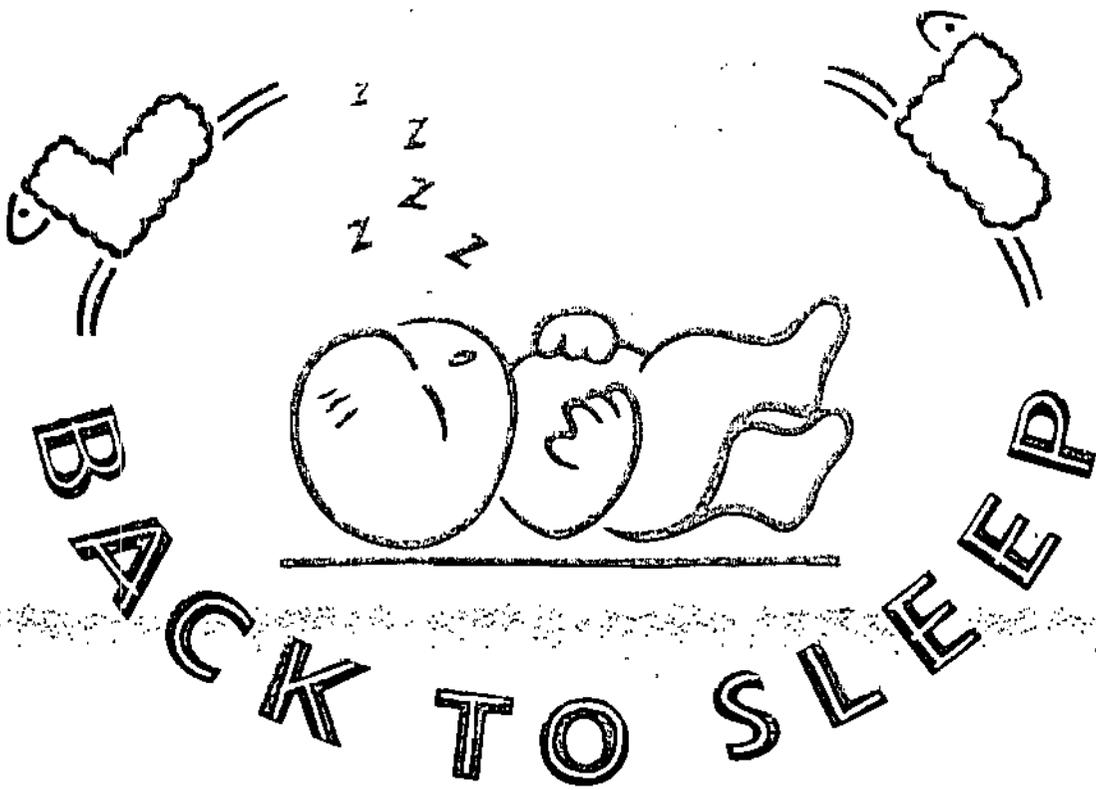


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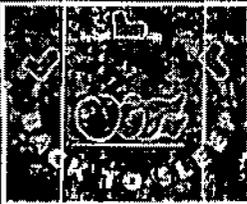


PHOTOCOPY  
PRESERVATION

# Reduce the Risk of Sudden Infant Death Syndrome (SIDS)



- ☑ Always place your baby on his or her back to sleep, even for naps
- ☑ Place your baby on a firm mattress, such as in a safety approved crib
- ☑ Remove soft, fluffy bedding and stuffed toys from your baby's sleep area
- ☑ Make sure your baby's head and face remain uncovered during sleep
- ☑ Do not allow smoking around your baby
- ☑ Do not let your baby get too warm during sleep
- ☑ Talk to childcare providers, grandparents, babysitters and all caregivers about SIDS risk



**Back to Sleep Campaign**  
31 Center Drive, Room 2A32  
Bethesda, MD 20892-2425  
1-800-505-CRIB



## "Tummy Time"

If you have any questions about your baby's sleep position or health, ask your doctor or nurse.



For more information about the Back to Sleep campaign, call toll-free, 1-800-505-CRIB (2742)

Or write to: Back to Sleep/NICHD, 31 Center Drive, Room 2A32, Bethesda, MD, 20892-2425.

Back to Sleep campaign sponsors include:  
National Institute of Child Health and Human Development  
Maternal and Child Health Bureau  
American Academy of Pediatrics • SIDS Alliance  
Association of SIDS and Infant Mortality Programs

Partners in this outreach include:  
National Black Child Development Institute  
Alpha Kappa Alpha Sorority  
Chi Eta Phi Sorority • Chicago Department of Health  
Congress of National Black Churches  
District of Columbia Department of Health  
National Association for the Advancement of Colored People  
National Coalition of 100 Black Women  
National Medical Association  
National Association of Black Owned Broadcasters  
Zeta Phi Beta Sorority

## What Other Things Can I Do to Keep My Baby Healthy?

Get good health care. Good care starts early in pregnancy and includes eating the right foods and not smoking, taking drugs, or drinking alcohol while pregnant. You should also have frequent check-ups with your doctor or nurse. This kind of care helps keep your baby from having problems that could put him or her at risk for SIDS.

Breastfeed your baby, if possible. Studies show that breastfeeding is good for your baby. Breast milk helps to protect the baby from some infections and keeps your baby healthy.

There is no scientific proof that bed-sharing between a baby and an adult reduces SIDS. In fact, in some cases, bed-sharing can be unsafe. If you choose to have your baby sleep in the bed with you in order to breastfeed, make sure your baby sleeps on his or her back. Avoid soft surfaces, pillows, and loose covers. Make sure the baby can't get trapped between the mattress and the framework of the bed (headboard, footboard), a wall, or other furniture.



Take your baby for scheduled well-baby check-ups. Also, make sure your baby receives his or her shots on time.

Most babies are born healthy and most stay that way as they grow.

### Enjoy your baby!

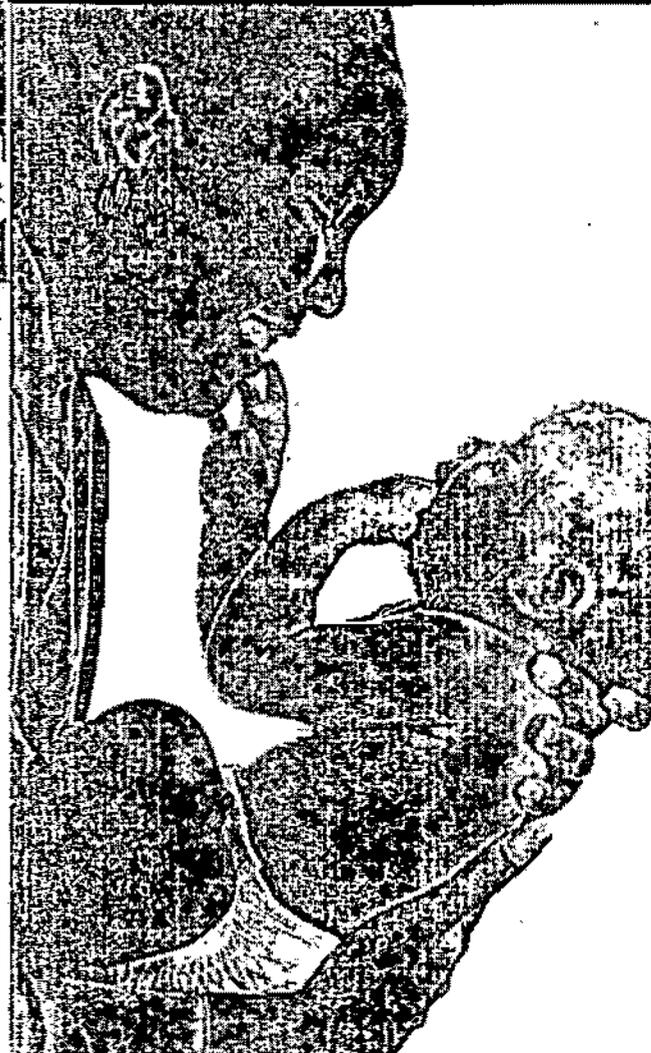


"I have one simple message—place babies on their backs to sleep. Save infant lives!"

David Satcher, M.D.  
U.S. Surgeon General

# Babies Sleep Safest On Their Backs

## Reduce the Risk of Sudden Infant Death Syndrome (SIDS)



## What is SIDS?

SIDS, a word that stands for Sudden Infant Death Syndrome, is the sudden and unexplained death of a baby under 1 year of age.

Because many SIDS babies are found in their cribs, some people call SIDS "crib death." But cribs do not cause SIDS.

## Facts About SIDS

Doctors and nurses don't know what causes SIDS, but they do know:

-  SIDS is the leading cause of death in babies after 1 month of age.
-  Most SIDS deaths occur in babies who are between 2 and 4 months old.
-  More SIDS deaths occur in colder months.
-  Babies placed to sleep on their stomachs are much more likely to die of SIDS than babies placed on their backs to sleep.
-  African American babies are twice as likely to die of SIDS than white babies.

Even though there is no way to know which babies might die of SIDS, there are some things that you can do to make your baby safer.

## Babies Should Sleep on Their Backs.

One of the best ways to lower the risk of SIDS is to put your baby on his or her back to sleep, even for naps.

This is new advice. Until a few years ago, doctors told mothers to place babies on their stomachs to sleep. If you have older children, your doctor may

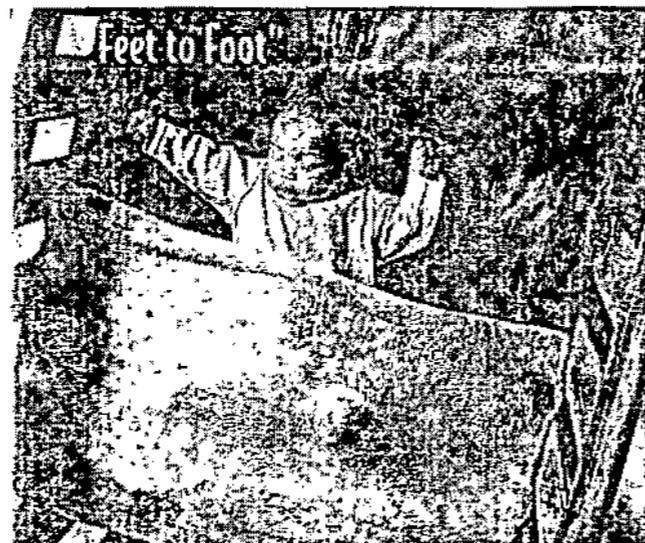
have told you that babies should sleep on their stomachs. But research now shows that fewer babies die of SIDS when they sleep on their backs. In fact, before the Back to Sleep campaign began to recommend back sleeping as the best way to reduce SIDS, more than 5,000 babies in the U.S. died from SIDS every year. But now, as the Back to Sleep message spreads and more babies sleep on their backs, the number of babies who die of SIDS is under 3,000 each year.

Back sleeping is the best sleep position for your baby and provides the best protection against SIDS. The U.S. Surgeon General, Davidatcher, M.D., says that back sleeping is the preferred sleep position.

Make sure everyone knows to place babies on their backs to sleep. Tell your baby's grandparents, aunts, uncles, child care providers, friends, babysitters, and anyone who cares for your baby. Some babies don't like sleeping on their backs at first, but most get used to it quickly. Babies who are on their backs can move their arms and legs and look around more easily.

*Is there a risk of choking when my baby sleeps on his or her back?*

Many mothers worry that babies sleeping on their backs will choke if they spit up or vomit while sleeping. Because babies automatically swallow or cough up such fluid, doctors have found no increase in choking or other problems in babies sleeping on their



backs. Millions of babies around the world sleep safely on their backs.

*What about side sleeping?*

To keep your baby safest when he or she is sleeping, use the back sleep position rather than the side position. Even though the side position is safer than sleeping on the stomach, babies who sleep on their sides can roll onto their stomachs. A baby sleeping on his or her stomach is at greater risk of SIDS. If you choose to place your baby on his or her side to sleep, make sure the lower arm is in front of the baby to help stop him or her from rolling onto the stomach.

Some products are designed to keep the baby in a certain position during sleep. But there is no proof that using any such product lowers the risk of SIDS.

Some babies have health problems that call for them to sleep on their stomachs. If your baby was born with a birth defect, spits up often after eating, or has a breathing, lung, or heart problem, you should talk to your doctor about the best sleep position for your baby.

*Are there times when my baby can be on his or her stomach?*

You can place your baby on his or her stomach for "tummy time," when he or she is awake and someone is watching. When the baby is awake, tummy time is good because it helps make your baby's neck and shoulder muscles stronger.

*Will my baby get "flat spots" on his or her head from back sleeping?*

For the most part, flat spots on the back of the baby's head are a passing condition that goes away a few months after the baby learns to sit up. Tummy time when your baby is awake is one way to reduce flat spots.

One other way to reduce flat spots is to change the direction that your baby lies in the crib (head toward one end of the crib for a few nights and then toward the other). Doing this means the baby is not always sleeping on the same side for his or her head. If you think your baby has a more serious problem, talk to your doctor or nurse.

## What Can I Do to Help Lower the Risk of SIDS?

-  Place your baby on his or her back to sleep, at nighttime and naptime. This is the best way to reduce the risk of SIDS.
-  Place your baby on a firm mattress, such as in a safety-approved crib. Don't put babies to sleep on soft mattresses, sofas, sofa cushions, waterbeds, sheep skins, or other soft surfaces.
-  Remove all fluffy and loose bedding from the sleep area. Make sure you take all pillows, quilts, stuffed toys, and other soft items out of the crib.
-  Make sure your baby's head and face stay uncovered during sleep. Keep your baby's mouth and nose clear of blankets and other coverings during sleep. Use sleep clothing with no other covering over the baby. If you do use a blanket or another covering, make sure your baby is "feet to foot" in the crib. Feet-to-foot means that the baby's feet are at the bottom of the crib, the blanket is no higher than the baby's chest, and the blanket is tucked in around the crib mattress.
-  Don't smoke before or after the birth of your baby. Create a smoke-free zone around your baby. Make sure no one smokes around your baby.
-  Don't let your baby overheat during sleep. Keep your baby warm during sleep, but not too warm. Your baby's room should be at a temperature that is comfortable for an adult. Too many layers of clothing or blankets can overheat your baby.



Summer 2000

**NICHD**

*National Institute  
of Child Health  
and Human  
Development*

*National  
Institutes of  
Health*

### **The Back to Sleep Campaign**

The "Back to Sleep" campaign is aptly named as its main recommendation is to place healthy infants on their backs or sides to sleep. Placing babies on their backs to sleep has been shown to reduce the risk of Sudden Infant Death Syndrome (SIDS).

Although it is difficult to change a national pattern of tummy sleeping, this campaign has been successful in reaching many parents and other caregivers, and back sleeping is being increasingly adopted. Prior to the campaign 70% of infants were sleeping on their stomachs; now only 17% are sleeping on their stomachs. The success of this recommendation is also borne out in the recent reduction in infant mortality rates to a low of 7.2 deaths per 1,000 live births. This reduction is largely due to the decline in SIDS deaths of nearly 40% between 1992 and 1997 (U.S. Vital Statistics).

### **Sudden Infant Death Syndrome**

Prior to the campaign there were more than 5,000 SIDS deaths a year in the United States. That number has now dropped to fewer than 3,000. A SIDS death is heartbreaking as an apparently healthy baby dies suddenly and without warning. Studies in other countries have shown that placing babies on their backs helped to reduce such deaths. Recent NICHD-supported research has identified almost undetectable defects in SIDS infants in a region of the brain that controls sensing of carbon dioxide, breathing, and arousal during sleep. Scientists are identifying the underlying problems that signal a risk of SIDS. But until this physiology is well understood and can be treated, this simple strategy of back sleeping saves many lives.

Surveys show that Back to Sleep is successful, but that much more needs to be done. The goal is to have fewer than 10% of all healthy babies sleeping on their stomachs. All caretakers of infants under one year of age need to be reached, including fathers, grandparents, child care centers, and babysitters. Minority groups need to hear the message in culturally sensitive ways. African American infants are 2 times more likely to die of SIDS than white infants. In FY 2000, the Back to Sleep campaign is targeting the African American population with new material and targeted outreach.

### **History of the Back to Sleep Campaign**

The Back to Sleep campaign is sponsored by a coalition of public and private organizations. The NICHD leads the campaign, along with the Maternal and Child Health Bureau, the American Academy of Pediatrics (AAP), the SIDS Alliance, and the Association of SIDS and Infant Mortality Programs. After weighing the evidence for the safety, the AAP made its recommendation in 1992. In 1994, NICHD began the campaign with an effort to reach every newborn nursery in the country. A toll-free telephone number was established for ordering Back to Sleep pamphlets, posters, and videos. Over 51 million pieces of Back to Sleep materials have been distributed.



## NICHD

### BACK TO SLEEP CHRONOLOGY

National Institute  
of Child Health  
and Human  
Development

National  
Institutes of  
Health

- 1988: Medical societies in the Netherlands adopt non-prone sleeping to protect against "cot death."
- 1991: Publication of population-based, case-control studies conducted in Tasmania, New Zealand, and Avon, England demonstrating a large association between being placed to sleep prone and SIDS.
- Despite the U.S. having a much higher prevalence of prone sleeping than these countries, the U.S. SIDS rate is much lower and contributes less to infant mortality rates.
- 1991 Public education campaigns begin in Australia, New Zealand, and the United Kingdoms advocating that infants be placed on their sides or back to reduce the risk for SIDS.
- Dec. 1991: The American Academy of Pediatrics (AAP) Task Force on Infant Sleep Position and SIDS is formed and begins to evaluate the studies on the role of prone sleep position as a risk factor.
- Feb. 1992: NICHD staff meet with scientists and health professionals from Australia, Britain, the Netherlands, and New Zealand for advice on research and public education issues.
- Mar. 1992: Meeting at NICHD of AAP Task Force and national and international experts to plan a research agenda to provide the basis for, and evaluation of a campaign. Experts divided on whether a recommendation should be made at this time.
- Apr. 1992: The AAP Task Force announces the recommendation that "healthy newborns be placed to sleep on their sides or backs to sleep to reduce the risk of SIDS."
- Apr./May 1992: U.S. national household survey of infant sleep position and related sleep practices initiated under NICHD sponsorship. These surveys are repeated annually.
- June 1992: The AAP Task Force position statement is published in "Pediatrics." This was followed by the publication of editorials expressing concerns regarding the recommendation.

- June/July 1992: Surveys of the membership of AAP, AAFP, and NACHC initiated under NICHD sponsorship to track practice of health professionals. Surveys of newborn nursery nurses added in 1993. These surveys have been repeated in 1994 and 1995.
- Apr. 1993: NICHD funds the prospective Tasmanian SIDS cohort study to obtain health outcome data on the safety of side sleeping position for newborns, a concern of U.S. practitioners. This study also provides the data to show a direct link between the success of the Australian campaign to increase side sleep position, and a 50% decline in the SIDS rate.
- Oct. 1993: NICHD funds analyses of the Avon Longitudinal Study of Pregnancy and Childhood, a prospective study of 14,000 that spans pre- and post-campaign periods in Avon, England, to obtain health outcome data on the safety of side or back sleeping for newborns.
- Jan. 1994: CPSC issues a safety alert warning parents not to place soft bedding under the baby and re-enforcing the AAP recommendation.
- Jan. 1994: NICHD with co-sponsorship from NIDCD and NCHS convenes international meeting of medical and scientific experts to review research data and outcomes from public health campaigns. The overwhelming opinion was that the evidence justified an increased effort to reach a larger audience with the AAP recommendation.
- Mar. 1994: The ad-hoc DHHS Interagency Panel on SIDS recommended to the Assistant Secretary of Health that DHHS adopt and promote the AAP recommendation.
- Mar. 1994: A Back to Sleep coalition was formed between the U.S. PHS, the AAP, the Association of SIDS and Infant Mortality Programs (formerly Assoc. of SIDS<sup>1</sup> Program Professionals), and the SIDS Alliance for the planning, development, and implementation of the Back to Sleep national public health education campaign.
- May 1994: Publication in "Pediatrics" of the proceedings of the January 1994 meeting and joint commentary from the AAP and selected federal agencies endorsing the AAP recommendation and the CPSC alert.
- May 1994: A meeting of maternal and child health organizations is convened by the U.S. PHS to enlist their active participation in the Back to Sleep coalition.

- June 1994: The Surgeon General issues a policy statement that "healthy infants be placed in their backs or sides to sleep to reduce the risk of SIDS."
- June 1994: The Back to Sleep campaign is launched at a press conference at the National Press Club, Washington, D.C.
- Aug. 1994: Campaign materials mailed to membership of AAP.
- Fall 1994: Campaign materials mailed to all U.S. hospitals with newborn nurseries (4,000).
- Fall 1994: PSAs sent to 6,700 radio station and 1,000 TV stations.
- Jan. 1995: Newspaper article distributed through North American Precis.
- July 1995: Campaign materials mailed to WIC regional clinics for distribution to local clinics.
- August 1995: Campaign materials mailed to membership of ACOG.
- Oct. 1996: AAP makes change in its recommendation regarding sleep position, to the back position being the best or preferred position and the side position as a reasonable alternative.
- Dec. 1996: Campaign materials updated with revised recommendation from AAP
- Jan. 1997: Revised campaign materials mailed to membership of AAP.
- Mar. 1997: Mrs. Gore becomes campaign spokesperson.
- Mar. 1997: Gerber Products Company announces corporate partnership. Back to Sleep message on 4 ½ million rice cereal boxes, in mailings to parents, and 1-800 information line.
- Apr. 1997: Revised campaign materials mailed to HMOs.
- May 1997: Revised campaign materials mailed to newborn nurseries (4,000).
- Nov. 1997: Mrs. Gore publishes editorial in US News and World Report and USA Today.

