pitcher.

Like the thirsty crow whose perseverance finally enabled her to drink water from the bottom of a pitcher, we must keep working toward health care reform even if the journey is longer and more arduous than we initially hoped.

Clearly, we didn't make as much progress this year as we expected we could. But in the course of the historic discussion of reform that took place across the country, we learned a lot. We learned that there are many good ideas out there about how to fix our health care system. We learned that the majority of Americans still want something to be done. And we learned that millions of families will xxx if we abandon them now.

Simply put, we have no alternative as a nation if we care about our economic future. When the President first proposed reform more than a year ago, his motivation was clear: sustaining a long-term economic recovery was impossible without controlling health care costs. And controlling health care costs was impossible until every American had health coverage.

Today, the economic imperative is even greater. Each year we delay, health care costs consume a greater portion of our national income. This year they account for one-seventh of our economy. In 2004, they will account for one-fifth. And if the trend continues, one can only imagine the economic peril we will face 20 or 30 years from now.

The pressure on our economy increases along with the number of people who cannot get health insurance. While it may seem counter-intuitive to say that expanding coverage will save money, the logic actually is not so skewed.

Here is one way to look at it: When the health care debate began, 37 million Americans were uninsured. Just this week, the xxxx reported that more than 39 million -- 15 percent of our population -- lack coverage, most of them working Americans. That means that in xxx months, two million more Americans were priced out of the insurance market for one reason or another.

The situation is even bleaker if one considers the health care outlook for children. Nearly 14 percent of children under 18 years old do not have insurance. Obviously this is a health catastrophe in the making -- and an economic one as well.

When 40 million men, women, and children who lack insurance get sick and need treatment, or are in an accident and are rushed to the emergency room, they usually receive care, at least minimally. And someone pays for it. The hospital or doctor covers their own costs by charging other patients -- those with insurance -- more for services. Hence, the stories we have all heard about hospital patients paying $25 for a Tylenol.

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have
What has changed is that discussions of our health care system became regular fare in town halls, hospitals, senior centers, offices, schools, and around the kitchen tables of America. Hopefully, these discussions will continue ~~among family members and friends, colleagues at work, and also among lawmakers~~ when the new session of Congress convenes in Washington.

(as we move ~~ahead~~, consider the future)
While the economic repercussions of inaction should be paramount in our minds, I hope Americans also will remember the moral incentives for reform. Millions of our fellow citizens are living in fear today that they will not be able to afford health care when they most need it. Millions of children are being denied the most basic treatments that every child in this country deserves.

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To: Lissa
From: Kathy
Date: Oct. 19, 1994
RE: Statistics for OP-ED piece.

1993

Children LESS THAN 18 without insurance:
9.574 million children
13.7% of total pop.

Total population of children less than 18:
69.799 million

Source: U.S. Census Bureau, March 1994 Current Population Survey, Dept. of Commerce.

Chilren LESS THAN 15 without insurance:
7.521 million children
7.8% of total pop.

Total population of children less than 15:
58.983 million

LIFE EXPECTANCY
Life expectance in 1993 for Americans is 75.5 years of age.
For males-72.1
For females-78.9

Comparison to other industrialized nations (1990):

	Male	Female
Japan	76.2	82.5
Canada	74.0	80.8
England	73.2	78.9
Germany	72.7	79.2
U.S.	71.8	78.9

DECLINE IN LIFE EXPECTANCY

Q: Why did life expectancy decline in 1993?

A: Provisional data from the National Center for Health Statistics show life expectancy for the U.S. population declined 0.2 years from 75.7 years in 1992 to 75.5 years in 1993. Among the leading causes contributing most to this decline were HIV infection, chronic obstructive pulmonary diseases, diabetes, and pneumonia/influenza. These negative effects offset the net improvements made in mortality from homicide, cancer, and selected causes of infant death. This data is provisional and more detailed final data will be available in a year which will allow us to study and understand the race and sex patterns contributing to this decline.

Q: Do you expect this provisional decline in life expectancy to hold up when the data becomes final?

A: Generally, provisional and final data track quite closely. However, race and sex data, while currently available in provisional form, will be much more reliable and accurate when it becomes final. Final data includes a full analysis of all 2 million-plus death records, rather than a 10 percent sample, which is what this is.

Q: Has life expectancy in the U.S. declined before?

A: Yes. From 1979 to 1980, life expectancy dropped from 73.9 years to 73.7 years, due to flu epidemics in 1980. However, now we are also dealing with an HIV epidemic which contributed greatly to this recent decline in life expectancy.

Q: Of all the above-mentioned causes contributing to this decline, which was the single most contributing factor?