- Nov. 1997: PSA by Mrs. Gore distributed to National Association of Broadcasters.
- Mar. 1998: Article by Mrs. Gore published in Child Magazine.
- June 1998: Letter to Ann Landers from Mrs. Gore published.
- Dec. 1998: Back to Sleep began outreach to more than 250,000 childcare center and licensed child care homes.
- Campaign materials and cover letter from Mrs. Gore and Secretary Shalala mailed to 90,000 licensed childcare centers and family childcare homes (Wave 1).
- Jan. 1999: Surgeon General Dr. David Satcher makes VNR and PSA for national distribution, targeting African Americans.
- Feb. 1999: Johnson & Johnson included Back to Sleep brochure in "First Aid Kit for New Parents."
- April 1999: Procter and Gamble announces corporate partnership.
- April 1999: Pampers Parenting Institute becomes a partner in the Back to Sleep campaign and distributes educational materials to health professionals and parents through articles and Web site.
- April 1999: The National Black Child Development Institute (NBCDI) becomes a partner in the Back to Sleep campaign.
- April 1999: Safety Alert issued by CPSC, AAP, and NICHD to remove soft bedding from cribs.
- July 1999: Pampers places Back to Sleep logo and message on newborn diapers and packages in English, Spanish and French.
- Aug. 1999: Wave 2 mailing to licensed childcare centers and family childcare homes (over 160,000).
- Aug. 1999: NICHD minority outreach video distributed to SIDS Alliance affiliates.
- Sept. 1999: NICHD, SIDS Alliance and National Black Child Development Institute (NBCDI) sponsor "Back to Sleep Strategy Meeting for Reaching the African American Population."

- Oct 1999: DC Department of Health joins Back to Sleep campaign and begins making plans for outreach in the District of Columbia.
- Dec. 1999: NICHD begins testing of new materials designed for African American outreach.
- April 2000: NICHD holds second Back to Sleep African American Outreach strategy meeting with the SIDS Alliance, NBCDI and outreach partners.
- May 2000: NICHD, D.C. Department Health, NBCDI, SIDS Alliance, and MCHB team up to target African American communities in DC with a bus poster. The Metrobus poster is displayed at the "Anacostia Gateway to Health and Wellness Fair."
- Oct. 2000 Release of the resource kit, "Reducing the Risk of SIDS in African American Communities," announced by Surgeon General, Dr. David Satcher at the National Black Child Development Institute's annual meeting in Washington, D.C.

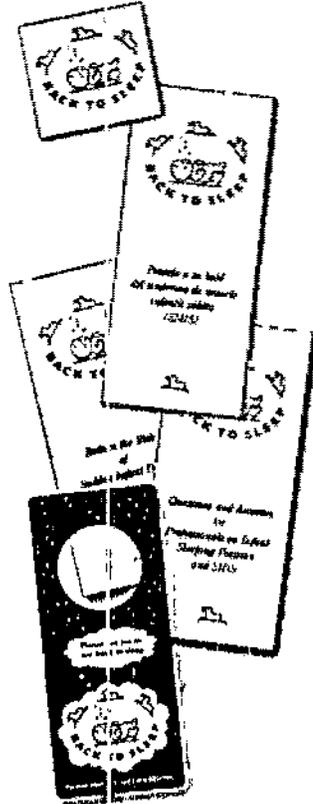
Bus poster displayed on 50 Metrobuses for the Month of October, National SIDS Awareness month.



# Order Form

## Free Campaign Materials

Please feel free to copy and distribute this order form.



ITEM	NO. OF COPIES
Parent Brochure: English	
Parent Brochure: Spanish	
Back to Sleep Logo Stickers	
Take Home Cards (bi-lingual, English and Spanish)	
Professional Brochure: Q & A's	
Back to Sleep Door Hanger	
Poster (LIMIT 20)	
60-minute Video Tape – English, continuous-play of 3-minute video (LIMIT 10)	
60-minute Video Tape – Spanish, continuous-play of 4-minute video (LIMIT 10)	
Order Forms	

NAME: \_\_\_\_\_

ORGANIZATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

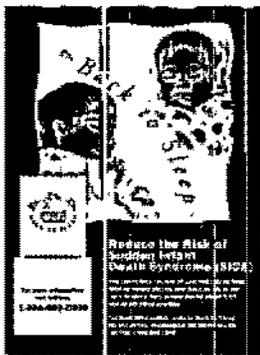
TELEPHONE: \_\_\_\_\_

To order materials — mail, fax, or call:

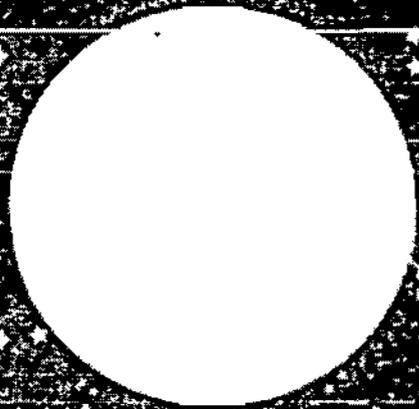
MAIL: NICHD/Back to Sleep  
 31 Center Drive, Room 2A32  
 Bethesda, MD 20892-2425

FAX: 301-496-7101

CALL: 1-800-505-CRIB



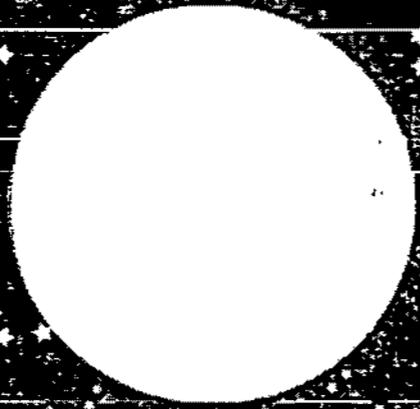
**Stand-up Event**  
 13" x 17 1/2" with attached brochure holder  
 Countertop display



Please put me on my back to sleep.



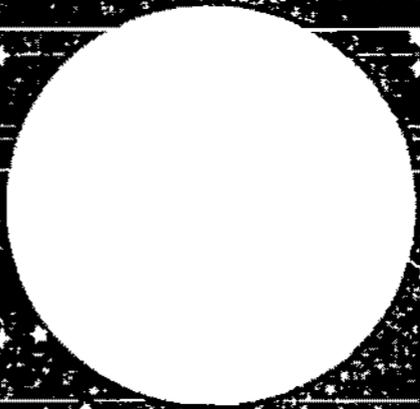
For more information, call 1-800-505-CRIB



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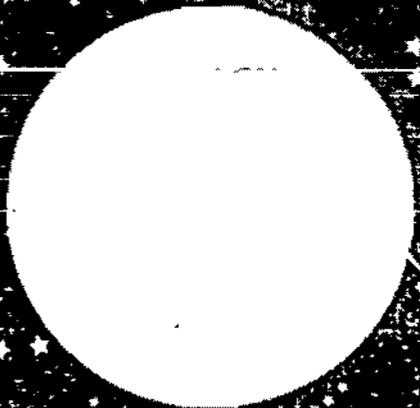
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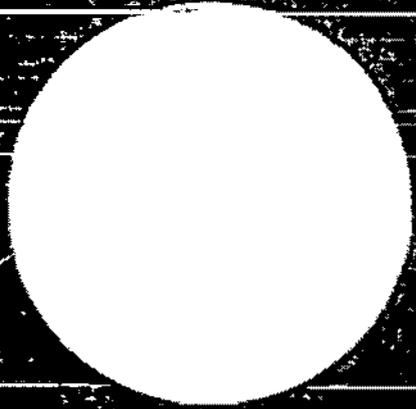
For more information, call 1-800-505-CRIB



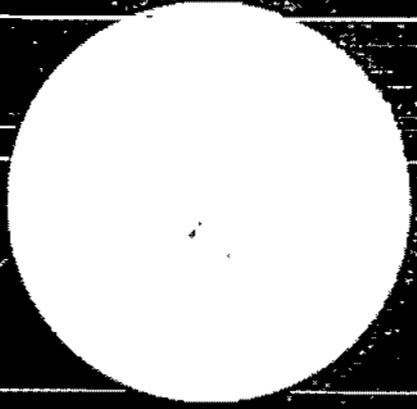
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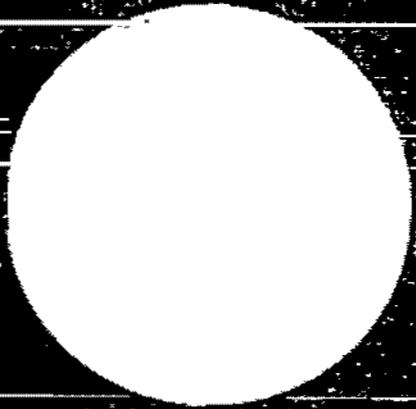
For more information, call 1-800-505-CRIB  
Designed by the California SIDS Program.



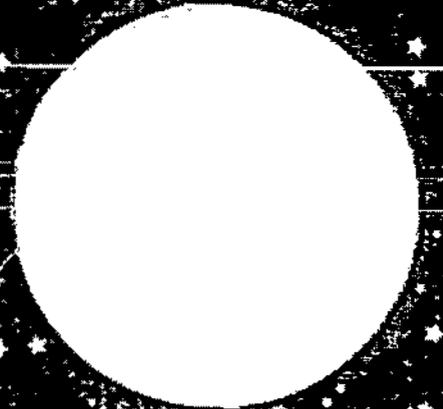
Designed by the California SIDS Program.



Designed by the California SIDS Program.



Designed by the California SIDS Program.



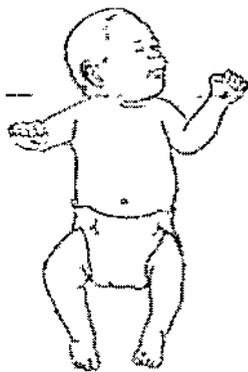
Por favor acuéstame  
de espaldas para  
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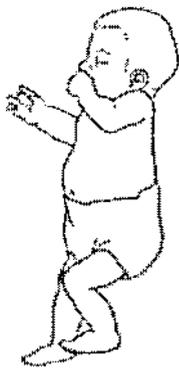
Para más información, llame al 1-800-505-2742.

## Best Sleep Position

Make sure your baby goes to sleep on his or her back. This provides the best protection against SIDS.



## Alternative Sleep Position



If you choose to use the side sleep position, make sure your baby's lower arm is forward to stop him or her from rolling over onto the stomach.

If you have any questions about your baby's sleep position or health, first talk to your doctor or nurse. For more information about the Back to Sleep campaign, call free of charge, 1-800-505-2742. Or you can write to: Back to Sleep, P.O. Box 29111, Washington, D.C. 20040

## What Is SIDS?

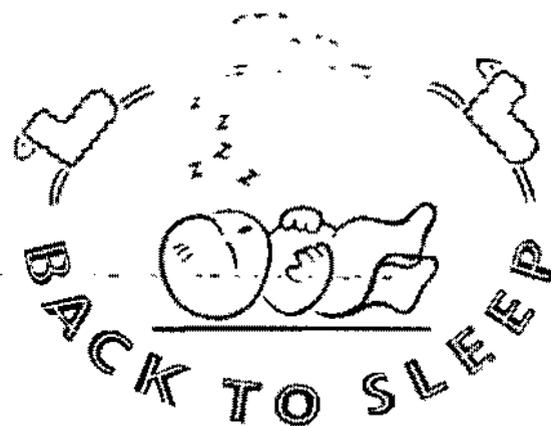
Sudden Infant Death Syndrome (SIDS) is the sudden and unexplained death of an infant under one year of age.

SIDS, sometimes known as crib death, is the major cause of death in babies from 1 month to 1 year of age. Most SIDS deaths occur when a baby is between 1 and 4 months old. More boys than girls are victims, and most deaths occur during the fall, winter and early spring months.

The death is sudden and unpredictable; in most cases, the baby seems healthy. Death occurs quickly, usually during a sleep time.

After 30 years of research, scientists still cannot find one definite cause or causes for SIDS. There is no way to predict or prevent SIDS. But, as this brochure describes, research has found some things that can help reduce the risk of SIDS.

This information is from the U.S. Public Health Service, American Academy of Pediatrics, SIDS Alliance, and Association of SIDS and Infant Mortality Programs.



## Reduce the Risk of Sudden Infant Death Syndrome (SIDS)



# Reduce the Risk of Sudden Infant Death Syndrome (SIDS)

Sudden Infant Death Syndrome (SIDS) is the sudden and unexplained death of an infant under one year of age. SIDS, sometimes known as crib death, strikes nearly 5,000 babies in the United States every year. Doctors and nurses don't know what causes SIDS, but they have found some things you can do to make your baby safer.

## Healthy Babies Should Sleep on Their Back

One of the most important things you can do to help reduce the risk of SIDS is to put your healthy baby on his or her back to sleep. Do this when your baby is being put down for a nap or to bed for the night.

This is new. Your mother was told and, if you have other children, you may have been told that babies should sleep on their tummy. Now, doctors and nurses believe that fewer babies will die of SIDS if most infants sleep on their back.

### Check With Your Doctor or Nurse

Most babies should sleep on their back. But a few babies have health conditions that might require them to sleep on their tummy. If your baby was born with a birth defect, often spits up after eating, or has a breathing, lung or heart problem, be sure to talk to a doctor or nurse about which sleep position to use.

Some mothers worry that babies sleeping on their back may choke on spit-up or vomit during sleep. There is no evidence that sleeping on the back

causes choking. Millions of babies around the world now sleep on their back and doctors have not found an increase in choking or other problems.

Some babies of first don't like sleeping on their back, but most get used to it and this is the best sleep position for your baby. Although back sleeping is the best sleep position, your baby can be placed on his or her side. Side position does not provide as much protection against SIDS as back sleeping, but it is much better than placing your baby on his or her tummy.

Your baby can be placed on his or her stomach when awake. Some "tummy time" during awake hours is good for your baby. Talk to your doctor or nurse if you have questions about your baby's sleep position.

## Other Things You Can Do to Help Reduce the Risk of SIDS

- **Bedding.** Make sure that your baby sleeps on a firm mattress or other firm surface. Don't use fluffy blankets or comforters under the baby. Don't let the baby sleep on a waterbed, sheepskin, a pillow, or other soft materials. When your baby is very young, don't place soft stuffed toys or pillows in the crib with him or her. Some babies have smothered with these soft materials in the crib.

- **Temperature.** Babies should be kept warm, but they should not be allowed to get too warm. Keep the temperature in your baby's room so that it feels comfortable to you.

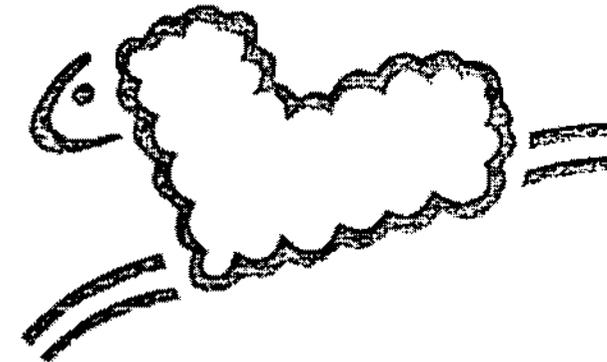
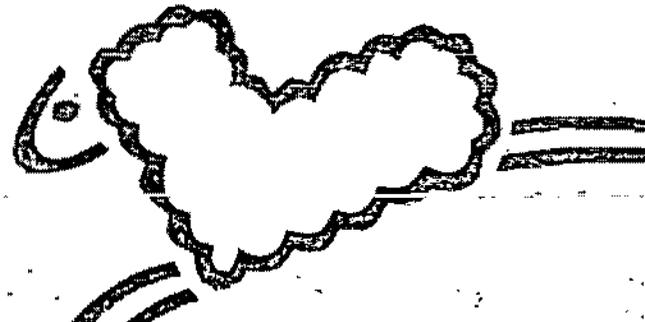
- **Smoke-free.** Create a smoke-free zone around your baby. No one should smoke around your baby. Babies and young children exposed to smoke have more colds and other diseases, as well as an increased risk of SIDS.

- **Doctor or clinic visits.** If your baby seems sick, call your doctor or clinic right away. Make sure your baby receives his or her shots on schedule.

- **Prenatal care.** Early and regular prenatal care can also help reduce the risk of SIDS. The risk of SIDS is higher for babies whose mothers smoked during pregnancy. For your baby's well being, you should not use alcohol or drugs during pregnancy unless prescribed by a doctor.

- **Breastfeeding.** If possible, you should consider breastfeeding your baby. Breast milk helps to keep your baby healthy.

Enjoy your baby! Remember, most babies are born healthy and most stay that way. Don't let the fear of SIDS spoil your joy and enjoyment of having a new baby.



## Mejor Posición Para Dormir

Asegúrese de que su bebé duerma de espaldas. Esta provee la mejor protección contra el SMIS.



## Posición Alternativa Para Dormir



Se decide poner a su bebé de costado para dormir, asegúrese de que el brazo de su bebé este de abajo hacia adelante para evitar que se den vuelta boca abajo.

Si usted tiene alguna pregunta acerca de la posición en que debe dormir su bebé o acerca de su salud, hable primero con su médico o enfermera. Para más información sobre la campaña para Dormir de Espaldas, llame gratis al 1-800-505-2742. O puede escribir a: Back to Sleep, P.O. Box 29111, Washington D.C.

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## ¿Qué Es El SMIS?

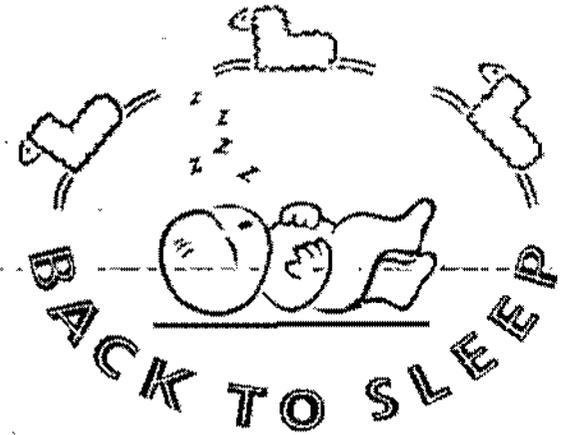
El síndrome de muerte infantil súbita (SMIS) es la muerte repentina e inexplicable de un niño menor de un año de edad.

El SMIS, conocido a veces como muerte de cuna, es la causa principal de la muerte en bebés de 1 mes a 1 año de edad. La mayor parte de las muertes por SMIS ocurren cuando el bebé tiene entre 1 y 4 meses de edad. Mueren más varones que mujeres y la mayoría de las muertes ocurren durante los meses del otoño, el invierno y principios de la primavera.

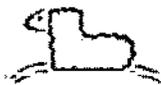
La muerte es repentina e imprevista; en la mayoría de los casos, el bebé parece estar sano. La muerte ocurre rápidamente, generalmente mientras duerme.

Después de 30 años de investigación, los científicos todavía no pueden encontrar una causa o causas definidas del SMIS. Pero, como explica este folleto, la investigación sí ha descubierta algunas cosas que pueden ayudar a proteger al bebé del SMIS.

Esta información viene del Servicio Salud Pública de los Estados Unidos, la Academia Americana de Pediatría, Alianza de SMIS, y la Asociación de Programas del SMIS y de la Muerte Infantil.



*Proteja a su bebé  
del síndrome de muerte  
infantil súbita  
(SMIS)*



# Proteja a su bebé del síndrome de muerte infantil súbita (SMIS)

El síndrome de muerte infantil, súbita (SMIS) es la muerte repentina e inexplicable de un niño menor de un año de edad. El SMIS, a veces conocido como muerte de cuna, afecta a casi 5.000 bebés en los Estados Unidos todos los años. Las médicas y las enfermeras no conocen la causa del SMIS, pero han descubierto algunas cosas que usted puede hacer para proteger a su bebé.

## Los Bebés Sanos Deben Dormir De Espaldas

Una de las cosas más importantes que usted puede hacer para proteger a su bebé del SMIS es poner a su bebé sano de espaldas para dormir. Hágalo cuando acuesta a su bebé para una siesta o para dormir de noche.

Esto es nuevo, a su mamá, y a usted si tiene otros hijos, se le ha dicho que las bebés deben dormir boca abajo. Ahora las médicas y las enfermeras creen que menos bebés morirán de SMIS si la mayoría de ellos duermen de espaldas.

Consulte con su médica o enfermera

La mayoría de los bebés deben dormir de espaldas. Pero algunos bebés tienen problemas de salud que requieren que duerman boca abajo. Si su bebé nació con un defecto de nacimiento, vomita frecuentemente después de comer o tiene un problema de respiración, de

los pulmones o del corazón, hable con un médico o una enfermera acerca de cuál posición debe usar para dormir.

Algunas madres se preocupan de que las bebés que duermen de espaldas se pueden ahogar con el vómito mientras duermen. No hay ninguna evidencia de que dormir de espaldas las haga ahogar en su vómito. Millones de bebés en toda el mundo duermen ahora de espaldas o de costado y las médicas no han notado ningún aumento en ahogos u otros problemas.

A algunos bebés no les gusta dormir de espaldas al principio, pero la mayoría se acostumbra y esta es la mejor posición para dormir a su bebé. Aunque la mejor posición para dormir a su bebé es de espaldas, también puede acostar a su bebé de costado. Acostar a su bebé de costado no provee la misma cantidad de protección contra el SMIS como el acostar a su bebé de espaldas, pero es mucho mejor que acostar a su bebé sobre su estomacito.

Puede poner a su bebé sobre su estomago cuando esto despierta. Un poquito de tiempo sobre su estomacito cuando esta despierta es buena para la salud de su bebé. Hable con su doctor o enfermera si tiene preguntas acerca de la posición en que debe dormir a su bebé.

## Otras Cosas Que Usted Puede Hacer Para Ayudar A Reducir El Riesgo Del SMIS

Cama. Asegúrese de que su bebé duerma sobre un colchón firme u otra superficie firme. No use montos mullidos o plumones debajo del bebé. No permita que el bebé duerma en una cama de agua, sobre una piel de oveja, una almohada u otro material blando. Cuando su

bebé es muy pequeño, no ponga juguetes rellenos o almohadas blandas en la cuna con él o ella. Algunas bebés se han ahogado con estas cosas blandas en la cuna.

Temperatura. No hay que dejar que las bebés tengan frío, pero tampoco hay que permitir que tengan demasiado calor. Mantenga el cuarto del bebé a una temperatura que es agradable para usted.

Nada de humo. Mantenga una zona libre de humo alrededor de su bebé. Nadie debe fumar cerca de su bebé. Las bebés y los niños pequeños expuestos al humo se enferman más con resfriados y otras enfermedades, aparte de tener menos resistencia al SMIS.

Consultas al médico o a la clínica. Si le parece que su bebé está enfermo, llame a su médico o a la clínica inmediatamente. Asegúrese de que su bebé reciba sus vacunas cuando le corresponde.

Cuidado durante el embarazo. El cuidado prenatal desde temprano y a lo largo del embarazo puede ayudar a reducir el riesgo del SMIS. El riesgo del SMIS es mayor para los bebés que sus madres fumaron durante el embarazo. Para la salud de su bebé, nunca debe tomar drogas (excepta si son recetadas por un médico) ni tampoco debe tomar bebidas alcohólicas durante el embarazo.

Amamantar. Si es posible, debe pensar en darle pecho a su bebé. La leche materna ayuda a mantener sano a su bebé.

¡Disfrute de su bebé! Recuerde que la mayoría de los bebés nacen sanos y siguen sanos. No deje que el temor del SMIS arruine su gozo y alegría de tener un nuevo bebé.

### *Will babies aspirate on their backs?*

While this has been a significant concern to health professionals and parents, there is no evidence that healthy babies are more likely to experience serious or fatal aspiration episodes when they are supine. In fact, in the majority of the very small number of reported cases of death due to aspiration, the infant's position at death, when known, was prone. In addition, indirect reassurance of the safety of the supine position for infants comes from the knowledge that this position has been standard in China, India, and other Asian countries for many years. Finally, in countries such as England, Australia, and New Zealand, where there has been a major change in infant sleeping position from predominantly prone to predominantly supine or side sleeping, there is no evidence of any increased number of serious or fatal episodes of aspiration of gastric contents.

### *Will supine sleeping cause flat heads?*

There is some suggestion that the incidence of babies developing a flat spot on their occiputs may have increased since the incidence of prone sleeping has decreased. This is almost always a benign condition, which will disappear within several months after the baby has begun to sit up. Flat spots can be avoided by altering the supine head position. Techniques for accomplishing this include turning the head to one side for a week or so and then changing to the other, reversing the head-to-toe axis in the crib, and changing the orientation of the baby to outside activity (e.g., the door of the room). "Positional plagiocephaly" seldom, if ever, requires surgery and is quite distinguishable from craniosynostosis.

### *Should products be used to keep babies on their backs or sides during sleep?*

Although various devices have been marketed to maintain babies in a non-prone position during sleep, the Task Force does not recommend their use. None of the studies that showed a reduction in risk when the prevalence of prone sleeping was reduced used devices. No studies examining the relative safety of the devices have been published.

Experience from sleep position campaigns overseas suggests that most infants can be stabilized in the side position by bringing the infant's dependent arm forward, at right angles to the body, with the infant's back propped against the side of the crib. There should be no need for additional support. Infants who sleep on their backs need no extra support.

### *Should soft surfaces be avoided?*

Several studies indicate that soft sleeping surfaces increase the risk of SIDS in infants who sleep prone. How soft a surface must be to pose a threat is unknown. Until more information becomes available, a standard firm infant mattress with no more than a thin covering, such as a sheet or rubberized pad, between the infant and mattress is advised.

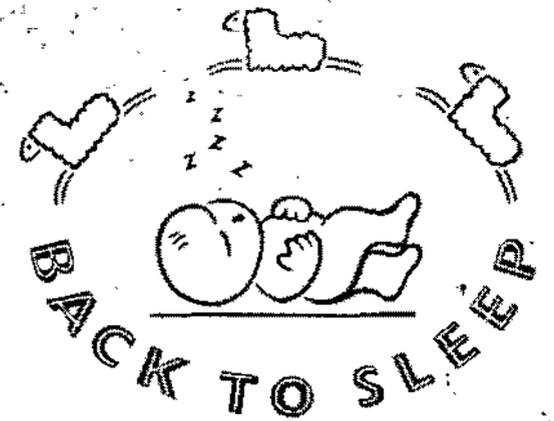
The US Consumer Product Safety Commission has also warned against placing any soft, plush, or bulky items, such as pillows, rolls of bedding, or cushions, in the baby's immediate sleeping environment. These items can potentially come into close contact with the infant's face, impeding ventilation or entrapping the infant's head and causing suffocation.

For information on sleep position and SIDS risk reduction, call the "Back to Sleep" campaign line: 1-800-505-CRIB.

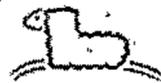
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## *Questions and Answers for Professionals on Infant Sleeping Position and SIDS*



In 1992, the American Academy of Pediatrics released a statement recommending that all healthy infants be placed down for sleep on their backs (Pediatrics, 1992;89: 1120-1126). This recommendation was based on numerous reports that babies who sleep prone have a significantly increased likelihood of dying of sudden infant death syndrome (SIDS). The recommendation was reaffirmed in 1994 (Pediatrics, 1994;93:820). Health care professionals are encouraged to read both publications for a review of the evidence that led to the recommendation.

A national campaign (the "Back to Sleep" campaign) was launched in 1994 to promote supine positioning during sleep. Periodic surveys have confirmed that the prevalence of prone sleeping among infants in the United States has decreased from approximately 7.5% in 1992 to less than 2.5% in 1995. Provisional mortality statistics suggest that the death rate from SIDS has simultaneously decreased by over 25% — by far the largest decrease in SIDS rates since such statistics have been compiled.

Although the recommendation appears simple (most babies should be put to sleep on their backs), a variety of questions have arisen about the practicalities of implementation. The AAP Task Force on Infant Sleep Position and SIDS has considered these questions and prepared the following responses. It should be emphasized, however, that for most of these questions there are not sufficient data to provide definitive answers.

*Is the side position as effective as the back?*

The vast majority of studies which showed a relationship between sleep position and SIDS examined whether babies were placed "prone" versus "non-prone" (i.e., side or back). However, a few recent reports indicate that the risk of SIDS is greater for babies placed on their sides versus those placed truly supine. There is some evidence that the reason for this difference is that babies placed on their sides have a higher likelihood of spontaneously

turning to prone. However, both non-prone positions (side or back) are associated with a much lower risk of SIDS than is prone. If the side position is used, caretakers should be advised to bring the dependent arm forward, to lessen the likelihood of the baby rolling prone.

*Are there any babies who should be placed prone for sleep?*

In published studies, the vast majority of babies examined were born at term and had no known medical problems. Babies with certain disorders have been shown to have fewer problems when lying prone. These babies include:

- infants with symptomatic gastro-esophageal reflux (reflux is usually less in the prone position).
- babies with certain upper airway malformations such as Robin syndrome (there are fewer episodes of airway obstruction in the prone position).

There may also be other specific infants in whom the risk/benefit balance favors prone sleeping. The risk of SIDS increases from approximately 0.86 SIDS deaths per 1,000 live births to 1.62 when babies sleep prone\* (that is, 998 of every 1,000 prone-sleeping babies will not die of SIDS). This relatively small increased risk may be reasonable to accept, when balanced against the benefit of prone sleeping for certain babies. Health professionals need to consider the potential benefit when taking into account each baby's circumstances.

If it is decided to allow a baby to sleep prone, special care should be taken to avoid overheating or use of soft bedding since these factors are particularly hazardous for prone-sleeping infants.

*Should healthy babies ever be placed prone?*

Since the initiation of the national campaign, some parents have misinterpreted the recommendation to say that babies should never be placed prone. This is incorrect. Developmental experts advise that prone

\*On the basis of the 1992 SIDS rate of 0.0013 in the United States, a prone prevalence of 58%, and the Mantel-Haenszel weighted odds ratio from seven published studies.

positioning during the awake state is important for shoulder girdle motor development. Therefore, parents should be advised that a certain amount of "tummy time," when the baby is awake and observed, is good.

*Which sleeping position is best for a baby born preterm who is ready for discharge?*

There have been studies showing that preterm babies who have active respiratory disease have improved oxygenation if they are prone. However, these babies have not been specifically examined as a group once they are recovered from respiratory problems and are ready for hospital discharge. There is no reason to believe that they should be treated any differently than a baby who was born at term. Unless there are specific indications to do otherwise (see exceptions above), the Task Force believes that such babies should be placed for sleep on their backs.

*In what position should babies be placed for sleep in hospital full-term nurseries?*

Nearly all of the studies have been performed on babies who were beyond the neonatal period, mostly babies who were 2 to 6 months of age. However, experience in other countries has shown that mothers generally position their babies at home similar to the way they were placed in the hospital. Therefore, the Task Force recommends that personnel in hospital nurseries place babies in a supine position or on their sides. If there are concerns about possible asphyxiation in the immediate neonatal period, the baby may be placed on the side and propped against the side of the bassinet for stability.

*If a baby doesn't sleep well in the supine position, is it okay to turn him or her to a prone position?*

Positional preference appears to be a learned behavior among infants from birth to 4 to 6 months of age. The infant, being placed in a back or side position in the newborn nursery, will become accustomed to this position.

If the parent finds that the infant has great difficulty going to sleep in the supine position, consider placing the infant prone and moving the infant to a back position when he or she is sleeping. Again, be sure to avoid overheating or use of soft bedding with such an infant.

*At what age can you stop using the back position for sleep?*

We are unsure of the level of risk associated with prone positioning at specific ages during the first year of life, although there are some data that suggest that the greatest decrease in SIDS incidence in those countries that have changed to mostly non-prone sleeping has been seen in the younger aged infants (2 to 6 months). Therefore, the first 6 months, when babies are forming sleeping habits, are probably the most important time to focus on. Nevertheless, until more data suggest otherwise, it seems reasonable to continue to place babies down for sleep supine throughout infancy.

*Do I need to keep checking on my baby after laying him or her down for sleep in a non-prone position?*

We recommend that parents do not keep checking on their baby after he or she is laid down to sleep. Although the infant's risk of SIDS could be increased slightly if he or she spontaneously assumes the prone position, the risk is not sufficient to outweigh the great disruption to the parents, and possibly to the infant, by frequent checking. Also, studies have shown that it is unusual for a baby who is placed in a supine position to roll into a prone position during early infancy.

*How should hospitals place babies down for sleep after they are readmitted?*

We recommend, as a general guideline, that hospitalized infants sleep in the same position that they have used at home, to minimize additional disruption to the infant. There may, however, be extenuating circumstances that would indicate preference for the prone position (e.g., an infant with significant upper airway obstruction).



NICHD

National Institute  
of Child Health  
and Human  
Development

National  
Institutes of  
Health

# Sudden Infant Death Syndrome

**S**udden Infant Death Syndrome (SIDS) is the diagnosis given for the sudden death of an infant under one year of age that remains unexplained after a complete investigation, which includes an autopsy, examination of the death scene, and review of the symptoms or illnesses the infant had prior to dying and any other pertinent medical history. Because most cases of SIDS occur when a baby is sleeping in a crib, SIDS is also commonly known as "crib death."

SIDS is the leading cause of death in infants between 1 month and 1 year of age. Most SIDS deaths occur when a baby is between 1 and 4 months of age. African American children are two to three times more likely than white babies to die of SIDS, and Native American babies are about three times more susceptible. Also, more boys are SIDS victims than girls.

## *What Are the Risk Factors for SIDS?*

A number of factors seem to put a baby at higher risk of dying from SIDS. Babies who sleep on their stomachs are more likely to die of SIDS than those who sleep on their backs. Mothers who smoke during pregnancy are three times more likely to have a SIDS baby, and exposure to passive smoke from smoking by mothers, fathers, and others in the household after

mothers who had no or late prenatal care, and premature or low birth weight babies.

## *What Causes SIDS?*

Mounting evidence suggests that some SIDS babies are born with brain abnormalities that make them vulnerable to sudden death during infancy. Studies of SIDS victims reveal that many SIDS infants have abnormalities in the "arcuate nucleus," a portion of the brain that is likely to be involved in controlling breathing and waking during sleep. Babies born with defects in other portions of the brain or body may also be more prone to a sudden death. These abnormalities may stem from prenatal exposure to a toxic substance, or lack of a vital compound in the prenatal environment, such as sufficient oxygen. Cigarette smoking during pregnancy, for example, can

to cause death. Other possibly important events occur after birth such as lack of oxygen, excessive carbon dioxide intake, overheating, or an infection. For example, many babies experience a lack of oxygen and excessive carbon dioxide levels when they have respiratory infections that hamper breathing, or they rebreathe exhaled air trapped in underlying bedding when they sleep on their stomachs. Normally, infants sense such inadequate air intake, and the brain triggers the babies to wake from sleep and cry, and changes their heartbeat or breathing patterns to compensate for the insufficient oxygen and excess carbon dioxide. A baby with a flawed arcuate nucleus, however, might lack this protective mechanism and succumb to SIDS. Such a scenario might explain why babies who sleep on their stomachs are more susceptible to SIDS, and why a disproportionately large number of SIDS babies have been reported to have respiratory infections prior to their deaths. Infections as a trigger for sudden infant death may explain why more SIDS cases occur during the colder months of the year, when respiratory and intestinal infections are more common.



**SIDS is the leading cause of death in infants between 1 month and 1 year of age.**

of these proteins can interact with the brain to alter heart rate and breathing during sleep, or can put the baby into a deep sleep. Such effects might be strong enough to cause the baby's death, particularly if the baby has an underlying brain defect.

Some babies who die suddenly may be born with a metabolic disorder. One such disorder is medium chain acylCoA dehydrogenase deficiency, which prevents the infant from properly processing fatty acids. A build-up of these acid metabolites could eventually lead to a rapid and fatal disruption in breathing and heart functioning. If there is a family history of this disorder or childhood death of unknown cause, genetic screening of the parents by a blood test can determine if they are carriers of this disorder. If one or both parents is found to be a carrier, the baby can be tested soon after birth.

#### **What Might Help Lower the Risk of SIDS?**

There currently is no way of predicting which newborns will succumb to SIDS; however, there are a few measures parents can take to lower the risk of their child dying from SIDS.

might help prevent a baby from developing an abnormality that could put him or her at risk for sudden death. These measures may also reduce the chance of having a premature or low birthweight baby, which also increases the risk for SIDS. Once the baby is born, parents should keep the baby in a smoke-free environment.

Parents and other caregivers should put babies to sleep on their backs as opposed to on their stomachs. Studies have shown that placing babies on their backs to sleep has reduced the number of SIDS cases by as much as a half in countries where infants had traditionally slept on their stomachs. Although babies placed on their sides to sleep have a lower risk of SIDS than those placed on their stomachs, the back sleep position is the best position for infants from 1 month to 1 year. Babies positioned on their sides to sleep should be placed with their lower arm forward to help prevent them from rolling onto their stomachs.

Many parents place babies on their stomachs to sleep because they think it prevents them from choking on spit-up or vomit during sleep. But studies in countries where there has been a switch

In some instances, doctors may recommend that babies be placed on their stomachs to sleep if they have disorders such as gastroesophageal reflux or certain upper airway disorders which predispose them to choking or breathing problems while lying on their backs. If a parent is unsure about the best sleep position for their baby, it is always a good idea to talk to the baby's doctor or other health care provider.

A certain amount of "tummy time" while the infant is awake and being observed is recommended for motor development of the shoulder. In addition, awake time on the stomach may help prevent flat spots from developing on the back of the baby's head. Such physical signs are almost always temporary and will disappear soon after the baby begins to sit up.

Parents should make sure their baby sleeps on a firm mattress or other firm surface. They should avoid using fluffy blankets or coverings as well as pillows, sheepskins, blankets, or comforters under the baby. Infants should not be placed to sleep on a waterbed or with soft stuffed toys.

Recently, scientific studies



**The back sleep position is the best position for infants from 1 month to 1 year.**

bedsharing, sometimes referred to as co-sleeping, may also reduce the risk of SIDS. While bedsharing may have certain benefits (such as encouraging breast feeding), there are no scientific studies demonstrating that bedsharing reduces SIDS. Some studies actually suggest that bedsharing, under certain conditions, may increase the risk of SIDS. If mothers choose to sleep in the same beds with their babies, care should be taken to avoid using soft sleep surfaces. Quilts, blankets, pillows, comforters, or other similar soft materials should not be placed under the baby. The bedsharer should not smoke or use substances such as alcohol or drugs which may impair arousal. It is also important to be aware that unlike cribs, which are designed to meet safety standards for infants, adult beds are not so designed and may carry a risk of accidental entrapment and suffocation.

Babies should be kept warm, but they should not be allowed to get too warm because an overheated baby is more likely to go into a deep sleep from which it is difficult to arouse. The temperature in the baby's room should feel comfortable to an adult and overdressing the baby should be avoided.

common in infants who have been breast fed. This may be because breast milk can provide protection from some infections that can trigger sudden death in infants.

Parents should take their babies to their health care provider for regular well baby check-ups and routine immunizations. Claims that immunizations increase the risk of SIDS are not supported by data, and babies who receive their scheduled immunizations are less likely to die of SIDS. If an infant ever has an incident where he or she stops breathing and turns blue or limp, the baby should be medically evaluated for the cause of such an incident.

Although some electronic home monitors can detect and sound an alarm when a baby stops breathing, there is no evidence that such monitors can prevent SIDS. A panel of experts convened by the National Institutes of Health in 1986 recommended that home monitors not be used for babies who do not have an increased risk of sudden unexpected death. The monitors are recommended, however, for infants who have experienced one or more severe episodes during which they stopped breathing

a monitor, parents need to know how to properly use and maintain the device, as well as how to resuscitate their baby if the alarm sounds.

***How Does a SIDS Baby Affect the Family?***

A SIDS death is a tragedy that can prompt intense emotional reactions among surviving family members. After the initial disbelief, denial, or numbness begins to wear off, parents often fall into a prolonged depression. This depression can affect their sleeping, eating, ability to concentrate, and general energy level. Crying, weeping, incessant talking, and strong feelings of guilt or anger are all normal reactions. Many parents experience unreasonable fears that they, or someone in their family, may be in danger. Over-protection of surviving children and fears for future children is a common reaction.

As the finality of the child's death becomes a reality for the parents, recovery occurs. Parents begin to take a more active part in their own lives, which begin to have meaning once again. The pain of their child's death becomes less intense but not forgotten. Birthdays, holidays, and the anniversary of the child's

the family, including themselves, will also suddenly die. Children often also feel guilty about the death of a sibling and may feel that they had something to do with the death. Children may not show their feelings in obvious ways. Although they may deny being upset and seem unconcerned, signs that they are disturbed include intensified clinging to parents, misbehaving, bed wetting, difficulties in school, and nightmares. It is important to talk to children about the death and explain to them that the baby died because of a medical problem that occurs only in infants in rare instances and cannot occur in them.

The National Institute of Child Health and Human Development (NICHD) continues to support research aimed at uncovering what causes SIDS, who is at risk for the disorder, and ways to lower the risk of sudden infant death. Inquiries regarding research programs should be directed to Dr. Marian Willinger, 301-496-5575.

Families with a baby who has died from SIDS may be aided by counseling and support groups. Examples of these groups include the following:

Association of SIDS and Infant Mortality Programs  
630 West Fayette Street  
Room 5-684  
Baltimore, MD 21201  
1-410-706-5062

National SIDS Resource Center  
2070 Chain Bridge Road  
Suite 450  
Vienna, VA 22181  
1-703-821-8955

SIDS Alliance (a national network of SIDS support groups)  
1314 Bedford Avenue  
Suite 210  
Baltimore, MD 21208  
1-800-221-7437 or  
1-410-653-8226

FOR RELEASE UPON DELIVERY  
JANUARY 14, 1993

\*OPENING STATEMENT BY

DONNA E. SHALALA

SECRETARY-DESIGANTE

U.S. SECRETARY OF HEALTH AND HUMAN SERVICES

AT

THE FINANCE COMMITTEE  
OF THE  
UNITED STATES SENATE

WASHINGTON, DC

\*THIS TEXT IS THE BASIS OF SECRETARY-DESIGNATE  
SHALALA'S ORAL REMARKS. IT SHOULD BE USED WITH THE

Good morning. Chairman Moynihan, Senator Packwood, Members of the Senate Finance Committee, it is an honor to come before you as President-elect Bill Clinton's choice to become Secretary of the Department of Health and Human Services. I want to thank the President-elect for asking me to lead HHS, an extraordinary Department that touches the lives of every American.

I want to thank this bipartisan delegation from my home state of Wisconsin -- Governor Tommy Thompson, Senator Herb Kohl, Senator Russell Feingold, and Congressman Scott Klug. I thank them for their support and their eloquent introductions, and, even more, I am proud to share with them a commitment to the people of Wisconsin.

Finally, I want to thank the Finance Committee Members who made time in their schedules to meet with me, advise me, and encourage me in the days since my appointment was announced.

As we met, I discovered that there is considerable common ground among us. We believe in public service as a noble calling. We are committed to aiding and assisting the elderly. We want to help the indigent return to the workforce. We want to defeat drug abuse and reclaim the future for an entire generation of at-risk children. We want to support and strengthen families. And we, the new Administration and the Congress, want to reach a consensus on a significant health care reform proposal that lowers costs and provides health care for all Americans. These issues are central to the Department of Health and Human Services because they are central to people's lives.

Mr. Chairman, before discussing the mission of the Department of Health and Human Services defined by President-elect Clinton, I would like to tell you briefly about how my professional background has prepared me to lead HHS.

All my life -- as a teacher, as an urban policy analyst, as the leader of two fine higher education institutions, and as a public servant at the Department of Housing and Urban Development -- I have devoted myself to the concerns of average working people and the struggles they face.

I have hands-on experience dealing with problems of teenage pregnancy, housing for single mothers, services for the elderly and handicapped, and the need to integrate social services in rural communities. At Hunter College and the University of Wisconsin-Madison, I directed large, multi-faceted public institutions that serve a broad spectrum of Americans with programs of the highest academic excellence.

At Madison, I administered a \$1 billion budget stretched ever more tightly due to cutbacks in federal aid. At both

institutions, I worked with and learned from the leadership of some of the nation's premier health care research centers, such as Hunter's Brookdale Center on Aging and Wisconsin's Waisman Center.

Throughout my career, I have worked to forge partnerships between the public and private sectors to help improve the health, education, and welfare of our children and their families. I have done this not only in higher education, but also as a member of the Committee for Economic Development, an organization of the chief executives of major corporations and educational institutions, and the Children's Defense Fund, the leading advocacy group for our nation's neediest children. I am deeply convinced that, in any major program of social reform, the business community must be involved from day one as full participants.

As this Committee knows, the nation is facing staggering challenges in areas served by the Department. Health care expenditures are exploding exponentially, even as 70 million Americans have no health coverage or insufficient coverage. On AIDS, we have not fully faced our responsibilities to combat the spread of the disease, to fund research, and to provide care to tens of thousands of patients who cannot afford adequate treatment. Tuberculosis, a nineteenth-century disease that we almost eradicated, threatens to come back in full force in the 1990's, especially in our large cities.