A: Although HIV infection appears to be the greatest contributing cause to the decline in life expectancy, many of the deaths from chronic obstructive pulmonary diseases could also have been triggered by influenza. In fact, looking at the pneumonia/influenza numbers alone understates their impact; special studies show influenza may have also contributed to deaths from other causes across the board, from heart disease to COPD.

Table 6. Provisional abridged life table for the total population: United States, 1993

[Data are provisional, estimated from a 10-percent sample of deaths. For further discussion, see Technical notes]

Age-interval	Proportion dying	Of 100,000 born alive		Stationary population		Average remaining lifetime
Period of life between 2 exact ages stated in years (1)	Proportion of persons alive at beginning of age interval dying during interval (2)	Number living at beginning of age interval (3)	Number dying during age interval (4)	In the age interval (5)	In this and all subsequent age intervals (6)	Average number of years of life remaining at beginning of age interval (7)
x to $x+n$	$_nq_x$	l_x	$_nd_x$	$_nL_x$	T_x	$\mathring{e}_x$
0–1	0.00809	100,000	809	99,311	7,553,588	75.5
1–5	0.00175	99,191	174	396,356	7,454,277	75.2
5–10	0.00113	99,017	112	494,780	7,057,921	71.3
10–15	0.00121	98,905	120	494,292	6,563,141	66.4
15–20	0.00435	98,785	430	492,950	6,068,849	61.4
20–25	0.00534	98,355	525	490,489	5,575,899	56.7
25–30	0.00619	97,830	606	487,634	5,085,410	52.0
30–35	0.00792	97,224	771	484,238	4,597,776	47.3
35–40	0.01022	96,453	986	479,940	4,113,538	42.6
40–45	0.01347	95,467	1,286	474,349	3,633,598	38.1
45–50	0.01849	94,181	1,741	466,871	3,159,249	33.5
50–55	0.02850	92,440	2,635	456,026	2,692,378	29.1
55–60	0.04392	89,805	3,944	439,732	2,236,352	24.9
60–65	0.06924	85,861	5,945	415,248	1,796,620	20.9
65–70	0.10236	79,916	8,180	380,013	1,381,372	17.3
70–75	0.14859	71,736	10,659	332,959	1,001,359	14.0
75–80	0.21800	61,077	13,315	272,909	668,400	10.9
80–85	0.31974	47,762	15,271	200,839	395,491	8.3
85 and over	1.00000	32,491	32,491	194,652	194,652	6.0

Table 7. Average length of life in years by race and sex: United States, 1950, 1960, 1970, 1980–93

[Data for 1992 and 1993 are provisional, estimated from a 10-percent sample of deaths; for all other years, data are final. For further discussion, see Technical notes]

Year	All races			White			All other					
							Total			Black		
	Both sexes	Male	Female	Both sexes	Male	Female	Both sexes	Male	Female	Both sexes	Male	Female
1993	75.5	72.1	78.9	76.3	73.0	79.5	71.5	67.4	75.5	69.3	64.7	73.7
1992	75.7	72.3	79.0	76.5	73.2	79.7	71.8	67.8	75.6	69.8	65.5	73.9
1991[1]	75.5	72.0	78.9	76.3	72.9	79.6	71.5	67.3	75.5	69.3	64.6	73.8
1990[1]	75.4	71.8	78.8	76.1	72.7	79.4	71.2	67.0	75.2	69.1	64.5	73.6
1989[1]	75.1	71.7	78.5	75.9	72.5	79.2	70.9	66.7	74.9	68.8	64.3	73.3
1988[1]	74.9	71.4	78.3	75.6	72.2	78.9	70.8	66.7	74.8	68.9	64.4	73.2
1987[1]	74.9	71.4	78.3	75.6	72.1	78.9	71.0	66.9	75.0	69.1	64.7	73.4
1986[1]	74.7	71.2	78.2	75.4	71.9	78.8	70.9	66.8	74.9	69.1	64.8	73.4
1985[1]	74.7	71.1	78.2	75.3	71.8	78.7	71.0	67.0	74.8	69.3	65.0	73.4
1984[1]	74.7	71.1	78.2	75.3	71.8	78.7	71.1	67.2	74.9	69.5	65.3	73.6
1983[1]	74.6	71.0	78.1	75.2	71.6	78.7	70.9	67.0	74.7	69.4	65.2	73.5
1982[1]	74.5	70.8	78.1	75.1	71.5	78.7	70.9	66.8	74.9	69.4	65.1	73.6
1981[1]	74.1	70.4	77.8	74.8	71.1	78.4	70.3	66.2	74.4	68.9	64.5	73.2
1980[1]	73.7	70.0	77.4	74.4	70.7	78.1	69.5	65.3	73.6	68.1	63.8	72.5
1970[1]	70.8	67.1	74.7	71.7	68.0	75.6	65.3	61.3	69.4	64.1	60.0	68.3
1960[1]	69.7	66.6	73.1	70.6	67.4	74.1	63.6	61.1	66.3	---	---	---
1950[1]	68.2	65.6	71.1	69.1	66.5	72.2	60.8	59.1	62.9	---	---	---

[1] Data are final; see Technical notes.