It is a scandal that we lag behind many of our competitors in the world community in immunizing our children against preventable diseases such as polio, rubella, mumps, and measles. One in five children are now impoverished. One in five. These are our children -- and our future is inextricably linked to them.

The Department of Health and Human Services can and must address these challenges -- though it won't be easy and it can't be done overnight. With more than 126,000 employees and a budget that covers 250 different categorical programs, the Department has the capacity to improve the lives of every single American.

With your cooperation, with vigorous leadership from the White House, and with public support, I believe the Department will again accomplish its traditional missions and its new assignments from the Clinton Administration. We intend to collaborate with state and local agencies, and with the private sector, as we usher in a new era of empowerment for the Department's civil service employees.

No problem afflicts families around the kitchen table more than the radical escalation of health care costs, and no problem

demands our greater attention as policymakers and public servants. The American people want, need, and have voted for health care reform. And we must have the courage and the wisdom to replace the existing system with something better.

We must lower the growth rate of health care expenditures so that it comes closer to the growth rate of the economy. Without such a reduction, we will price American families out of the health care market, price American exports out of the global market, and place large barriers before our efforts to reduce the budget deficit. It is also imperative that we gradually provide coverage to the 35 million Americans who have no health insurance and to the 35 million more who have inadequate insurance. President-elect Clinton has said that it is time to treat access to high-quality health care as a right and not a privilege.

Ultimately, the Clinton Administration will bring a landmark health care reform bill to the American people and the Congress -- a proposal that will bear the imprint of a broad array of Americans, and reflect the ideas of consumers, providers, both political parties, state and local government, labor and health professionals, and the business community. As we develop the legislation, we will frequently ask this important Committee to provide its input and expertise, so that we get this job done promptly, and we get it done right.

As we reform the health care system, the Department will be devoting its attention and energy to other areas of critical need. We will vigorously stress prevention -- in areas ranging from preventive health care and pre-natal care to family planning and disease control -- so that we treat the causes of illness and indigence, as well as their consequences.

For children, this means strengthening our commitment to the Head Start program, and giving our young people a healthy start through increased immunizations. For public assistance recipients, this means embarking on an innovative effort to make Welfare a truly transitional program, as part of our overall plan to ensure that those who work full-time do not have to raise their children in poverty.

For rural areas, this means helping communities empower themselves to meet their own health needs. We need to improve the quality of the rural health care delivery system, and adopt equitable federal reimbursements for their hospitals, clinics, and health professionals. A rural perspective must be at the table as we shape the new health-reform agenda.

HHS must develop a more comprehensive program of aggressive  
preventive education,  
treatment, and research

to find a vaccine and a cure for AIDS. Silence and bigotry combined to slow our nation's response to this dread disease; we lost time, and that meant we lost precious lives. We want HHS to assume a very prominent role in the war on AIDS, and we will vigorously support the soon-to-be-appointed AIDS czar.

For seniors, we will place a high priority on addressing their health care needs. We must enhance home care, community-based personal services, and respite care, in order to give more patients the choice of living at home and preserving their independence. Further, we will continue vigorous research on Alzheimer's disease, Parkinson's disease, and other debilitating conditions, both to ensure that Americans live high-quality lives, and to reduce our reliance on expensive, acute, and long-term care.

I will also strive to make the first four years of the Clinton Administration the "Years of the Woman" in health care. We must continue the quest to find better treatments and even cures for ovarian and cervical cancers, breast cancer, osteoporosis, and other serious conditions that women face. We must develop a comprehensive maternal and child health network and a greater number of family planning programs, which will reduce the number of unplanned pregnancies, low birth-weight babies, and infant deaths. Now that the nation is better informed about date rape and domestic violence, HHS must work closely with state and local governments and the non-profit sector to develop strategies to prevent their occurrence.

From health care reform to welfare reform, from the fight against AIDS to the defense of our children's health, the Department of Health and Human Services HHS has an ambitious and critically important agenda. In this work, we will save lives and serve the economy. I want to emphasize that all of our innovative efforts in health and human services must be accompanied by leadership at the White House and the Department that stresses individual responsibility. We should never start programs that discourage people from taking control of their lives.

Our goal is to do more than merely administer programs.

We will produce results. We will treat all Americans as if they are customers in a private business. We will invest their money as wisely as if it were our own. We will treat those individuals who seek our services with dignity and attention, innovation and compassion -- with fairness and integrity.

Thank you for your kind attention to my testimony. I am happy to take your questions.

FOR RELEASE UPON DELIVERY  
AUGUST 8, 1994

\*REMARKS BY

DONNA E. SHALALA

SECRETARY

U.S. SECRETARY OF HEALTH AND HUMAN SERVICES

AT

WHITE HOUSE PRESS CONFERENCE  
ON HEALTH CARE REFORM

WASHINGTON, DC

\*THIS TEXT IS THE BASIS OF SECRETARY SHALALA'S ORAL  
REMARKS. IT SHOULD BE USED WITH THE UNDERSTANDING  
THAT SOME MATERIAL MAY BE ADDED OR OMITTED DURING  
PRESENTATION.

GOOD MORNING:

This is indeed a very historic week in America.

Beginning tomorrow, and for the first time in our nation's history, both houses of the Congress will begin floor debate on comprehensive health care reform legislation.

In the 19 months of this debate, we have made dramatic progress in our effort to guarantee a lifetime of health security for every American.

But one major roadblock remains in the way.

Opponents of real reform are arguing for yet another delay as they throw together incremental, half-way proposals that would not only provide the security Americans need but leave millions of working families in the lurch.

The President and the members of his Administration are enthusiastic and we are determined that this process will end in a victory for the American people.

It will end in legislation that, for the first time, provides every American with the rock-solid guarantee of health insurance that can never be taken away.

But this is not a victory that can be taken for granted.

From now until this legislation is passed, each of us will spend the majority of our time fighting for health care reform.

This is not a fight for political victory.

And it is certainly not a fight for partisan victory.

It is, as I have said, a fight for the American people.

The data we are releasing today shows just how urgent this issue is.

For those of you from the Jenny Craig school of government, I should report that the weight of this report is [**how many pounds?**].

It is that heavy because it contains information about every community in this nation.

It shows how many people in each community are living

without health insurance today.

It breaks down that data into those who are working or the dependents of a worker.

And it shows how many children are uninsured.

What these reports illustrate is the economic and human cost of our current health care system and the danger we face if we follow the advice of some in Congress to do nothing or enact some form of half-way solutions.

Let me give you just one example:

In the state of New Jersey, nearly one million people are without health insurance.

That's a 56 percent increase since 1988.

And in that state, 45,000 people are losing coverage every month.

Clearly the people of New Jersey can't afford to wait another year.

Let me remind you that 83 percent of the people in New Jersey without health insurance are members of working families.

That means they get up every day, go to work, dream the American dream --

Yet live with the nightmare of having no health insurance.

Until we enact real health care reforms, the people of New Jersey -- those with insurance and those without it -- won't have the peace of mind they need to concentrate on raising their families.

And the state's government will continue to spend 20 percent of its entire budget on Medicaid alone.

That leaves very little for education, law enforcement, and critical infrastructure repairs.

Incremental reform won't fix any of this, in fact, it will make things worse.

The important thing to recognize, here, is that New Jersey is not unique.

In fact, I chose New Jersey as an example because it is so

typical in its data to the rest of the country.

In every state -- in every Congressional district -- the problem is the same.

Millions of Americans -- especially millions of working Americans -- are getting up every day without health insurance.

As the Congress begins this historic debate, I hope that they and the American people remain focused on what this is all about.

It's not about whose bill weighs the most.

It's not about whose commercial to believe.

It's not about whose district needs help the most -- because the truth is we all do.

This debate is about the American people.

It's about what kind of lives they will lead --

And what kind of future they will leave for their children.

It's about fairness.

It's about equity.

And it's about fulfilling our national destiny.

Thank you.

FOR RELEASE UPON DELIVERY  
THURSDAY, MAY 1, 1997

\*REMARKS BY

DONNA E. SHALALA

U.S. SECRETARY OF HEALTH AND HUMAN SERVICES

TO THE

GIRLS IN THE MEDIA

LOS ANGELES, CALIFORNIA

\*THIS TEXT IS THE BASIS OF SECRETARY SHALALA'S ORAL REMARKS. IT SHOULD BE USED WITH THE UNDERSTANDING THAT SOME MATERIAL MAY BE ADDED OR OMITTED DURING PRESENTATION.

1

So, why am I here? Let me start with why I am not here. I am not here to make headlines by blaming you for all the ills in our society. I am not here to advocate that government should run onto the set yelling, "rewrite!" After all, in this nation, we have a precious First Amendment that we all must honor.

And besides, I come from a Washington world where people still think that if you have something really important to tell children -- hand them a brochure. I don't know one young person who has spent 5 minutes reading a brochure. What they do is absorb popular culture by the ton. Logging on. Calling up. And, watching -- no, yelling -- at their television sets. And that is why I am here.

When I told people that I was coming out here to talk to the media about the health of young girls, a lot of them said, "Why? The media has nothing to do with the public health. Forget it."

And I will tell you what I told them. Believe it or not, you are part of the public health system. You increasingly fill the vacuum once occupied by traditional institutions -- like family and religion, schools and communities.

Young girls wear your clothes, tape your shows, read your magazines, buy your products with fierce loyalty -- loyalty elected officials could only dream of. They are watching and listening for hours on end, absorbing life lessons about values; lessons about their lives and futures; lessons about how to deal with dangers -- like teen pregnancy, drugs, and depression.

You have their attention. The question is, what are you going to tell them? And the answer is up to you. So, as I said, "I'm not here to shake my finger at you. But, I'm not here to tell you everything is o.k. either.

I'm here to challenge you as professionals, parents, and citizens to use your incredible power to help us transform the lives of young girls from a national tragedy into a national triumph.

I was thinking a lot about this speech last Thursday. It was Take Our Daughters to Work day -- and our department was hosting young girls from around DC. Anyone who has worked with young girls knows that they ended up hosting us.

But, the highlight of the day was an event we had with Gloria Steinem and the former Miss Black USA where the kids got a chance to ask questions. I wasn't exactly thrilled with the first question. "It was how old are you?" But, I was thrilled by the girls' responses. Especially their response to the posters we had of Olympic gymnast Dominique Dawes, who they say is a real role model.

It turns out that at age 6, when most kids are glued to the TV set, Dominique was writing this word, in crayon, over and over again on her bathroom mirror: Determination. That's what it takes to be a champion: determination.

And determination is what it's going to take from us to ensure that every girl -- every single girl -- looks in the mirror and calls herself a champion.

Right now, that is not the case. Right now, too many girls are spending hours in front of the mirror. Any parent will tell you that's nothing new. What is new is that they're peering at their reflections through a modern-day looking glass. The distorted images that they see upset them. And as people who care about children, they should scare us too.

I'm going to be blunt. We have a generation of 9 to 14 year old girls at serious risk. All of us have seen it happen to girls in our own lives. Young girls once strong and full of resilience, somehow lose their very selves during adolescence and enter the second decade of their lives without the strength and confidence that got them there.

While growing up these days is tough for everyone, the research tells us that girls experience adolescence differently than boys. While boys often become more aggressive, girls often turn inward and self-destruct. While boys often smoke to be rebellious, girls often do it to stay thin.

Young girls become less likely to engage in physical activity. More likely to be depressed. More likely to attempt suicide. And more likely to have a negative body image. What we know is that all of these factors are related, that no one problem stands alone, and that girls with poor body images often have the riskiest attitudes about tobacco, drugs, and sex.

And we know from surveys that more than half of nine year-olds have dieted. That's nine year olds. Unbelievable? Not when so much of their self image is tied up with being thin and attractive. And not when we've all heard stories of anorexic girls who hear people say, "you look great" right up until the time they are hospitalized.

A social worker in Los Angeles told me a story about a 14 year-old girl she was interviewing. When she asked the girl what she likes about herself, the answer is all too typical, "I don't know." But she does know what she would change about herself and here she rattles off a whole list of physical attributes like her eyes and hair and weight.

The truth is, this young woman, and too many like her, are more worried about gaining weight and being accepted than they are about excelling in school or staying healthy.

Let me be clear: This isn't all your fault. But, it is your problem. It is my problem. It is our problem. It's an American problem. And, together we have a responsibility to help solve it.

That's the purpose behind our Girl Power! campaign: to team up with parents and other adults to help 9-14 year-old girls make the most of their lives.

Not with a one-size-fits-all campaign of the past. The kind that treats problems in isolation and provides only one answer: Say no. We've taken a comprehensive approach. With targeted health messages about the behaviors -- like drugs, smoking and teen pregnancy -- that girls should avoid, yes. But also with strong positive messages about leadership, opportunity, and physical activity -- messages that tap into the strength girls have when they are younger.

With PSAs, hats, diaries, billboards and other materials, we are telling every girl: You are unique. You are valuable. And, if you put your mind to it, you can succeed.

So, what does Girl Power mean to young girls? I put that question to girls during Take Our Daughters to Work Day. And, as usual, they said it far better than I ever could. They wrote "Girl Power is being anything you want to be. Increasing your knowledge, helping others. Girl Power is standing up for what you believe in. Choosing right from wrong. Exercising. Being Drug Free." And finally, a young girl simply wrote, "I think Girl Power is special."

Our job is to ensure that every girl feels this way throughout her life. And that's what we're working to do. Let me give you just a few recent examples. Last month, I went to the Women's Final Four to release the first ever government report showing that sports and physical activity can have a positive impact on all aspects of a girl's life.

For the first time in history, a President is taking big steps to kick Joe Camel and the Marlboro Man out of our children's lives. Just last week, for the first time, a Judge said that yes, cigarettes are a drug delivery device. And yes, the FDA can regulate them. This is an historic public health triumph -- a triumph we should all be proud of.

And today, I'm also proud to be kicking off Teen Pregnancy Prevention Month by announcing some more good news. We are releasing a study today showing that for the first time in more than 20 years, 15-19 year old girls are less likely to have sex. And if they do have sex, they're more likely to use contraceptives.

These positive trends are the same for teenage boys. They're part of the reason we're finally seeing declines in teen pregnancy rates. And what they tell us is that teenagers are hearing the message that sex and pregnancy puts them on a fast track to a bad future. And they're hearing the message that condoms can prevent pregnancy, AIDS, and other STDs.

But these results also tell us that it's too late to start talking to girls at age 15. We need to reach them early. On this and every issue. That's why I am pleased to announce today two new grant programs that fill important gaps in our fight against teen pregnancy.

First, we are dedicating one million dollars this year to communities -- so they can work with volunteers to give 9-14 year-old girls the confidence and opportunities they need to abstain from sex and other risky behaviors -- and make the most of their lives. I am also announcing today another million dollars in grants to educate and encourage young males to make responsible decisions.

But, whether the message is sports or teen pregnancy prevention, the government will never be able to deliver it alone. It's going to take each and every one of us. That was the message of the President's volunteerism summit. And that is why, as part of Girl Power!, Dominique Dawes is appearing in print and radio PSAs. It's why we're teaming up with the U.S. National Women's Soccer team to send clear messages to girls that tobacco and fitness just don't mix. It's why I joined with NIKE's P.L.A.Y. CORPS program last week to announce a new partnership aimed at training college-age coaches to work with young girls. And, it's why I am here today. To ask for your help and your leadership.

When I was growing up, I still remember how my parents and other caring adults encouraged me. By telling me I played a good game. That I delivered a good line. That I was special. Yet, while parents are still by far the most influential people in girls' lives, we know that girls too often turn away from them just when they need them the most.

Instead, girls today often look to their peers and to our most powerful mirror -- the mirror of popular culture -- to tell them who they are and who they should be. But, when they look in that mirror, what do they see?

I am speaking to you as a talented and privileged few, with great power, but also great responsibility. And I am speaking to you as leaders who have already helped us make great progress in the last 20 years -- progress in the numbers and types of girls depicted in the media.

When girls click on the TV today, they see more women like Elaine on "Seinfeld" with good jobs and a good sense of humor. They see more girls like Claudia on "Party of Five" who not only shows great musical skills, but also strong personal skills as she navigates through real life issues like her brother's alcoholism and her violin teacher's homosexuality.

They see articles like the one appearing in Seventeen this month about choosing the right college. And they see girls like Lisa on the "Simpsons," whose intelligence and saxophone playing put Bart and the other boys to shame. I'm actually told that some teachers give Lisa credit for the recent surge in saxophone interest among girls in band class.

So, have we come a long way? Absolutely. But, we still have much to do.

Because too often our culture still bombards girls with images that tell them that being unnaturally thin -- actually gaunt -- is sexy and healthy. They're told that smoking will make them thin and glamorous and cool and successful. That it's "a woman thing." And they're told that drinking will make them feel popular and grown-up.

What the Children Now/Kaiser Family Foundation survey showed is that, despite improvements, girls are still depicted more often talking about their appearances and romantic relationships and less often talking about their jobs.

And many characters on shows are becoming thinner and thinner, actually reaching weights that are unhealthful and unattainable.

At the same time, about 70 percent of girls say they have wanted to look like a character on TV and almost a third of girls have changed their appearance to make it happen. And in an article about make-up, a young girl's magazine this month shows a girl's picture with these words: "Look sexy -- not silly."

I ask again: When they look in the mirror, what are girls seeing? Too often they are seeing that they don't measure up to the images created for them. That they're not good enough. Or thin enough. Or pretty enough. And boys are learning lessons too. Lessons about how to value and treat girls.

I know that many of you are entertainers and business people by trade. I know that you need to be ever mindful of the bottom line of ratings and profits. But, there is another bottom line that I'm asking you to pay attention to. It's your role as citizens and guardians of the public trust. And, it's the bottom line of young girls and their families.

You alone will probably never save or ruin a young girl's life. But what you show girls can have a tremendous impact on how they view themselves and how others -- boys and adults alike -- view them. That's why I'm asking you to take an even larger role in the great national drama to improve the health of American girls.

I'm asking you to think about the public health consequences of every thing you do. I'm asking you to join with us to send the right messages to girls -- the same messages we'd like our daughters or other family members to hear. Put simply, I'm asking you to hold up a more accurate mirror.

First, I challenge you to use your immense creativity to develop programming appropriate for 9-14 year-old girls. From Saturday morning cartoons to Seventeen, there is a wealth of programs and products for very young girls and for older girls. But, there is a gap in the middle.

We all know that girls have a tendency to be attracted to images and problems faced by older girls. And that's especially true when they don't have many great, more age-appropriate alternatives. But, there is a big untapped market and an even greater social need for materials that really speak to 9-14 year old girls. And we must create them.

Every time a girls sees a show or reads a magazine where all the girls pictured are paper thin, no one needs to explicitly say, "To be popular and successful, you must be gaunt." The message is clear. And the image created is outside the reach of most healthy girls.

That's why my second challenge is to create more characters, images, and role models that girls can reach and relate to. Girls who look like them and face everyday choices like them. Girls who make them proud of who they are and what they can become. Characters and images that teach both boys and girls to value girls who are smart and talented and confident and successful. All the things people want for their daughters.

Finally, and perhaps most important, we need to give girls and their parents information that will help -- not hinder -- their ability to navigate the rough waters of early adolescence.

If you're doing a story about a teenager getting pregnant, consider making the plot not just about passion, but about the consequences -- the poverty and lost futures that our research shows unwed mothers and their children are likely to face. If you're doing an article about eating disorders or depression or domestic violence, try giving girls and their parents places to turn for help. And if you're doing a show about smoking and drugs, you can find ways to show girls making the right choices and parents and peers sending the right messages. Messages that say smoking isn't cool.

I know -- and you know -- that education and entertainment can go hand in hand. And they must.

I understand that you're production schedules are grueling -- and that up-to-date public health information isn't just lying around the office. So, I've come here this afternoon to offer more than a challenge. I've come to offer help.

At our department, we have up-to-date information about the use of drugs, alcohol and tobacco among girls. We have access to the best experts on issues ranging from depression to physical activity. We have information about approaches that work to cut down teen pregnancy and improve the health of girls. And, we have Girl Power! campaign materials that send girls the right messages about their bodies and minds -- indeed their futures.

You write the drama or develop the products, and we'll be there with the accurate information you need on any topic -- anytime. That's why I'm pleased to include in the packet you received today a number you can call at HHS -- and our web site address -- so you can get the facts you need when you need them.

I made the same offer when I spoke to talk show producers and then again to soap opera producers. Both times the naysayers said that the media leaders would simply put resources in the circular file. Both times they were wrong.

After those conferences, the calls started coming in -- and information started pouring out. It is my hope that this conference will strengthen the dialogue between leaders in the public health and entertainment industry.

Because, we all know that government doesn't raise children. Our schools don't raise children. And the media doesn't raise children. Parents raise children -- but, as the President's summit made clear, all of us have an obligation to give them a helping hand.

We need to ask ourselves, "When given the choice and the power to influence girls' lives, did we choose to have a positive effect, a negative effect, or no effect at all?"

Because, somewhere a girl is looking in the mirror today. What will she see? Will she know that her health and future are more important than her image? That the size of her ambition is more important than the size of her clothes? That the dreams she creates for herself are more important than those created for her by others? Will she, like Dominique Dawes look in the mirror and see not defeat, but determination?

A 9 year-old named Cherlnell does. She wrote a poem called, "What makes me feel powerful." "When I get an A+ or an A on a test. When I get told I am smart. When people tell me I will become something big. That's what makes me feel powerful. Strong-willed is independent and brave. And I'll stay like that forever"....

It is our job to ensure that every girl in this country "stays like that forever."

Thank you.

FOR RELEASE UPON DELIVERY  
SATURDAY, MAY 10, 1997

\*REMARKS BY

DONNA E. SHALALA

U.S. SECRETARY OF HEALTH AND HUMAN SERVICES

AT

COMMENCEMENT ADDRESS

THE UNIVERSITY OF MISSISSIPPI

"NOTHING EVER HAPPENS ONCE AND IT'S FINISHED"

OXFORD, MISSISSIPPI

\*THIS TEXT IS THE BASIS OF SECRETARY SHALALA'S ORAL  
REMARKS. IT SHOULD BE USED WITH THE UNDERSTANDING  
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PRESENTATION.

Chancellor Khayat, Trustees, faculty, distinguished guests, parents and members of the class of 1997: Congratulations. Congratulations for working hard. For making your parents proud. And for convincing the Board of Trustees that Ole Miss needs a Fall break.

I know that all of you will take time today to thank your families for their love and support that got you to this day. You should also thank hard working people all over Mississippi – citizens you will never meet – who pay taxes to maintain this great public university.

I am honored to come to the University of Mississippi – this place of great history; of intellectual achievement; and two of the best tennis teams in the SEC.

Being in the Tad Smith Coliseum, I'm reminded how important sports are to a great university life in this country. I have never made an apology for their special role in creating a sense of community. There is no greater feeling than being young on a Saturday in the Fall and walking with friends to a football game on a great American university campus.

I know exactly how you feel at this moment.

I'll never forget my own college graduation. In the air, you could feel the sense of accomplishment, excitement, and the most chilling feeling of all – the absolute fear that the commencement speech would *never* end.

They say Salvador Dali gave the shortest speech ever. He said, "I will be so brief, I have already finished." Then he sat down. While I can't beat that, I do understand that a commencement address does not have to be eternal to be immortal. As a former Governor liked to say, "Commencement speakers should think of themselves as the body at an old-fashioned Irish wake. They need you in order to have the party, but nobody expects you to say very much."

And, because that's what graduation speeches are really about – giving advice – in the spirit of David Letterman, as you head out into the world, let me offer you Donna Shalala's top ten pieces of advice for Ole Miss graduates.

10. Be diplomatic. When your parents ask you how long you think you'll be living at home after graduation – lie.

9. Be direct. When an interviewer asks, "What is your long term goal?" Say: Early retirement.

8. Face Reality. When your alarm goes off at 6:30 a.m., it's not a nightmare – it's a *job*.

7. Be patient. Wait at least 24 hours after graduation before asking your parents for money.

6. Listen to voices of experience. Robert Frost said: "By working faithfully eight hours a day, you may eventually get to be a boss and work twelve hours a day."

5. Be good Americans – vote, pay your taxes, and above all else, rewind your videotapes before you return them.

4. Be an optimist. When you think your anxiety has reached an all-time high, remember the famous maxim: Things can *always* get worse.

3. Be loyal. Wherever you live, make sure you can watch Ole Miss beat Mississippi State.

2. Be honest. When relatives ask you what you're going to do the rest of your life, tell them the truth: You have *no* idea.

1. But in all seriousness – and without the David Letterman drum roll – my number one piece of advice is: Remember, you are a part of history.

Three years ago, John Grisham came here and explained why he went to law school instead of joining the Peace Corps. I joined the Peace Corps and skipped law school. Now I live in a city called Washington – where *everyone* is a lawyer, and lots of people write fiction – mostly about themselves.

As Chancellor Khayat mentioned, before I decided to make Washington my home, I was Chancellor of a Big Ten university. That's that *other* great conference. There I experienced lots of long hours; late night pizzas; and people longing for a real job. In Washington, my life is still long hours; late night pizzas, and yes, people longing for a real job.

So, William Faulkner was right in *Absalom, Absalom* when he wrote: "Nothing ever happens once and it's finished."

Our lives repeat themselves because what we do is often a mirror of who we are.

I come today with political values and beliefs deeply rooted in my past. My religion; my heritage; my working class background; and my activist days in the 1960s. I was at a university very much like this one when, in 1966, Robert Kennedy came to Ole Miss to heal old wounds, and to encourage young people everywhere to "put their talents to work in the service of the American dream." That dream was my dream, and now it is your dream.

So I have to change – but only slightly – the words Chancellor Khayat spoke at his inauguration just over a year ago. My message to each of you is this: I come as a

stranger, but I am one of you. Because before region. Before race. Before age. Before gender. Even before history – there is humanity.

We can – and should – hold on to our individual cultures and traditions, but, we are linked to each other – and to our creator – by the joys we experience; the losses we endure; the yesterdays we remember; and the tomorrows we imagine.

So, not only am I one of you. As Americans we are one.

Today, every road leads to Oxford. And every hope your parents and I have for the future is a hope for your future. Because, more than anything else on this earth, I believe in you – and your generation.

But our hope for you will not be fulfilled until we complete this century's most important task: Building an American house that can never be divided by race or religion. At a time when blacks and whites still see the justice system through very different eyes. When churches are still burned and synagogues defaced. And when inequality still plagues our boardrooms and our neighborhoods. The time has come for every corner of our nation to end what Faulkner in the "The Bear" simply called the "curse" of race.

We should do this because it is right and just.

And we should do this because when the doors of opportunity open; when no person's creativity and intelligence is held back; when the engine of freedom is linked to the entrepreneurial spirit – our entire nation prospers.

The fact is, race is not a southern dilemma. And race is not a northern dilemma. Race is an American dilemma – and we must solve it together.

That is why I don't believe it is for me to tell you where Ole Miss or the south should go from here. Those decisions are for you to make – just as they must be made in every other community across this land.

But I will say that the great dream of America – that we all be judged on our talents, respected for our common humanity; and welcomed in the American Promised Land – is not yet realized. And until it is, the words of poet T.S. Eliot can be a warning for the 21<sup>st</sup> century: "Time past and time present are both perhaps present in time future." We want to learn from time past – but not be a prisoner of it. We want to appreciate time present – but not be satisfied with it. We want to reach time future – but not regret what we might have changed.

This is not to say that over the past 30 years we haven't made enormous progress. We have. Not only have laws changed, hearts have changed. When he was Lt. Governor, Paul Johnson, Jr. tried to keep James Meridith from registering at the University of Mississippi. But when he became governor of this great state he said, "If

we must fight, let it not be a rear guard defense of yesterday, but let it be an all out assault on our share of tomorrow." That's what the south has done over the last 30 years.

You turned toward a new day and found your share of the American Dream. The south is no longer perceived as trying to catch up with the rest of America. The south is America. An America of growing wealth and prosperity. An America of expanding opportunity. An America led by sons of the South like President Bill Clinton, and Mississippi's distinguished Senator Trent Lott. An America respected and emulated around the world.

But also an America still plagued by poverty, infant mortality, and millions of children living without health insurance.

The question is, as we enter the 21<sup>st</sup> century, how will we re-write the fate of this other America? I've already suggested one answer: By continuing the racial progress we've already made so that no person is either locked out – or made to feel left out – of the American dream.

But I have another answer.

As many of you know, when William Faulkner won the Nobel Prize in Literature, he gave one of the most memorable acceptance speeches ever. I'm going to paraphrase, slightly, what he said. 'We are immortal, not because we alone among creatures have an inexhaustible voice, but because we have a soul capable of compassion and sacrifice and endurance.'

In other words, we survive by helping others to survive.

You are about to enter a world where you will no longer be judged by your grades, but by your character. By the promises you keep, and the changes you shape. By the love you give and the help you repay. By the examples you set, and the challenges you meet. By your guts and your heart. These are the standards by which we will judge each one of you – no matter what profession or dream you choose.

The great Irish poet, William Butler Yeats wrote a poem called "September 1913." In it he said, "Romantic Ireland is dead and gone." Despite these words, his poem was not about despair. It was a poem about letting go – and about seizing tomorrow. Seizing change.

At the doorstep of the 21<sup>st</sup> century, you must be your own messengers of change – honoring the past while having the compassion, sacrifice and endurance to re-write the future.

As you begin this long journey, I promise you it will be both enormous fun and serious business. Thirty years ago, I sat in a seat much like yours – not knowing exactly

where life would take me, but promising myself that, I would never play it safe. I've kept that promise.

As you prepare to leave Ole Miss, my deepest hope is that you won't play it safe either. That you'll stand your ground – and when necessary, stand conventional wisdom on its head.

I wish for you the best of everything – and that all your dreams come true.

I wish you compassion, sacrifice and endurance.

I wish you good health, great friendships, and love.

I wish you uncomfortable but exciting lives.

And I wish you fun. Yes, I said fun in the years ahead, and many visits back to campus when the "oak and maple leaves in their full autumn glory flutter throughout the Grove."

Congratulations and God speed. Thank you.

REMARKS BY

DONNA E. SHALALA

SECRETARY OF HEALTH AND HUMAN SERVICES

PHI SIGMA ALPHA LECTURE

AMERICAN POLITICAL SCIENCE ASSOCIATION

AUGUST 28, 1997

WASHINGTON, D.C.

It is a pleasure to join so many friends and colleagues from the American Political Science Association.

You call this a lecture.

But I prefer to think of it as an opportunity to share knowledge – because Phi Sigma Alpha represents the collected wisdom of each generation's brightest young political scientists. The President told me he was a member of Phi Sigma Alpha when he was at Georgetown.

As you know, I spent many years studying and teaching political science and public policy. But I must admit that what I learned didn't fully prepare me for the mysterious ways of our nation's capital. So, I've tried to combine my knowledge of political theory with practical experience in managing the Department of Health and Human Services.

Thinking about a large organization like HHS reminds me of the movie *Sunset Boulevard*, in which Joe Gibbs says to aging actress Norma Desmond. "You used to be in silent pictures. You used to be big." To which Norma replies: "I am big! It's the pictures that got small."

I quote this bit of movie trivia to illustrate that there are many big things Americans like: Cars. Open spaces. Movies. But we don't like big bureaucracies. Americans think that large government organizations are too complex, too impersonal, too inefficient, and cost too much.

And without doubt, they're partly right.

This was very much on my mind in 1993 when the President asked me to become CEO of one of the largest government organizations in the world.

As many of you know, I had already served in the Carter administration and two leading public universities. But I knew that taking over the leadership of HHS – a Department whose budget, at that time, consumed 40 percent of federal spending – would be unlike anything I ever did before.

Because of its size and complexity, HHS is one of the most difficult jobs in the world for a public official. It is also a Department whose policies touch the lives of every American. We have not accomplished everything we wanted to. All of us have taken some wrong turns, and endured the hard lessons of that great teacher: Experience.

Let me start by knocking down two myths. The first, described by Hargrove and Glidewill, is that my job – and others like it – are simply impossible. Too many difficult clients. Too many internal conflicts. Too little public confidence.

It's not true. Managing a large organization is the art of the possible. And, as I'll describe shortly, with some common sense lessons, it can be done.

The second myth goes back to the theories of Frederick Taylor.

That organizations are essentially machines. Pull the right levers in the right way, and you'll get the right result.

Were it only that easy.

In complex organizations there will be failures for any number of reasons: poor communication; impractical or unclear goals; lack of public or congressional support; lack of sufficient expertise or resources; too much – or too little – oversight. And too much work.

Between these two extremes: That nothing works or that everything can be made to work, lies some basic truths about large modern organizations.

So, in the spirit of David Letterman, but without the drum roll, I offer you Donna Shalala's Top Ten Lessons for Managing a Large Complex Bureaucracy.

Some of these lessons are well established norms for administering large public and political organizations. You've read about them. You've written about them. And some of you may have even practiced them. Others are borrowed from recent scholarship, such as Doig and Hargrove's analysis of what makes an innovative and successful leader in government. And some of the lessons are from two decades of experience as a sub-cabinet official in the Carter Administration; as a student of government and politics; and as a leader of large public universities. Finally, some of these lessons are well known. Others less so. But I believe they are all applicable to large public organizations.

Number One: Know the Cultures of Your Organization.

I said *cultures*, not culture.

Organizations are usually made up of many smaller units – each with its own history, needs, culture and constituencies – but working toward a larger objective. That is certainly the case at major research universities. The goal is the same: well educated students and quality research. But different colleges, schools, and departments often take very different roads to reach that goal.

So, Levin and Sanger are right when they emphasize the importance of understanding these cultures and constituencies. NIH is a good example.

Have you ever tried to apply standard personnel rules to hiring scientists? I can tell you right now: They don't work. Scientists have their own language and traditions. And their own measures for assessing merit.

When I became Secretary, personnel managers in the Office of the Secretary had overall responsibility for hiring scientists for NIH. These personnel officers were highly skilled, but they weren't used to hiring first rank scientists in a competitive market place. I thought the scientists at NIH were best able to judge scientific competency and credentials.

There are also times when it's actually helpful for an organization to have more than one identity.

When NIH, CDC, FDA and the Public Health Service all line up in favor of a particular policy, say, banning the marketing of tobacco to children, that policy will more likely be accepted by Congress, the public – and, we hope – the courts.

Unique cultures within a department can also increase credibility.

That's why a cabinet secretary is not always the best salesperson for a departmental policy. In criminal investigations, the FBI is usually called on to speak on behalf of the Justice Department. If there's a major fire, the local Fire Commissioner may have more credibility than the mayor.

And at HHS, I like to let the experts – especially physicians and scientists – speak directly to the public, because the great scientific agencies – CDC, FDA, NIH, NCI and the Public Health Service – are institutions trusted by the American people. The physician-scientists who head them, while appointed by a President, have enormous credibility. They must be the re-assuring voice – and face – explaining the Hanta virus outbreak; food borne illnesses; AIDS transmission; and the age women should start having annual mammograms.

Finally, the press provides its own cultures and traditions.

That's why there is no substitute for a public affairs staff with Washington experience. And I've had the best.

Number Two: Make Sure the Right Hand Knows What the Left Hand is Doing.

There's a scene in the movie *Ben Hur*, where Ben Hur is trying, without success, to get his four new chariot horses to run. The Bedouin who owns the horses tells him that each horse has its own personality, and they must be harnessed together in a way that allows them to run as a team.

The same holds true for any large organization. The sum has to be greater than the parts.

The different agendas of smaller units have to be melded or modified – and a belief in the larger team built. What can an administrator do to promote teamwork and a corporate identity?

When I first became Secretary, I encouraged my top appointees to distinguish the HHS forest from their particular tree by asking each of them to participate in each other's budget hearings – and to prepare a budget for the entire Department. In other words, to look at the Department from my perspective.

When they took a look at the big picture, some senior administrators recommended cuts in their own budget requests. We are still using that process.

There are, of course, other ways to share information, build cooperation, and keep an organization the size of HHS speaking with one voice. One, described by Roger Porter as "centralized planning," has been rejected by most leaders, even very forceful ones like Richard Darman. A second, which Porter calls "multiple advocacy," lies between centralized planning and ad hoc decision making, and generally uses existing systems, some of which, in the case of HHS, I've been fine tuning.

For almost any public organization, the primary system for melding a team and an agenda is the budget process – which is increasingly important in an era when money is tight and budgets have to be balanced. In fact, in this new era, the budget process has the potential of being divisive and competitive – instead of a road to team building and unity.

But at HHS, and other public agencies, there are other ways to build a team.

At HHS, the Executive-Secretariat controls the enormous paper flow.

But more important, Exec-Sec is the honest broker. It ensures that ideas are considered throughout the Department – and that everyone is brought to the table. That way, I get the benefit of every viewpoint. And when a decision is made, every participant owns it.

The Assistant Secretary for Policy and Evaluation runs the numbers, evaluates the likely consequences of a proposed policy, and makes recommendations to the Secretary.

And there are some units within the Office of the Secretary that are designed to coordinate what the entire Department does, especially in an emergency.

When Mad Cow Disease was discovered in England, we wanted to avoid panic by getting out accurate information about the steps that had been taken to protect American beef – years before.

The Assistant Secretary for Health did that. Overseeing the work, and the public statements, of the FDA, NIH, CDC and the Public Health Service – and coordinating with the Department of Agriculture.

On to Number Three: Don't Overlook the Needs and Abilities of the Career Public Service.

My first day of work started with many top jobs in the Department unfilled. And it stayed that way for some time. So what did we do? We ran the Department with the top civil servants – the people who are responsible for most of our day to day leadership. It was fun.

Hugh Heclo in his 1977 book, A Government of Strangers wrote this: "If democratic government did not require bureaucrats and political leaders to need each other, it might not matter so much when in practice they discover they do not."

I don't agree. The two sides do need each other.

I also don't share Heclo's belief that career civil servants resist the leadership and policy turns of political leaders.

I think the relationship is reciprocal. That both institutional and political guidance are needed. And that trust can be built by using the experience and institutional memories of career civil servants. In fact, when I became Secretary, I wanted to send a very strong message to the civil service – that they were important. That we were going to be a team. So my first appointment was from the Senior Executive Service – a career person of both great competence and experience. We need to make sure we respect the integrity of the civil service in words and action. In fact, relying on career professionals is especially important in the age of downsizing.

Today, political staffs are doing more work, with less help, and in less time. This is an open invitation for policy mistakes and failure. But many of these potential mistakes and failures can be avoided by using the career civil service to identify hidden minefields from the past – and to help plan, not just implement, policies for the future.

Which bring me to Number Four: Choose the Best and Let Them do Their Jobs.

The days of political appointments as a spoils system are over.

A large organization is complex; its programs difficult to manage; and their purpose almost always vital to the well being of the American people. That's why political appointees must be experts in their fields – and skillful leaders and managers.

They must be adept at both policy and politics.

Otherwise they will not get the respect and cooperation they need from career staff. So, while we've worked to create a team, I believe that the most important thing any public administrator can do is choose the right top management.

At HHS, the President nominated many leading experts in their field. They were Democrats – and our party was ten deep in talent for each position.

Some even compared our team to the incomparable 1927 Yankees: Phil Lee and Jo Boufford at Public Health; Mary Jo Bane at Children and Families; Harold Varmus, Rick Klausner and Ruth Kirschstein at NIH; David Satcher at CDC; David Ellwood at Planning and Evaluation; Bruce Vladeck at HCFA; Melissa Skolfield at Public Affairs; Harriet Rabb as General Counsel; June Gibbs Brown as Inspector General and we retained David Kessler at FDA and brought Claudia Cooley from OPM to the Executive Secretariat.

Each of these leaders had years of academic and – or – professional experience in their areas of expertise – not to mention a deep sense of mission. But we also worried about the next generation. I always try to remember that we are replaced by those we recruit.

Which brings me to: Number Five: Stitch Together a Loyal Team.

I've always thought that you need to instill loyalty in both professional and personal ways. We worked hard to make everyone feel a part of a team. That they are listened to.

I talked about how proud I am of our appointments – and their diversity of skills and experience. But that core team showed up with different agendas, different approaches to achieving their agendas – and often without knowing much about their new colleagues.

So I encouraged a healthy debate in private, but made it clear that I didn't want arguments in public. I can't say we were always successful. But for the most part we put together a loyal and cooperative team of very nice people who liked each other. And I encouraged that by creating events for my top staff where they could get to know each other better.

At Hunter, the top administrators and faculty once did a play with the students. Although Hunter is a big commuter school, the play bonded us for years.

Which brings me to: Number Six: Stand up and Fight for the People Who Work for You.

People behave in large organizations pretty much the way they behave outside of work. They are motivated by friendship, support and loyalty. That's why showing the people who work for you that you really care about them pays dividends.

I had a unique opportunity to do that during the government shutdown.

The shutdown actually strengthened HHS because it gave people a renewed sense of loyalty to each other and the Department. I sent everyone a letter saying: We're fighting for you. And to show my support, I was very visible – making the case in the media about the devastating impact of the shutdown.

Then we did something almost no other agency thought of.

During the shutdown, pay checks were supposed to be half the normal amount. We found a legal way not to cut pay so drastically. We put off taking out deductions in our employees checks until after Christmas. So they were made whole – and they appreciated our caring.

We also managed our budget with considerable skill to avoid RIFS – the entire Department held vacancies and helped to absorb cutbacks.

Number Seven: Set Firm Goals and Priorities – and Stick With Them.

The old saying is still true: To govern is to choose.

But in a large organization, with a limitless number of decisions to make – and a very limited time with which to make them – how do you choose?

Let me start by saying that Larry Lynn was correct when he wrote, "public executives need a frame of reference to aid them in skillfully allocating their time, attention, and political influence." But they also need a reality check.

Managing is not the same as coming up with a wish list. And if you try to do everything, you'll accomplish nothing. You need to set priorities.

I have six secretarial initiatives.

And I have asked all the agencies within HHS to not only focus on those initiatives – but to do cross-cuts. Share information. Pool money and other resources. Work in teams. Don't duplicate efforts.

Setting priorities doesn't mean choosing only what's easily achievable.

When the President first came to office, we set a goal of increasing child immunizations. We established targets, and as the President recently announced, we met them.

But at least some of my six initiatives will be more difficult. For example, reducing teen pregnancy.

One reason is – and this is another reality check – the roots and solutions are often beyond any government's control. Which means whether you work for a mayor, a governor, or a President, you need to set ambitious – yet realistic goals; figure out your role in meeting them; and then team up with partners outside of government to accomplish them.

The reverse side of goal setting is delegating responsibility and demanding accountability – from both political appointees and career staff. You have to show confidence in the people who work for you – and at the same time have a system for obtaining timely information and measuring results.

One caveat: Delegation is not the same as abdication.

When I became Secretary, there was a move to delegate all departmental regulations to the individual agencies. Literally hundreds every year. I didn't want to go that far. So I set up four criteria.

If a regulation fell under any one of them; for example, it's impact on the economy was 100 million dollars or more, that regulation would have to be approved by the Secretary.

Which brings me to: Number Eight: Don't Forget Politics is Always Part of Policymaking.

There is no way to succeed in the world of government without paying attention to that other world: politics.

For HHS, that means primarily the White House and Congress.

None of us, whether we're political or career, can operate in a vacuum. All of these external pressures – from the economy to the press, from the governor's office to, yes, regulators in Washington – affect government decisions and raise questions for which there are no simple answers.

I have two rules of thumb in politics. One, be fiercely loyal to the President on policy and appointments. Two, be skillfully bi-partisan in the administration of the Department.

When I go up to Capitol Hill to testify before Congress, I present the Administration's case as vigorously as I can. When I return to the Department, it doesn't matter to me if a Medicaid waiver request, or any other request, comes from a Republican governor or a Democrat governor. They get the same professional consideration.

And when there is a threat to the public health in a particular state, the politics of that state never makes a difference in how HHS responds.

Which brings me to Number Nine: Look for Allies Where You Don't Expect to Find Them.

To manage a large organization in this age of instantaneous communication, it always helps to look beyond the usual borders – and to reach out to non-traditional allies. That's why I believe in being nice to Republicans – and spending time speaking to newspapers like *The Washington Times* and *Wall Street Journal*.

Two papers not exactly known for supporting Democratic causes.