Table E. Provisional number of divorces and divorce rates, by month: United States, 1992 and 1993

[Data are provisional; include reported annulments. Rates on an annual basis per 1,000 population. Data are estimated for some States; see Technical notes. Due to rounding, figures may not add to totals. Figures include revisions and, therefore, may differ from those previously published]

Month	Number		Rate	
	1993	1992	1993	1992
Total	1,187,000	1,215,000	4.6	4.8
January	92,000	103,000	4.2	4.8
February	87,000	93,000	4.4	4.6
March	113,000	104,000	5.2	4.8
April	98,000	101,000	4.6	4.8
May	103,000	102,000	4.7	4.7
June	101,000	103,000	4.8	4.9
July	100,000	109,000	4.6	5.1
August	100,000	100,000	4.6	4.6
September	101,000	99,000	4.8	4.7
October	102,000	100,000	4.7	4.6
November	94,000	97,000	4.4	4.6
December	96,000	105,000	4.4	4.8

rates for showing changes in mortality risk over time and for showing differences between race-sex groups within the population.

The unadjusted monthly death rate per 1,000 population was lower for January 1993 than for January 1992. For all other months of 1993, death rates were higher than for the previous year (table F).

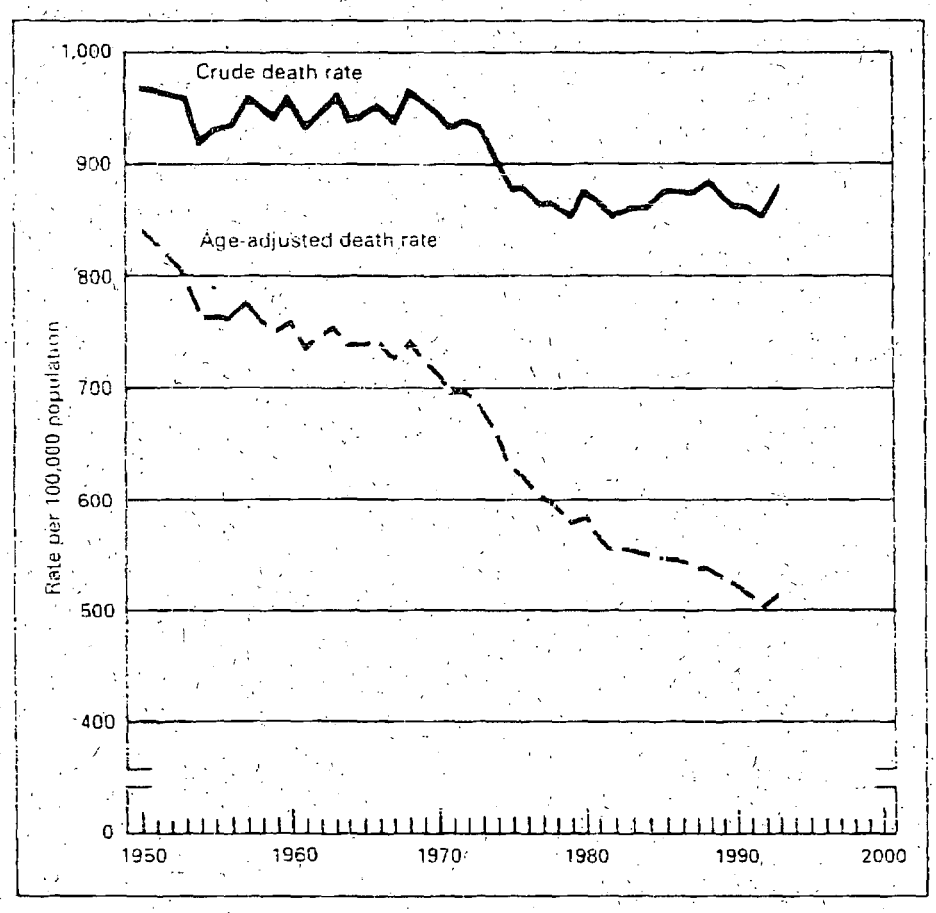

Figure 2. Crude and age-adjusted death rates: United States, 1950–93

Death rates by race and sex, and by age

Among the major race-sex groups, age-adjusted death rates increased from 1992 to 1993 for white males, white females, and black males. The change in the age-adjusted death rate for black females from 1992 to 1993 was not statistically significant. The lowest estimated age-adjusted death rate was for white females (366.1 deaths per 100,000 population), followed by black females (583.1), white males (631.2), and black males (1,051.1). Between 1992 and 1993 provisional death rates by age increased for the following age groups: 25–34 years, 45–54 years, 65–74 years, 75–84 years, and 85 years and over. Changes in death rates for the other age groups between the 2 years were not statistically significant (table G).