That's why we work hard to make friends out of adversaries; to cooperate with the leadership of both parties; to disagree without rancor; and to build on areas of agreement. And that's why if it will help me communicate better, I enlist help from people who don't expect me to come knocking on their door.

Number Ten: Be Flexible. Be Realistic. And Don't Expect to Win Every Time.

Perhaps the biggest mistake the manager of a large organization can make is to stand in one place for too long. Change comes. And as NASA's Jim Webb once noted, these changes come from both inside and outside the organization.

That doesn't mean there shouldn't be a strategic plan and systems in place for carrying out the operations of a large organization. But it does mean that governing is as much art as it is science.

We must expect the unexpected. And be nimble enough to change course – even in mid-sentence – if that's what it takes. In other words, keep moving.

In 1994, we lost on universal health care – in part because the other side organized quickly and framed the debate. By 1996 we were flexible enough to find a slower more incremental – and successful – approach. Last year we passed Kassebaum-Kennedy. This year we passed a budget that will provide up to 5 million uninsured children with coverage. A great victory.

The unexpected can also mean having something removed from your plate. In 1993, the Social Security Administration was part of HHS. It no longer is. Downsizing in the federal government – unheard of in 1993 – became the norm in 1994 and 1995.

The unexpected can mean a changing economy. Low unemployment is helping to lower the welfare rolls.

But with unexpected change comes unexpected opportunity. The opportunity to be creative. To find more efficient and less costly ways to deliver services. To find new partners and break new ground. To be – in the words of Mark Moore – an “explorer commissioned by society to search for public value.”

I've certainly felt like an explorer since becoming a member of a remarkable President's Cabinet.

This trip of discovery – although risky, difficult, and once in a while disappointing – has been the trip of a lifetime. I wish I had time to tell you how much fun public service is most of the time. My dream is that a young member of Pi Sigma Alpha who today is preparing for a career in the academy will have similar opportunities to spend some time in government.

I also believe that the disciplines of political science and public administration will be enriched as more students of government have a chance to be practitioners.

Thank you.

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\*REMARKS BY

DONNA E. SHALALA

U.S. SECRETARY OF HEALTH AND HUMAN SERVICES

JO OBERSTAR MEMORIAL LECTURE ON CANCER AWARENESS

GEORGE WASHINGTON UNIVERSITY

SCHOOL OF MEDICINE AND HEALTH SCIENCES

WASHINGTON, D.C.

\*THIS TEXT IS THE BASIS OF SECRETARY SHALALA'S ORAL REMARKS. IT SHOULD BE USED WITH THE UNDERSTANDING THAT SOME MATERIAL MAY BE ADDED OR OMITTED DURING PRESENTATION.

It's indeed an honor to commemorate breast cancer awareness month by giving a lecture dedicated to the life and life's work of such a remarkable woman. Jo Oberstar was a wife...a mother...and a woman who spent her life in the service of peace and community. Even after being diagnosed with breast cancer, Jo did not retreat inside herself. Instead, she continually reached out to help other women with the disease. As we know, Jo lost her courageous battle with breast cancer in 1991. But her spirit lives on in this lecture series, which is also helping women with breast cancer by focusing the national spotlight on the disease...and helping to dispel the darkness of ignorance and apathy.

My family...like many of your families...has been touched by breast cancer. Many of us can remember what it was like when Betty Ford went public with her own struggle against breast cancer. That was 25 years ago. It was a time when the disease was only whispered about in the shadows. But like Jo, Betty Ford used her public position to bring breast cancer into the light. Betty Ford went public not long after our national war on cancer was declared. And we've certainly come a long way since then.

I was thinking about that as I watched the recent WNBA Basketball Championships. There's a player named Cynthia Cooper, who I'm sure you'll be hearing a lot more about in the years ahead. She's an Olympic gold medalist. She's the star of the 1997 Champions, the Houston Comets. She's even been compared to Michael Jordan. But she's often seen in the company of another champion. Someone whose been her inspiration—her mother...a breast cancer survivor. During the Championship Game, the announcers kept telling the story of her mother's courageous battle. And Cynthia herself appeared in an ad to raise awareness about breast cancer.

As I watched all of this I thought: Gone are the days when a diagnosis of breast cancer is considered a death sentence—to be suffered in silence. Today, one of America's top female athletes openly discusses breast cancer on television. Today, we have a whole generation of women, like Cynthia's mother, who can call themselves breast cancer survivors. The overall breast cancer mortality rate for American women has dropped over 6 percent in recent years. An article in last week's New England Journal of Medicine suggests that radiation, when combined with surgery and chemotherapy, can dramatically reduce the risk of death from breast cancer. And I'm pleased to announce today that in a span of just six years, we have seen an increase of almost 30 percent in the number of American women getting recommended mammograms.

While we can't raise the victory flag in the war against breast cancer—for the first time the tide seems to be going our way. This couldn't have happened without the people in this room, from the researchers, to the activists who held our feet to the fire. It couldn't have happened without dedicated elected officials like Congressman Oberstar. And it couldn't have happened without our President. President Clinton has a deep

understanding of breast cancer, having seen his own mother fight a courageous battle against it. And he's strongly committed to lifting this deadly shadow that hangs over the life of every woman--of every family.

I'm proud that we created the first National Action Plan on Breast Cancer, a public-private partnership that has just one goal: The complete eradication of breast cancer. No, we haven't reached that goal yet. But since 1993, we've almost doubled discretionary spending for breast cancer research, prevention and treatment. And those sustained investments have moved us further along in our journey to remove breast cancer from the medical books and consign it to the history books.

As my colleague Dr. Klausner, the Director of our National Cancer Institute, no doubt made clear last year at this lecture, we've seen truly exciting breakthroughs in research. In genetics, we've discovered genes linked to hereditary breast cancer—discoveries that can help us detect the disease early when we can still treat it and beat it. And now genetic fingerprinting offers the potential of predicting which women will suffer a cancer relapse, so we can aggressively treat them even before the disease strikes again.

Our cutting-edge research on normal and cancer cells is beginning to unravel the molecular differences that account for the uncontrolled growth and migration of cancer cells throughout the body. By understanding these differences, scientists and researchers hope to develop targeted interventions to more effectively treat breast cancer. But this kind of cell research relies on the availability of breast cancer tissue. And that's why we're establishing a national system of tissue banks to ensure that researchers have adequate samples to continue their cancer treatment work without interruption.

But research isn't only unlocking doors to cancer treatments, it's also providing us with windows on cancer prevention. It's incredible. We have the potential to usher in a new generation of drugs that are more effective, more selective—and that could actually prevent breast cancer before it happens. What we know is that estrogen and estrogen metabolism play important roles in breast cancer development. We know that we need to find ways of attacking estrogen in the breasts, without disturbing it elsewhere. And we've seen the drug Tamoxifen—which is now used to treat breast cancer—actually prevent its recurrence. Our Breast Cancer Prevention Trial is looking at 13,000 women at high risk for breast cancer—and within two years we'll know if Tamoxifen can also reduce their chances of ever getting the disease. These revolutionary discoveries are really changing the way we look at breast cancer treatment and prevention.

At the same time, we know that, right now, early detection remains our most powerful weapon in the war against breast cancer. We know that 93 percent of breast cancer cases are successfully treated when detected early. We know that early detection is often the main difference between becoming a breast cancer survivor...and a breast

cancer statistic. And we know that the best way to detect breast cancer is through regular mammograms and annual exams. That's why I'm proud that as of January 1<sup>st</sup>, all Medicare eligible women over 40 will have more help paying for their mammograms. I'm proud that we replaced years of confusion with a clear and consistent scientific recommendation for women in their 40s: Regular mammograms can save your life. And I'm proud that under the Mammography Quality Standards Act, we're giving American women greater confidence in the safety and accuracy of their mammograms.

We're also supporting a variety of research projects to further improve the quality of mammography screening. We're working with the Department of Defense, the CIA, NASA and other public and private entities to explore ways in which imaging technologies from other fields could be applied to the early detection of breast cancer. In particular, the computer technologies that have been used to improve spy satellites—and helped win the Cold War—may now improve breast cancer detection, and help us win a very different war.

Around the world, we're also seeing research in cutting-edge alternatives to mammography—including a high-tech bra fitted with heat sensors and an electronic memory chip—designed to detect cancer by measuring changes in breast temperature during a woman's menstrual cycle.

All of us should take heart in these accomplishments. We should take heart in the fact that we're—bit by bit—chipping away at this terrible disease. But we should never become complacent. Because, in the words of poet Robert Frost, we still have miles to go... We still have miles to go when more than 180,000 women this year will hear those four terrifying words, "You have breast cancer." We still have miles to go when too many women are still playing a deadly game of Russian roulette—ignoring mammography, regular exams and their health. And we still have miles to go when more than 44,000 women will be taken by breast cancer in 1997—and 44,000 grieving families, like Jo Oberstar's, will be left behind to pick up the pieces. So while we continue to fight to eradicate breast cancer—and these statistics—we must put our best science and technology to work.

We must, above all, strive to ensure that all women have the information and the services they need to best protect themselves today. This is our paramount challenge. It's a challenge that government cannot meet alone. And it's a challenge that can only be met if we bring down four barriers: access, discrimination, fear and lack of information.

To overcome barriers to access, we need to make sure that all women—especially women of color—enjoy the full benefits of our scientific knowledge. We've recently seen some good news on this front. We're closing the gap between the percentage of Hispanic women and non-Hispanic women over 50 who are getting mammograms. But there's also some troubling news. While the breast cancer death rate declined over 6 percent for white women between 1991 and 1995, it only declined 1.6 for African-Americans.

And while, as I pointed out earlier, more women are getting mammograms, there are still too many who aren't. We need to address this problem and find new ways to help all women prevent, treat and fight breast cancer.

That's why we're reaching out to almost 1 million women in all fifty states—especially low income women and women of color—to make sure they know about and have access to mammograms. That's why the National Action Plan on Breast Cancer is using the information superhighway to provide health care professionals, activists—and families—with the power to continue fighting breast cancer. And that's why the First Lady is leading a mammography awareness campaign aimed at women over 65—those women most at risk.

We've also seen it in action right here at George Washington University Hospital. Its "Mammovan" is taking the war against breast cancer right into the neighborhoods of our nation's capital. This specially equipped van travels throughout Washington breaking down barriers to access and bringing screening services directly to those who may need it the most. We need more vehicles for good health like the Mammovan.

But breaking down barriers to access isn't enough. We also need to destroy the barrier of discrimination. In a study just released this week, 4 out of 10 Americans said they worry that they will lose their jobs if their employers find out they have cancer. But Americans are also worried of what might happen if someone finds out their at risk for cancer. Because the revolutions in genetic information that I spoke about offer the potential of improving our health, or revealing our family's darkest secrets. In the aftermath of Tuskegee, we saw that public distrust, when left unchecked, can lead groups to bypass important care.

Likewise today, concerns about discrimination could deter women who have the gene for breast cancer from getting tested or seeking treatment—because they may fear losing their health insurance. As our Administration has made clear, we need to protect the privacy of genetic information...of all medical information. And we need to eliminate genetic discrimination and make sure that no American is afraid to walk through the doors of their doctor's office for fear that their genetic secrets will be used to close the door to affordable health insurance.

But that's not the only kind of fear we need to tackle. For many women, the biggest fear about breast cancer is the fear of not knowing what to do, or when to do it. As I noted earlier, we recently sent women in their 40's a clear and consistent scientific message about mammography. Now it's up to all of us to get the word out.

But other women may ignore mammography, regular exams—or the lump in the breast—because they fear what they may find out. We also need to get out the message that, when it comes to breast cancer, ignorance is not bliss. Because it's not just that what you don't know can hurt you. More important, it's that what you do know can help you.

We know that just because a woman has a genetic risk of breast cancer doesn't mean she'll get it. We know that only 5 to 10 percent of breast cancer cases have genetic roots. And we know that the number one risk factor for breast cancer is simply aging. We need to get out the facts in order to dispel the excessive fear that many women have about contracting breast cancer—and replace that fear with power.

Which is my fourth and final challenge. There's an old saying that "As the twig is bent, so grows the tree." If we want the messages of breast cancer awareness month to take root, then we can't just preach in October—and we can't start preaching when a woman enters adulthood. The messages must start early, and they must be enforced often. Because it's never too early to start learning about breast cancer. Hadassah has a program called "Check it Out" which teaches high school students about detecting and preventing breast cancer. Dr. Susan Love in her new breast book makes it clear that breast health awareness must begin in adolescence.

And all of us also need to send young women—indeed all women—clear messages about the importance of a healthy lifestyle in preventing breast cancer and other diseases. That means getting physically active, eating right, and never—ever—smoking. Recent studies have indicated that smoking and excessive alcohol consumption may increase a woman's chance of getting breast cancer, especially if she begins these risky behaviors as an adolescence.

Having a frank, open discussion about breast cancer with a girl, today, can help save a young woman's life, tomorrow. A young woman like Kim... Kim is only 27 years old. But instead of struggling with career or relationships like most people her age, Kim is struggling with aggressive breast cancer. And instead of a future bright with job promotions or family celebrations, her future is clouded right now by chemotherapy, a mastectomy and bone marrow transplants. Kim is young. She is scared. She is fighting a personal battle against breast cancer. And she doesn't know if she'll become a survivor... or a statistic. It's for women like Kim... for women like Jo Oberstar—and for all of their loved ones—that we must continue the war against breast cancer. And I've no doubt that, although it will be a long and difficult fight, working together—we will win.

Thank you.

FOR RELEASE UPON DELIVERY  
THURSDAY, OCTOBER 23, 1997

\*REMARKS BY

DONNA E. SHALALA

U.S. SECRETARY OF HEALTH AND HUMAN SERVICES

AT

WHITE HOUSE CONFERENCE ON CHILD CARE

WASHINGTON, DC

\*THIS TEXT IS THE BASIS OF SECRETARY SHALALA'S ORAL  
REMARKS. IT SHOULD BE USED WITH THE UNDERSTANDING  
THAT SOME MATERIAL MAY BE ADDED OR OMITTED DURING  
PRESENTATION.

Whether I'm talking to parents struggling to make ends meet or women trying to balance work and family, there are two words that always come up: child care. Parents usually talk in whispers: Most would rather tell their bosses they have a flat tire than admit they have a child care problem. Now, thanks to the President and Mrs. Clinton, we've brought the issue of child care into the spotlight and turned the private conversations families have into a national discussion we all must have.

This is not the first time in our history that we've faced this challenge. When Rosie the Riveter entered the work force during World War II, her family needed child care. So President Roosevelt and Congress acted to provide it.

Today, as Secretary Rubin pointed out, millions of daughters and granddaughters of the World War II generation are in the work force – not to win a war, but to win financial security for their families and independence for themselves. So once again, families need child care. And, once again, the national government must be a partner with states, communities, businesses and families to meet our nation's growing child care needs. Why? Because investing in child care and after school programs is one of the best investments we can make in our economic future.

As a big Cleveland Indians fan, I've obviously been thinking a lot about the World Series. And when I think about where we stand in understanding and addressing the child care issues facing our nation, I see us in the 7th inning stretch – knowing that we're doing better, but not as well as we should. Knowing that the picture of child care is uneven – some communities are doing well and others are not stepping up to the plate. And knowing that the most important part of the game is yet to come.

Because of the leadership of the President and First Lady, the early innings have brought real progress. We're spending more. This year we invested \$3 billion in the Child Care Development Block Grant – an increase of almost 70 percent since 1993. This grant, combined with state funds, is helping to care for 1 million children from welfare families and the working poor. Since President Clinton took office, our investment in Head Start has almost doubled to \$4 billion – and now serves nearly 800,000 children a year. And our Dependent Care Tax Credit – valued at \$2.5 billion – will help 5 million families pay for child care this year.

We're learning more. Research funded by our National Institute of Child Health and Human Development found a direct link between high quality child care and a child's subsequent cognitive and language development. And we're reaching out more. We started a National Child Care Information Center to share information with states and communities. We're fostering public-private partnerships. We're providing states with technical assistance and models that work to help them address quality and other important issues. And we're linking child care and health care agencies to improve safety and give children the health care services they need.

But as the President made clear this morning we must DO more – and we need to do better. Because today only about one million children receive federal child care

assistance even though 10 million are eligible. And because the 7th inning stretch is a time not only to stand up, but also to look out – to engage in a real national dialogue about where we are, and what each of us must do to take us where we need to go.

Let me give you a snap shot of where the gaps are on three issues: Availability, affordability, and quality. For parents, these areas really boil down into three basic questions about child care: Can I get it? Can I afford it? And can I trust it?

First, can I get child care? We don't have a big centralized child care system. We have a diverse system that includes everything from company sponsored day care centers to family day care to informal arrangements with friends and relatives. Yet, too many parents don't have access to even one of these options. As the General Accounting Office report made clear, parents are running up against major shortages of care – especially for infants, for children with disabilities, for school age children, and for families working nontraditional hours.

Over half of our schools do not offer after-school services to children – and those same children – especially in low-income communities – often cannot find after-school care in their neighborhoods either. It's especially tough for middle school and junior high kids. As they move through adolescence, they desperately need imaginative programs and caring adults after school – but too few of them are getting it.

Even when child care is available, it is often inaccessible, because there is no transportation from home, work, or the place of care. But assume that parents can find and get child care: It still has to be affordable or it doesn't do them much good.

Which brings me to the second question every parent is asking about child care: Can I afford it? As Mrs. Clinton has pointed out, families earning less than \$1200 dollars a month pay about a quarter of their income for child care. The federal government is trying to ease this burden. And we've done a pretty good job of helping people move from welfare to work by expanding child care. For example, most federal assistance goes to families at or near the poverty line. For a family of four, that would be income of just over \$16,000 dollars.

But this problem extends far beyond poor families. It is a challenge that faces all working families. It's great that many states are trying to make child care more affordable by linking eligibility to income instead of welfare status. But we need to be careful. Because even as many states increase eligibility, they are also increasing the amount they expect parents to pay.

And even when parents can get – and afford – child care. They still need to ask themselves: "Can I trust it?" That is the third and last piece of the child care problem I want to highlight: quality and safety.

No matter where you live or what kind of care you choose, parents should always have confidence that their children are getting the best. We have many extraordinary child care settings that we should be proud of. They're in the military, in businesses, in

schools and in communities. Yet, many child care arrangements have serious shortcomings. Part of the problem is low reimbursement rates from many states.

Another part is inadequate licensing. All states have some form of child care licensing. But many children – even infants – are in care that is exempt from it. To make matters worse, in some states our Department found numerous instances where child care facilities did not comply with the states' health and safety standards. And unlike the military, where child care centers are inspected many times each year, in the civilian sector, too many child care programs don't receive even a single inspection during the year.

Perhaps the biggest threat to quality are poor training and low wages for child care workers. Most child care staff only earn around \$12,000 dollars a year with few, if any, benefits. These low wages cause a third of child care workers to leave their jobs every year, which can be damaging to young children who need stable care.

In addition, last year, more than half the states required little or no training for child care staff before they started work. We're trying to close that gap. Under our new Child Care Development Fund, all states using federal funds are required to provide basic health and safety training. To prevent SIDS deaths in child care settings, our department is educating child care workers about the importance of putting infants to sleep on their backs – and the importance of telling their parents to do the same. And we believe that all child care centers receiving federal funds should have to make sure that the children they serve are immunized.

As I said, I consider this conference to be our 7<sup>th</sup> inning stretch. But reaching the end of the game will be the tough part. It means making sure that all parents have the information and the personal assistance they need to make one of the toughest decisions of their lives. It means making sure that states don't have to make impossible trade-offs when choosing which children are eligible, how much parents pay, and how much child care providers are reimbursed.

And, it means making sure that parents don't ever have to make impossible trade-offs either – trade-offs between keeping their jobs and keeping their children safe.

As the other panelists will make clear, that's only going to happen if all of us continue to share information and invest resources – from the federal government, to the states, to the private sector, to communities and parents. And that's only going to happen if we judge ourselves not on what we say today, but on what all of us do tomorrow.

Thank you.

FOR RELEASE UPON DELIVERY  
MONDAY, NOVEMBER 3, 1997

\*REMARKS BY

DONNA E. SHALALA

U.S. SECRETARY OF HEALTH AND HUMAN SERVICES

FAMILY VIOLENCE PREVENTION FUND NATIONAL CONFERENCE

WASHINGTON, D.C.

\*THIS TEXT IS THE BASIS OF SECRETARY SHALALA'S ORAL REMARKS.

IT SHOULD BE USED WITH THE UNDERSTANDING THAT SOME

MATERIAL MAY BE ADDED OR OMITTED DURING PRESENTATION.

Will Rogers liked to tell the story of a famous congressman, who prepared a speech but didn't have a chance to deliver it. Greatly distressed, he asked that his oration be printed in the Congressional Record. The speech contained all kinds of promises for a better, brighter future. The congressman was so certain that he was writing for the ages, that he wrote the word "applause" in the text everywhere he thought he'd get one. Unfortunately, the young printer couldn't read the congressman's handwriting. So every time he saw the word applause, he wrote: "applesauce."

I like that story because it nicely sums up what Americans think about political promises—they're as solid as applesauce. But some promises are too important not to keep—like our promise that battered women will receive the help and support they need. And our promise that every home should be a safe home.

That's why it's a great honor to join all of you today. Because you're developing trail blazing approaches to prevent and treat domestic abuse. Because, as your conference title suggests, when it comes to addressing family violence, you'll help guide us into the new millennium. And because we've come a long way in fighting the epidemic of domestic violence, but, unfortunately, we still have a long, and difficult, road ahead of us.

...It wasn't very long ago that a battered woman was forced to suffer the cuts and bruises, the terror and tears, in silence. It wasn't very long ago that family violence was considered a family matter. And it wasn't very long ago that when a battered woman called out for help, she got the same response as Doris. In the late 1970's, Doris was living with the familiar cycle of pain and abuse. Her husband beat her when she was pregnant. He beat her after she miscarried. He beat her after she delivered children. But Doris was also forced to endure another tragedy. Because in the 1970's there were no lifelines for battered women—no safe havens to heal, no safe passageways to a better life. When she went to doctors and hospitals, battered and bruised—in one case seven months pregnant and black and blue from head to toe. No one questioned her. No one offered a helping hand. The abuse only stopped when her husband was imprisoned for a series of crimes, including rape.

Today, two decades later, domestic violence is still causing terror and tears. But the story isn't quite the same. Because many of the calls for help are now answered. I witnessed some of these calls when I recently toured the National Headquarters of our National Domestic Violence Hotline in Austin, Texas. On the phone, there were women, like Doris, who are trying to break the cycle of domestic abuse. Since we established the hotline in February of 1996, almost 140,000 women have been able to reach out for help—24 hours a day, 365 days a year.

But we knew all along that when the switchboard starting lighting up, we had to be ready with more than statements of support. We needed to be ready with real support systems—with referrals for counseling and shelters. And we needed to create a continuum of care...a seamless system of protection and prevention...a system that

protects and follows women at risk from incident to safety..... a system that leaves no gaps large enough for a woman or child to fall through...and a system that can help heal shattered bones...shattered lives...and shattered dreams.

That's exactly what our Administration has fought to do... With 50 percent more funding for shelters... With tougher penalties for abusers... With better training for police, prosecutors and judges... With more community policing and prevention..And with more public-private partnerships. Just last week, I was at the White House with the Vice-President, and CEO's from companies like Liz Claiborne and Bell Atlantic Mobile, talking about what we can all do—individually and collectively—to confront domestic violence in the workplace. These are all important steps—steps we should be proud of. But they are steps to build on, not to rest on.

Because while we've made great progress in the legal and social service areas, as Doris' story pointed out, one important—and very dangerous—gap still exists in our continuum of care. We haven't focused enough on how our health care system can prevent and treat domestic violence—we simply must do better. Because a battered woman may never call the police...she may never contact a lawyer...she may never enter a shelter, but, eventually—even if it's only for a routine check-up—she will probably visit a doctor, nurse or community health worker. And we must be ready when she does. That's why this year we want to further improve identification and appropriate treatment of domestic violence by the health care system... We want to increase data collection and research about family and intimate violence... And we want to better reach out to health care professionals like you, strengthening our ability to screen, treat and prevent violence against women.

We in government cannot accomplish any of this alone. We need all of you who are on the front lines to continue to work with us to help battered women and their children move out of the shadow of abuse. And that's why I'm here. Many of you, as individuals or members of community or professional organizations, have already made important contributions... The 10 state teams participating in this conference are developing innovative strategies to address domestic violence... As I'm sure Dr. Dickey pointed out in her remarks, the American Medical Association has been working with its state associations to develop domestic violence training programs. And it has run two conferences with the American Bar Association to discuss how the organizations can attack the problem together. The Joint Commission for Accreditation of Hospitals and Health Organizations has made screening family violence one criteria for accreditation. At our Department's recent National Nursing Summit on Violence Against Women, leaders in the nursing field came from all over the country to share program ideas, protocols and experiences with domestic violence. And many hospitals and emergency rooms have begun programs for assisting and screening battered women right on site.

One of the most promising of these programs is WomanKind, which provides services in three Minnesota hospitals, and is currently being evaluated by us. In 1986, Susan Hadley, a community-based battered women's advocate at Fairview Southdale

Hospital near Minneapolis, created a one person, around-the-clock, domestic violence and intervention program that provided information and referrals to battered women in the emergency room. Today, Womankind is a formal department within the Fairview health care system. Its services include 24-hour per day case management, advocacy, crisis intervention, hospital-wide training, domestic violence support groups and ongoing assistance after a woman leaves the emergency room. But Womankind not only provides a lifeline for countless battered women, it also demonstrates the difference that a single person can make in the battle against domestic violence... And it serves as an excellent model for how we can attack domestic abuse in our changing health care world.

Because revolutions in our health care delivery system—including managed care—have confronted us with a whole new set of questions that face everyone from patients to insurers: How can we build the trust that's necessary for a woman to confide about domestic violence when she may be seeing a variety of doctors and nurses? How do we ease a woman's fears about privacy? How can we take the prevention strategies that are at the heart of managed care and apply them to domestic violence? The point is, how do we ensure, in this new world of health care, that no woman or child falls through the cracks?

We can successfully address these questions only if we meet four challenges... and only if we understand that fighting domestic abuse through the health care industry is not a one-person sprint. It's really like running a great relay race—Where the ultimate prize is a lot more important than a gold medal or a blue ribbon... Where the success of the team's efforts depends on the performance of each runner, each giving their all. And where the pivotal moment is that second when the baton is passed from one runner's hand to another's.

When it comes to domestic violence, the starting line for treatment and prevention is usually when a woman walks—or is carried—through the door of an emergency room or doctor's office. And just like the relay runner, every health care professional must be prepared. And that's the first of our four challenges. In a managed care environment, a woman doesn't generally have one doctor—a Marcus Welby or Ben Casey taking care of her throughout her life. So it's particularly important that every doctor, nurse, physician's assistant and midwife is learning about domestic abuse right along with anatomy and physiology.

Our 1997 survey of Women's Health in the Medical School Curriculum showed that of the 117 American and Canadian medical schools responding, 76 percent taught about domestic abuse as part of another required course. However, this could mean that during a lecture only 15 or 30 minutes is devoted to the topic. Only 12 percent require a separate course in domestic violence, and only 17 percent offer a distinct elective in the topic. Even more disturbing were the results of our 1995 National Survey of Hospitals. Of the 495 American hospitals that completed the questionnaire, only 5 offer distinct residency programs in women's health, and only 17 offer fellowship programs. Of the 5 residency programs, none specifically address domestic violence or rape. And of the 17

fellowships, only Pittsburgh's VA Medical Center offers it's fellows the option of rotating at a battered woman's shelter or rape crisis center.

Doctors—and other health care professionals—need to know the signs of abuse, what questions to ask, and how to screen women from all cultures and ethnic groups who may have suffered domestic abuse. They need to know that if they suspect child abuse, they also need to screen the parents. And they need to continue learning throughout their careers with refresher courses and seminars so they can effectively identify and screen battered women.

Together with many of you, we're working to develop effective training models and curricula. We've teamed up with Group Health of Puget Sound to test the effectiveness of training in improving the help that battered women receive. And I'm especially pleased that, just this month, all the major nurses associations in the country joined with us to craft a long-term national strategy to address domestic violence. At the heart of this strategy is the development of recommendations for universal domestic violence education at all levels. All of these efforts will help ensure that Doris' experience is never repeated.

But once a health care professional correctly identifies a woman as a possible victim of abuse, we're now faced with our second challenge. We must ensure that battered women are not afraid to talk to a health care professional—or even to seek treatment. Because even if we educate every health care professional in the country about domestic abuse, we won't have the seamless system we envision, and we still won't be able to help battered women, if they are unwilling to talk about—or even acknowledge—the abuse. Many women are scared that their privacy won't be protected... They may be scared that they will suffer the violent consequences when the batterer is arrested... They may be scared that they can't support themselves, or their children, if their abusive husband or partner is taken into custody... Or they may be scared that they will lose their health insurance.

It's tragic that the initial response of too many insurance companies was to deny thousands of battered women insurance, or re-insurance, because they viewed abuse as a pre-existing condition. But under the recently passed Kennedy-Kassebaum legislation, it's illegal for insurance companies to discriminate based on a pre-existing condition when a person transfers from one plan to another. We need to make sure battered women know this. We need to make sure that no battered woman is afraid to walk through the doors of her doctor's office out of fear that domestic abuse will be used to close the door to affordable health care. And, as our Administration has made clear, we need Congress to pass legislation that will balance our national priority interests—including law enforcement—with the legitimate needs of personal privacy.

But let's assume that a woman feels comfortable enough to disclose her abuse to the medical professional that's treating her. Then what? That's our third challenge.

If we want this seamless system to work, doctors and other health care professionals and institutions need to see themselves as part of a much larger community—collaborating to successfully treat and prevent domestic violence.

That's why we've teamed up with the Rhode Island Department of Health, and its partners in the health care, academic, law enforcement and advocacy communities, to produce a statewide program to reduce domestic violence. One of the main goals of the program is to provide technical assistance for the development of a seamless system of public education, victim identification training and referral protocols. Because, as Doris' case illustrates, identifying the abuse is only part of the responsibility. I realize that with doctors and professionals being asked to do more in less time, this isn't easy. But health care professionals need to know what community resources, such as shelters, counseling centers, support services and law enforcement remedies, are available. They need to be ready to make referrals and recommendations. And they need to help ensure that a battered woman knows the options, so she can receive the aid she needs.

Yet, in order to develop strategies and interventions to prevent domestic violence, we need to come to terms with the true scope and nature of the problem. And that's our fourth and final challenge. But we can't meet this challenge if we continue to disagree about which numbers to cite or which definitions to use when discussing domestic abuse. The two National Family Violence Surveys conducted over the last twenty years didn't ask important questions about stalking, emotional abuse or sexual abuse... And the Department of Justice's Crime Victimization Survey asked if a person was ever the victim of a crime of violence committed by someone they knew. In order to answer yes, a woman has to believe that physical, sexual, or emotional abuse is a crime. I know that it's extremely difficult to obtain reliable and valid data on the prevalence and incidence of domestic violence. But until we get agreement on regular tracking, definitions and epidemiological data, we can't see the whole picture... we can't develop trustworthy rates over time... we can't gain a better understanding of trends... and we can't measure our progress.

We are moving forward on this front, and that's important. In the next few months, a new household survey on domestic violence, that was funded by our Department and the National Bureau of Justice Statistics, will provide data on prevalence; impact; severity; which domestic violence services are being utilized; and the characteristics of battered women and their abusers. Hopefully, this will provide a clearer picture of the problem.

But one survey is simply not enough. We need those regular surveys that monitor the health and well being of our nation to incorporate domestic violence as a relevant indicator. We need more data from health care professionals that's based on thorough screening of domestic abuse victims. And we need a better understanding of program effectiveness, as well as cost. Above all, we need to stop arguing about the numbers, and instead focus our attention on the problems, their solutions—and the women and children who need our help.

**FOR RELEASE UPON DELIVERY  
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**\*REMARKS BY**

**DONNA E. SHALALA**

**U.S. SECRETARY OF HEALTH AND HUMAN SERVICES**

**AT**

**CDC INTERNATIONAL CONFERENCE  
ON EMERGING INFECTIOUS DISEASE**

**ATLANTA, GEORGIA**

**\*THIS TEXT IS THE BASIS OF SECRETARY SHALALA'S ORAL REMARKS.**

**IT SHOULD BE USED WITH THE UNDERSTANDING THAT SOME**

**MATERIAL MAY BE ADDED OR OMITTED DURING PRESENTATION.**

I could not begin today without recalling an important anniversary in the history of fighting infectious disease. Two hundred years ago, the U.S. Public Health Service, of which CDC is an essential part, began as a humble maritime hospital in New York City. Its mission was simple—to stop infectious disease from coming in on ships and spreading across our country. And for two centuries, under outstanding leaders like David Satcher and Bill Foege, the CDC has continued to fulfill the mission of preventing the spread of infectious disease.

Today, as we celebrate the anniversary of the Public Health Service, and one of its leading lights becomes our Surgeon General, another historic event has also re-emerged. As most of us are probably aware, last month, one of the great detective hunts of the 20<sup>th</sup> century finally came to an end. Scientists at the U.S. Defense Department confirmed that tissue from a woman's body buried near the Bering Strait contains genetic material from the 1918 Spanish flu virus—the virus which caused the worst pandemic the world has ever known. And this latest discovery will help us map the genetic structure of the microbe that sent a wave of death crashing around the globe 80 years ago.

It's hard to believe today that a simple flu could be so nearly apocalyptic. In just eleven months, at least 24 million people were killed, while the majority of humanity was infected. And the infected often never knew what hit them. In the morning you would feel fine, by night you could be dead—drowned as your lungs filled with fluid. There was no explanation, no protection, no cure. The pandemic produced scenes from a Gothic horror novel—but it was all too real. In Philadelphia alone, 11,000 died from the flu in a single month. The dead were left in gutters—and death carts roamed the city in a surreal scene from Medieval times. And as the deaths mounted all over the world, orderly life began to break down. Schools and churches closed; farms and factories shut down; homeless children wandered the streets, their parents vanished. The acting U.S. Army Surgeon General, Victor Vaughn, calculated that if the pandemic continued its mathematical rate of acceleration—it soon could spell the end of humankind.

But then, as silently, as mysteriously, as quickly as it came—the terror began to fade away. People stopped dying. The victims were buried. Life returned to normal. The great flu was soon pushed off the front pages...and out of the public imagination. But we all wondered if perhaps another pandemic had begun when the avian flu first appeared last year. It was an influenza subtype that had never before produced illnesses or deaths in humans—and now it did. And while it appears that the spread of the avian flu has halted, without the appearance of human-to-human transmission, we know that the danger is far from over. Because the critical period may be just beginning—since we're now at the start of the traditional flu season in Hong Kong.

But the emergence of avian flu points up a broader concern. We must guard against complacency over infectious disease. It's easy to assume that modern medicine has defeated this enemy once and for all. Our comfort is a natural byproduct of our progress and success—the remarkable breakthroughs in antibiotics and vaccines, thanks to the work of scientists and researchers at CDC, NIH and worldwide. Most recently, we finally eradicated smallpox from every nation on earth—consigning one of history's deadliest killers from the medical books to the history books. But, in reality, infectious disease remains the leading cause of death, worldwide, and the 3<sup>rd</sup> leading cause in the United States. While we may be winning some old battles, we're struggling with some new adversaries -- the emerging infectious diseases such as Ebola ... Hantavirus ... new strains of tuberculosis ... HIV and AIDS ... and Lassa Fever, to name a few. In fact, the World Health Organization has labeled the growing threat of infectious disease a global crisis.

Undeniably, the time has come to replace complacency with a new sense of urgency -- to launch a renewed, unified, global effort to fight infectious disease. This conference is a great start. Nature may have the power to create a pandemic—but together we have the power to prevent it; to stop it; to overcome it; to cure it. And there is no time like the millennium. For today, history and human progress have created an "ironic contradiction" in the fight against infectious disease. That some of the same forces that invite pandemics can also be harnessed to fight pandemics. With the globalization of travel and trade, of immigration, communication and industrialization, we have a smaller world with porous borders. Nations are more interconnected ... people are more interdependent ... and humanity is less divided by what the Indian poet Tagore called our "narrow domestic walls." So the bad news is, we have fewer barriers against the spread of infectious disease. Yet the good news is, those fewer barriers mean new avenues to progress and the potential for sharing information and efforts to stop infectious disease.

We now have the power to push infectious diseases off the world stage—but only if governments, world health organizations, the private sector, scientists and researchers work together to hasten their exit with a global strategy. So I'm glad we're here today. But how do we successfully wage this global battle against infectious disease? I believe the answer lies in what we can learn from the 1918 pandemic. It provides three important lessons—lessons that are also challenges for all of us.

The first lesson is that we must assume it could happen again. We know that influenza pandemics have regularly swept the world every 10 to 40 years. And it has now been 30 years since the last influenza pandemic, the Hong Kong flu, killed 700,000. We also know that nature is creative, and the flu has great potential for mutating. If a strain changes dramatically, then we could suddenly have a virus for which we may have no immunity—no vaccine, and no cure. But, of course, the threat's not just the flu -- the spectrum of new infectious diseases is constantly expanding. While old infectious diseases, such as tuberculosis, have evolved into entirely new killers—because they developed antibiotic resistance.

The advent of the antibiotics in the 1940's was one of the chief reasons we began to defeat infectious disease. However, we know that almost as soon as antibiotics were available—the microbes mutated and developed resistance. In the 1950's to 1970's, we produced so many new antibiotics that there was always an alternative medication. But today, the flood of new antibiotics has diminished to a trickle—while the microbes have continued to grow resistant. Antibiotic-resistant bacteria are becoming more common in hospitals and among patients with depressed immune systems. In Japan in 1996, and in the U.S. last year, we started to see a strain of staph infection, the most common hospital acquired infection, which could sometimes withstand vancomycin—our most potent treatment. But almost simultaneously, the first antibiotic to fight a new generation of “super bugs,” Synercid won limited approval from an FDA advisory panel. If it wins full approval, it will be the first drug in a new arsenal of weapons. This is certainly good news. And the FDA continues to work with drug manufacturers to bring new antibiotics to market as safely and rapidly as possible.

But antibiotic resistance isn't just a medical problem—it's also a behavioral problem. Right now, patients too often demand antibiotics for every illness—even for viral infections like the flu that don't respond. And they often don't finish the course of medication, allowing the remaining bacteria to develop resistance. What's more, many doctors over-prescribe. And the pharmaceutical industry has limited its antibiotic development due to cost. The widespread use of antibiotics in farm animals may also be helping the spread of drug-resistant germs. Given the consequences, we must act now to combat the diminishing effectiveness of antibiotics. That's why the CDC is strengthening surveillance and implementing education campaigns about the problem; why NIH is studying resistance; and why the FDA is promoting judicious antibiotic use. But this isn't a job for government agencies alone. Each and every one of us who understand the risks needs to spread the message that antibiotics are being misused, abused and overused.

Of course, the next pandemic could also result not from a mutating bug or ineffective antibiotics—but from an act of bio-terrorism. And whether bio-terrorism is state sponsored, or undertaken by a lone terrorist, it's not just a problem for the military or law enforcement—it's also a challenge for the entire public health community. If a specific threat is issued—perhaps someone claims to have released a toxic agent in a public place—then it's trained public health officials who must first verify that an incident has actually occurred. And they may need to decontaminate the area; identify exposed populations; and deliver preventive measures and treatments. But, too often, a threat isn't issued—no warning is given. In such a situation, public health officials must first quickly determine the deadly agent, the route of exposure and the likely source.

My department is coordinating with our partners in other agencies and the military to ensure the proper training of state and local health officials; the availability of vaccines and drugs; and the enhancement of our surveillance capacity and expertise. There's also an administration-wide effort to train emergency response teams and health care providers in 120 cities. It's critical that we enhance our ability, now, to address the growing threat of potential bio-terrorism.

Which brings me to my second lesson. If a pandemic could happen again, then we must do everything we can to be prepared. We cannot wait until the next deadly microbe appears on the world stage. That's why my Department has been leading a federal, state and local effort to develop a "pandemic influenza plan" since 1993. As a result of the avian flu episode, we've sped up the process to complete the plan, and to pursue its full implementation. Meanwhile, the CDC is studying the impact of anti-viral medications and alternative ways to produce vaccines. The NIH is working in partnership with the pharmaceutical industry to develop and test innovative vaccines—including a nasal spray that delivers an inoculation dose of the virus. And the FDA is issuing new drug permits for experimental influenza vaccines. I know you'll be hearing a lot more about all of this work during the course of the conference. With new viruses knocking at the door, we can't afford to be caught unprepared. Because it's only in the movies—like the film "Outbreak"—where we can save the world from a deadly disease in just 24 hours.

Of course, we need this same kind of commitment in responding to all emerging infectious disease. What we need, and what the CDC has championed, is the creation of a world-wide "surveillance and response network" that can quickly identify and stop an outbreak. We've already laid the groundwork for such a system with bilateral and multilateral talks on disease monitoring with our partners in Europe, Japan, Asia and Africa. For example, at the Denver Summit in 1997, the group of eight industrialized nations, including the United States, pledged to help develop a global disease surveillance network and coordinate an international response to infectious disease. And working through the Trans-Atlantic Agenda with the European Union, the United States and EU countries have begun to share surveillance data on Salmonella infections. Additionally, through the US-South Africa Bilateral Commission our two countries are working to train health personnel in South Africa in surveillance and applied epidemiology. And I look forward to working closely with the newly nominated Director-General of the World Health Organization, Dr. Gro Bruntland, on her commitment to further globalize our approach to surveillance and response.

U.S. agencies such as the CDC are already supporting the efforts of the World Health Organization to improve communications networks, and to build regional centers for monitoring disease. Currently, the CDC and WHO jointly run 12 world monitoring stations for the flu alone. Perhaps the best example of the kind of monitoring and surveillance system we need to have, worldwide, is the excellent system that stopped the avian flu outbreak in Hong Kong. On a routine basis, officials collect throat swabs from people with flu-like symptoms. The samples are analyzed; and if something looks suspicious, it's immediately sent to the CDC—which functions as one of the WHO International Reference Labs for East Asia. So when the very first known case of the avian flu was diagnosed in a 3 year old boy, the warning bells went off immediately. When a second case appeared in November, health officials around the world went on alert—and a team from the CDC left for Hong Kong.

Over the next two months, the CDC worked to define the extent of the outbreak: including who was becoming ill; why they were becoming ill; and whether the virus could spread from person to person—and so cause a pandemic. Fortunately, the slaughter of over one million chickens seems to have halted the virus—at least for now.

Hong Kong's surveillance system proved that early detection of infectious disease can prevent their spread. David Heymann of WHO once asked a provocative question: What would have happened if we had had an excellent surveillance system in place in Africa when the AIDS outbreak first occurred? Perhaps we could also have halted that virus in its tracks. And perhaps we would have spared ourselves the second great pandemic of the 20<sup>th</sup> century. AIDS taught us that, regardless of a person's sexual orientation...or color...or wealth...or home, if we hesitate in our fight against infectious diseases, if we fail to detect and track them early, they will eventually affect us all.

But we cannot simply deal with each potential pandemic as it arises. In this age of wonder and change, we must also look over the horizon and seize new possibilities to head off infectious diseases before they can occur. We need to fully harness this golden age of global telecommunications, from satellites to the internet, to create a truly global surveillance and monitoring network. And we need to fully harness this golden age of scientific discovery, to find new ways to prevent, stop, overcome and cure infectious disease. That's one of the reasons that President Clinton proposed the 21<sup>st</sup> Century Research Fund. It's a historic national effort to spur the best minds of this generation to unlock scientific discoveries, to unravel scientific mysteries, and to uncover scientific advances. Today, the pace of medical discovery today isn't limited by science, or imagination, or intellect—but all too often by resources. So the research fund will provide a 1.1 billion dollar budget increase for the NIH next year. It's the first down payment on an unprecedented 50 percent expansion of NIH over the next five years. And it will enable NIH to do more to develop new ways to diagnose, treat and prevent disease. We're also seeking a boost in CDC funding to step up our ability to identify and investigate infectious disease outbreaks, including food born outbreaks. And the CDC will play a key role in a new initiative by the U.S. Agency for International Development to develop programs in targeted countries to fight the growing threats of bacterial resistance, tuberculosis and malaria. This new American investment in fighting infectious disease will not only pay off in America. Because in this world without borders, a discovery by any one nation will benefit us all—and brings us a little closer to preventing the next pandemic.