Expectation of life

The expectation of life at birth in 1993 was 75.5 years, a decline of 0.2 years compared with life expectancy in 1992. This is the first decline in life expectancy since 1980. This decline may reflect elevated mortality associated with influenza epidemics in 1993. Provisional data show that for the white population from 1992 to 1993 life expectancy at birth declined by 0.2 years for males and females. For the black population, life expectancy at birth declined by 0.8 years for males, but did not change significantly for females. The expectation of life at birth for a given year represents the average number of years that a group of infants would be expected to live if throughout life they were to experience the age-specific death rates prevailing during the year of their birth.

Major causes of death

The 15 leading causes of death in 1993 accounted for 86 percent of all deaths in the United States (table H). For ranking procedures, see Technical notes. The leading causes of death for 1983–93 have generally been the same, but the order has often varied. For 1993 the 15 leading causes of death were the same causes and in the same order as for 1992.

Table 26 (page 1 of 2). Life expectancy at birth and at 65 years of age, according to sex: Selected countries, 1985 and 1990

[Data are based on reporting by countries]

Country [1]	At birth		At 65 years	
	1985 [2]	1990 [3]	1985 [2]	1990 [3]
	Life expectancy in years			
Male				
Japan	75.0	76.2	15.8	16.5
Sweden	73.6	74.8	14.7	15.5
Israel	73.6	74.6	15.1	15.6
Greece	73.5	74.6	15.3	15.8
Canada	73.1	74.0	14.9	15.5
Switzerland	73.5	74.0	15.0	15.3
Netherlands	73.1	73.9	14.1	14.4
Italy	72.2	73.6	14.0	15.0
France	71.8	73.4	14.9	16.1
Spain	73.1	73.4	15.0	15.5
Norway	72.6	73.4	14.4	14.6
England and Wales	71.9	73.2	13.3	14.3
Australia	72.2	73.2	14.2	15.0
Cuba	72.3	72.9	15.7	15.9
Federal Republic of Germany	71.6	72.7	13.7	14.3
Austria	70.4	72.6	13.6	14.7
Costa Rica	72.0	72.5	14.2	14.4
Singapore	70.2	72.3	12.9	14.4
Denmark	71.7	72.2	13.9	14.0
Ireland	70.8	72.0	12.8	13.2
Belgium	70.8	72.0	13.3	14.1
New Zealand	71.0	71.9	13.5	14.3
United States	71.1	71.8	14.5	15.1
Northern Ireland	70.3	71.8	12.7	13.2
Scotland	70.1	71.2	12.5	13.2
Finland	70.5	71.0	13.4	13.8
Portugal	69.5	70.1	13.6	13.8
Yugoslavia	68.1	69.5	13.1	13.6
Chile	67.4	69.4	12.9	14.0
German Democratic Republic	69.5	69.3	12.4	12.8
Puerto Rico	70.2	69.1	15.0	14.9
Bulgaria	68.3	68.2	12.6	12.8
Czechoslovakia	67.3	67.3	11.8	11.9
Romania	67.1	66.6	12.8	13.3
Poland	66.8	66.5	12.5	12.5
Hungary	65.1	65.1	11.8	12.1
U.S.S.R.	62.9	64.2	12.0	12.4
Female				
Japan	81.0	82.5	19.5	20.6
France	80.1	81.8	19.4	20.7
Switzerland	80.4	81.0	19.3	19.7
Sweden	79.9	80.8	18.7	19.4
Canada	80.0	80.8	19.5	19.9
Spain	79.7	80.5	18.4	19.2
Italy	78.8	80.4	17.7	19.0
Netherlands	79.9	80.3	18.9	19.2
Norway	79.6	79.9	18.6	18.7
Greece	78.5	79.8	17.4	18.3
Australia	78.7	79.8	18.2	19.1
Austria	77.4	79.2	17.0	18.2
Federal Republic of Germany	78.3	79.2	17.7	18.2
Finland	79.0	79.0	17.7	17.9
England and Wales	77.6	78.9	17.3	18.2
United States	78.2	78.9	18.5	18.9
Belgium	77.8	78.2	17.5	17.8
Israel	77.0	78.1	16.5	17.3
New Zealand	76.9	78.1	17.3	18.1
Denmark	77.7	77.9	18.0	18.0

See footnotes at end of table.