Which brings me to the third lesson of the great pandemic of 1918. We have the power to prevent the next pandemic, and defeat emerging infectious diseases—but only if our nations step up the fight together. Because diseases recognize no borders, in our fight against them, neither can we. Or as Dr. Bruntland has stated, when it comes to public health, "solutions, like the problems, have to be global in scope."

That's why, U.S. and Japanese scientists have held three international conferences together on infectious diseases and research. It's why some members of the Asian-Pacific Economic Cooperation Area, including Thailand, Indonesia and the Philippines, have developed a communications network to track cases of multi-drug resistant tuberculosis. And it's why the CDC, the FDA and other U.S. agencies are providing assistance to the Russian Federation and the Newly Independent States, which have faced a significant increase in infectious disease in the post-Soviet era.

But if we truly want to end the threat of infectious disease, then we must do even more together. And so, I want to offer the following challenges:

We must inject into global gatherings—no matter where they are, no matter what the subject—the urgency of working together to defeat infectious disease. We must never let research into infectious disease become a forgotten step-child of medical research. We must all continue to invest in vaccine research and development, and ensure that preventive vaccines are available, affordable and effective everywhere. We must work with all of our partners in the private sector to ensure that drugs, vaccines and tests are available during an infectious disease emergency. We must try to ensure that all urban populations have access to essential facilities—especially clean water, because vaccines and medicines can do little if water is unclean. We must work together to deal with conditions such as urban overcrowding, poverty and poor sanitation which are spreading infectious disease in many parts of the world. Finally, we must do what we are doing at this conference: We must pool our greatest resources—our restless imagination and intellect—to fight this collective fight. For as Joshua Lederberg once noted, “Pitted against microbial genes, we have mainly our wits.”

Let us pit our wits—and our will—to this battle, together, to heed the lessons of the great pandemic, and so ensure that it does not happen again; that we are prepared; and that we always work together. And if we do, then our children—the children of the millennium—will remember the 21<sup>st</sup> century as a time of health and hope... a time of promise and possibility... a time of medical miracles and scientific marvels. And I've absolutely no doubt that we can do it... that we must do it... that we will do it.

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\*REMARKS BY

HON. DONNA E. SHALALA

U.S. SECRETARY OF HEALTH AND HUMAN SERVICES

AT

HARVARD MEDICAL SCHOOL HEALTH POLICY LECTURE

BOSTON, MASSACHUSETTS

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PRESENTATION.

It's always a pleasure for me to return to this great university and this great city. I'm reminded that Mark Twain once remarked that in Boston a person isn't judged by his wealth or background—but only by how much he knows. But if we learned anything from the film "Good Will Hunting"...besides the fact that Skylar showed an appalling lack of good sense for leaving Harvard to go to another med school...we learned that knowledge alone is an insufficient yardstick for measuring an individual.

As future doctors, health care professionals and scientists, none of you will be judged by MCATs, or grades, or knowledge alone, but ultimately by your character and your humanity—How well you remain true to that most sacred part of the physicians' oath: To always put the needs of your patients first. Putting the needs of patients first...this has always been the hallmark, and the benchmark, for doctors who are both good and great. But I won't deny that in health care today, you'll face challenges filling this mandate that were unheard of when "Marcus Welby" made house calls, or even when "St. Elsewhere" opened its doors to Boston's poor.

Because as Shakespeare noted in *A Comedy of Errors* "There is something in the wind." And it's the winds of change that are sweeping the world of medicine and stirring revolutions...Revolutions in biomedical research that are yielding not only new treatment options, but also new ethical dilemmas...Revolutions in technology that are fostering an interconnected world of medicine where doctors will be wired to computers, data bases and research centers around the world...Revolutions in the doctor-patient relationship that have led to an understanding that individuals must take greater responsibility for their own well-being...And, of course, revolutions in the delivery of health care.

The face of health care has certainly changed. And the tradition of Rex Morgan and Ben Casey—of always putting the patient first—may seem completely alien in this brave new world—the world that all of you have inherited. But it's the duty of everyone involved in health care to ensure that the spark of this tradition is never extinguished. That the revolutionary winds don't sweep away what's most sacred in medicine. And that our medical system remains the best in the world for every American...every day...everywhere.

But how do we do this? Above all, we need a Patients' Bill of Rights that's part of an overall strategy to ensure and improve health care quality for everyone—no matter where they live...who they are... or who they see. And—for the very first time—I want to discuss this strategy with you today. Because its cornerstone, the Bill of Rights, is changing the very future of health care—and your future as well. And because you not only have a stake in this brave new medical world—you also have a vital role to play. As Harvard graduates, you'll be privileged to have one of medicine's finest credentials—but along with privilege comes responsibility. You are health care's future leaders, and you must help drive the effort to ensure and improve health care quality—and so keep our medical system the very best in the world, while we work together to make it even better by ensuring that there is a strong evidence base for the care we provide.

That's also the ultimate goal of the Patients' Bill of Rights. Its story begins two years ago when President Clinton called for the creation of a Health Care Quality Commission, and asked Labor Secretary Alexis Herman and me to co-chair it. The President understood the bitter irony of American medicine today. Our health care system has no equal, with some of the finest doctors, medical schools, hospitals, science and technology in the world. But too many Americans feel that an ill wind is blowing through the health care system. They share the same bad experiences: The mistakes...the rejections...the uncertainty...the frustration—in other words, the poor quality. When movie audiences erupt in applause when a character complains about her HMO, it's more than ire in a crowded theater. It's a rising public voice saying loud and clear—"no"—when it comes to our health care system, this can't be "as good as it gets." It's the American people demanding: Do something. Do something to guarantee that American consumers get the quality care they deserve, expect and need. So the President charged our Commission with two important tasks: First, to draft a Patients' Bill of Rights to ensure the quality of health care. And second, to develop a comprehensive strategy—a blueprint—to continuously improve the quality of health care.

Last November, we delivered to the President our Patients' Bill of Rights. And just like the original Bill of Rights, it provides some very basic guarantees for the well being of all our citizens. It guarantees access...quality...choice...privacy...and recourse for shoddy care. It protects both patients and providers. And it's based on one very sound premise: That every type of health insurance, whether managed care or fee for service, Medicare or employee sponsored, PPO or HMO, must deliver high quality health care...for every American...every day...everywhere. To support this premise, the Patient Bill of Rights lays out eight basic principles, which I want to briefly outline.

First, consumers should have the information they need to make knowledgeable choices. They need to know what's in a health plan and what's excluded...which health professionals are in a plan's network...how they can appeal a decision to deny coverage...and if a plan will restrict their access to certain drugs. Consumers also need information about the quality of the health plans, doctors, and hospitals that seek to serve them, so they can shop among plans armed with insights and knowledge.

The second principle is that consumers should have greater choice in health care. Because thanks to the winds of change, far too many Americans actually have fewer and fewer choices...Employers have cut the number of insurance plans they offer...choice of doctors has been reduced...and many people with acute or chronic conditions have difficulty gaining access to specialists. It seems that the spirit of Henry Ford may be haunting some aspects of health care. When Ford was making the model T, he once remarked, "A customer can have a car painted any color he wants—so long as it's black." Among its provisions, the Bill of Rights also says that people with chronic or severe conditions should have direct access to specialists...Women should have the choice of going directly to an obstetrician/gynecologist for routine and preventive services...And health plans that use "networks of providers" must include a sufficient number and mix of physicians to adequately provide the promised services.

The third principle of the Bill of Rights says consumers have a right to emergency care whenever and wherever the need arises. You and I know that if you're experiencing chest pains, you should go to the nearest hospital emergency room. But too many health plans were denying claims for emergency care when the chest pains turned out to be a false alarm. In other words, the good news suddenly became bad news. If we want to improve our nation's health, then people can't be reluctant to enter a hospital—simply because they're afraid they won't be able to afford the admission price. The fourth principle is that patients and doctors must be able to communicate freely. Patients need all the available information about treatment options, alternatives, risks, benefits, and consequences. The Bill of Rights says there should be no gag rules. There should be no contractual agreements to hamper the flow of information between doctors and their patients. And there should be full disclosure of any financial factors that might color a doctor's advice to a patient.

Fifth, the Bill of Rights states that there must be an environment of mutual respect and nondiscrimination in the health care industry and in insurance enrollment—regardless of race, sex, age, sexual orientation or other factors. You may be amazed and alarmed at the huge gap between the races in America when it comes to health ... African-Americans suffer diabetes rates 70 percent higher than white Americans... While Latinos have two to three times the rate of stomach cancer... And Vietnamese women suffer from cervical cancer at nearly five times the rate of white women. So the President has called for \$400 million, over 5 years, to close the gaps between minority populations and white Americans in infant mortality; diabetes; cancer screening and management; heart disease; HIV/AIDS; and immunization levels by the year 2010. And by addressing the health needs of minority Americans, we'll improve the health status of all Americans.

The Bill of Rights also says that there should be no discrimination based on a person's genetic makeup. Our scientists are making remarkable progress in identifying genetic predisposition to disease. But the windows that this is opening on disease prevention and treatment should never be used to close the door to health insurance.

The sixth principle in the Patients' Bill of Rights states that a patient's health records must be kept confidential. Once, our medical secrets were protected by the family doctor who kept them locked away in his file cabinet. Today, information is being shared by whole networks of providers and insurers. But unbelievably, we have federal laws that protect the privacy of our motor vehicle records, our credit card records and even our video store records—but not our health care records. As our administration has made clear, we need Congress to quickly pass legislation that will rectify this situation and ensure our privacy—and ensure that our health records will heal us, and not reveal us.

The seventh principle says that consumers must have recourse to challenge decisions made about their care. Consumers should be able to appeal those decisions to an external group of experts who are independent of their health care plan, and who had nothing to do with the original decision to deny coverage.

Finally, the Bill of Rights says that along with rights come responsibilities. These include taking personal responsibility for exercising; for not smoking; for working with your doctor to make decisions; and for making a good faith effort to pay medical bills. One of the cornerstones of these responsibilities is disease prevention. From day one, President Clinton has led the fight to protect our young people from the number one preventable cause of death in America. I'm talking about smoking. To further this aim, he's willing to support any legislation that does five things: Raises the price of cigarettes by up to \$1.50 a pack over the next decade; reaffirms the FDA's authority to regulate tobacco products; stops tobacco companies from marketing to our kids; and furthers our other public health goals—while also protecting tobacco farmers. We need comprehensive tobacco legislation, because each day...every day... every year, 3,000 of our young people begin to smoke illegally—And 1,000 of them will die a little sooner as a result. With appropriate legislation, we'll be able to improve both these statistics—and the state of America's health.

Of course, for those who need treatment and care, they also need the Patients' Bill of Rights...eight basic principles...eight straightforward proposals...eight common sense remedies for what ails our health care system. In February, the President signed an executive order that guarantees that everyone enrolled in Medicare, Medicaid, veterans health care systems and other federal plans enjoys the benefits of the Patients' Bill of Rights. That's 80 million people—one third of all Americans. With this single stroke of a pen, he's changed the face of health care in America forever. But we must now guarantee these protections to every American...every day...everywhere. We need Congress to pick up its collective pen and finish the job—extending the protections of the Bill to the remaining two-thirds of our citizens.

Guaranteeing the rights of consumers is an important first step in ensuring the quality of our health care. But to paraphrase poet Robert Frost, we still have miles to go. We must seize the opportunity to not only ensure quality care—but to improve it. Because for all its strengths, our health care system is still plagued by errors, inappropriate treatments and gaps in care. Our Commission took a long, hard look at our current state of quality. And we identified three overall problems. First, there are too many errors committed in the health care system. A landmark study by Harvard's own Dr. Lucian Leape found that an average of one million patients are injured in hospitals every year due to avoidable errors—and an estimated 180,000 die as a result. Second, there is a great deal of over- and under-utilization of health care services. For example, one in five hysterectomies may be inappropriate. While an estimated 18,000 Americans die annually because they don't receive beta blockers after their first heart attack. Finally, as documented by Dartmouth's Dr. John Wennberg, there is tremendous variation in national, regional and local health care services offered in this country.

All three of these problems are systemic. And they partially arise because of the revolutionary winds that are sweeping health care—and the explosion of new medical technology and information. For example, 20 years ago, a new doctor had to read an average of 500 articles a year about the latest advances in medicine. Today, you'll have to plow through at least 10,000 articles—each and every year.

But let me strongly emphasize that the Commission is not pointing any fingers. These problems don't arise because of a few bad apples spoiling the barrel. They don't arise because of inept practitioners or evil managers. And they certainly don't arise out of the movement toward managed care. In fact, by collecting and analyzing data on the health of the population they serve, managed care plans have helped to move quality measurement forward by quantum leaps. Let me be perfectly clear here—I was actually in a managed care plan more than 25 years ago, long before most people ever even heard of the concept. And I believe that, when done right, managed care can provide a seamless system of care from prevention to primary care to patient management. But—like every aspect of our health care system—we must protect what works in managed care, while addressing the problems that, quite frankly, worry too many consumers.

So our Commission undertook the President's second charge and developed a comprehensive strategy—a blueprint—to improve health care quality across America, and to specifically address the problems we identified. We developed a set of six goals, "National Aims for Improvement", which pinpoint those areas that we found required the greatest attention: One, reducing the underlying causes of illness, injury, and disability. Two, expanding research on new treatments and their effectiveness. Three, ensuring the appropriate use of health care services. Four, reducing health care errors. Five, addressing oversupply and undersupply of health care resources. And six, increasing patients' participation in their own care. We also called for development of uniform national measurement standards so that health care plans can compete on quality—not just on cost.

Of course, we must now turn all of our goals into reality. To help accomplish this, the President is already looking to the next logical steps. He strongly supports the Commission's recommendation to create a permanent Advisory Council on Health Care Quality to monitor progress on meeting our goals and to set new ones. And he's asked the Vice-President to convene a "Forum for Health Care Quality Measurement and Reporting" in June. It will bring together consumers, providers, labor, business, insurers and government to set uniform quality standards to help health care purchasers measure and compare quality.

But ensuring and improving health care quality isn't a task that government can accomplish alone. We need every member of the health care profession—whether doctor, nurse, administrator or policy maker—to bring their intellect and their imagination...their compassion and their commitment...their experience and their ethics to this task. And we especially need you—our new generation of doctors—and all of your energy and commitment. I challenge you to harness the winds of change that are sweeping health care, so you'll be the best trained and the most skilled generation of doctors ever. I challenge you to remember that the art of medicine must never be sacrificed to the business of medicine. I challenge you to help ensure that the sacred duty of always putting the patient first is never swept out of the halls of medicine. And I challenge you to bring not only your knowledge, but your character and your humanity, to medicine—so that our health care system will always be "as good as it gets." I've no doubt that you can do it...that you must do it...that you will do it. And when you do, you'll be both good and great...You'll foster medical miracles and scientific marvels...And you'll help ensure that our health care system remains the best in the world for every American...every day...everywhere.

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\*REMARKS BY

DONNA E. SHALALA

U.S. SECRETARY OF HEALTH AND HUMAN SERVICES

AT

PROMOTING WOMEN'S HEALTH ACROSS GENERATIONS

BI-NATIONAL ISRAEL-U.S. CONFERENCE

JERUSALEM, ISRAEL

\*THIS TEXT IS THE BASIS OF SECRETARY SHALALA'S ORAL REMARKS. IT SHOULD BE USED WITH THE UNDERSTANDING THAT SOME OF THE MATERIAL MAY BE ADDED OR OMITTED DURING PRESENTATION.

Minister Matza, what began as a meeting of our two minds is now an international meeting of minds to improve the health of Israeli and American women.

This is not the first time that the thoughts and dreams of my country -- and the thoughts and dreams your country -- have been woven together like the four wicks of the *Havdalah* candle.

Israel and the United States are both inscribed in the Book of Life as sanctuaries for the persecuted and defenders of religious freedom. That inscription will never be erased, and the ties that bind us together will never be broken.

Yet, in times like these, when the shadow of war grows and recedes -- and may grow again -- our bond of friendship takes on special meaning. We have learned over the years, that while all of us must be vigilant to protect our borders from without -- as women we must be equally vigilant to protect ourselves from within.

Our bodies. Our minds. Our spirits. Our futures.

Prime Minister Golda Meir once said, "Old age is like a plane flying through a storm. Once you're aboard, there's nothing you can do." I'm not about to start an argument with a truly great Jewish sage, and I can almost hear Prime Minister Meir saying to me, as I know she said to others, "Don't be humble, you're not that great."

Still, I will add a coda to the Prime Minister's view of old age.

There's a lot we can do to make sure we reach old age -- and once "on board," to have a comfortable, long and healthy flight. Our goal should be to protect women's health from the first day of life until the last. This is morally right. We are all daughters of Sarah and Miriam -- strong, smart and equal partners in God's plan.

But there are practical reasons too.

At the start of the 20<sup>th</sup> century, the average woman did not live much beyond her childbearing years. As we approach the 21<sup>st</sup> century, the average woman is living well beyond her daughter's childbearing years. So women are being exposed to more chronic diseases and disabilities. Heart disease and lung cancer among women are on the rise. Osteoporosis is crippling thousands of older women -- and as we live longer, the problem is expected to get worse.

Maimonides once said that the goal of good health is to find wisdom. For American women, the goal has been to acquire the wisdom needed to find good health. The Clinton Administration is doing that with courage and pragmatism. And we're getting results. In the United States, our budget for women's health has grown over \$1 billion dollars in four years.

We have a 93 percent breast cancer survival rate when the disease is detected early. Mammograms are free for low-income women -- and women 65 and older.

We now have an office of women's health inside every major health agency.

We have women's health centers in our major universities.

We have a network of advocacy organizations.

We have a generation of scholars -- many of whom have come here for this meeting.

Today I want to tell you where all this progress came from. Let me start with this story from the Talmud. A rabbi saw a widow that he knew lived far away. He asked her: "Is there no synagogue nearer your home?" She answered, "Yes, rabbi, but the more trouble I take, the greater my reward will be."

That is how we made women's health a battle that our national leaders -- from both political parties -- could not ignore. That doctors could not ignore. That health insurance companies could not ignore. That the media could not ignore.

Heroic women, and men too, fought this battle by lifting their voices and digging in their heels. But, I didn't come to Israel just to tell you to work hard and make your voices heard. You already do that.

I've come bearing a package of ten.

Not ten commandments. But ten lessons from our experience putting women's health on the national agenda -- and keeping it there. To come up with these ten lessons, I reached back into the annals of Jewish humor, wisdom, and common sense for help.

*Lesson One: Remember the past.*

The Talmud says, every woman has a mind of her own. But historically, women's health focused on women's reproductive anatomy -- and not much else. You can't have a national policy of keeping women healthy throughout their lives when women -- and their doctors and nurses -- believe that the childbearing years are the only ones that count.

Fortunately, that perception has changed. The change began with a rebellion against women's clothing in the last century. Under the banner of the Popular Reform Movement, the cry heard throughout the land was: "Cast off your corsets!" These crazy contraptions were not only uncomfortable, they were unhealthy.

In the 1960s and 1970s, feminism empowered women to demand more choices – and better information about their health – throughout their lives. A group of women in Boston published a book called, *Our Bodies, Our Selves*. This revolutionary women's health manual – which has been translated into both Hebrew and Arabic – answered many questions about women's health that doctors couldn't answer – or worse, wouldn't answer.

In the 1980s, women's health moved from outside the barricades to inside the halls of medicine. We experienced large increases in the number of women entering medical school, clinical research, bench science and teaching. At the same time, there was a renewed interest in the importance of maternal health.

Fast forward to the 1990s.

With more women in power – not only in health care but also in the courts, Congress, business and government – the definition of woman's health expanded dramatically. And with that expanded definition, came an expanded agenda. New research. New clinical trials. New screening programs for heart disease, cervical cancer and bone loss. This was a remarkable history. The question became, what do we do with it?

Some would have been content to say: Frame it. Hang it on a wall. And turn out the lights – our work is finished. But not this generation of leaders in the United States. We decided that all that was accomplished was nothing more than a great floor on which to build something better.

Which brings me to *Lesson Two: Women must see their whole selves*.

The *Baal Shem Tov* said, "If the vision of a beautiful woman comes suddenly to mind let a man say to himself: Why be attracted to any part. Better to be drawn to the All."

Exactly. But not just men. Women too.

We wanted women to understand that every attribute of their lives is an attribute of their health. So we opened the door of what it means to be a healthy woman wider than it had ever been opened before. How?

First, by carrying out the Women's Health Initiative at the NIH – the largest clinical trial in history. Second, by looking at women's health as a seamless change of seasons across a lifetime – with no season more or less important than any other. Third, by making prevention a centerpiece of our strategy. And fourth, by declaring that violence against women is a public health problem that is both unacceptable – and preventable.

Just last month, our Centers for Disease Control and Prevention found that 18 percent of women report being the victims of rape or attempted rape in their lifetimes. Numbers like these cry out for a better answer than, 'It's is a police problem. Let them deal with it.'

That's why Attorney General Janet Reno and I chair a National Advisory Council on Violence Against Women, and why both my Department and the Justice Department administer the Violence Against Women Act. Justice enforces tough new programs to prosecute offenders, while we fund shelters, community programs, and research to prevent violence.

Even when women see themselves as whole, they still need a way to make their voices heard.

*That's Lesson Three: Build an army from the ground up.*

A great rabbinic sage said, "Do not mistake talk for action."

The point of this lesson is simple: mobilize, mobilize, mobilize. Israel has a long history of incorporating women into the IDF. In fact your general of the Women's Corps is here. But there is no standing army for women's health. We had to build one, and you will too. That means organizing networks of women's health advocates all over the country.

We started small, with community based organizations. These groups met in living rooms, schools, and houses of worship. They recruited new members, marched, petitioned, and carried their message to local politicians. Eventually they formed the National Women's Health Network – a national organization whose voice today is heard in the halls of Congress and state legislatures.

Other armies were built – many to fight for particular issues. HIV/AIDS created a movement for better therapies, protection against discrimination, and health insurance coverage. Our National Action Plan on Breast Cancer – which I'll mention again shortly – came about in part because 2.6 million women – organized by the National Breast Cancer Coalition – signed a petition drive.

Today, new armies are focusing on making sure women have access to care – and that the care they receive is of the highest quality. Building an army is hard enough. Making sure it marches to victory is even more difficult.

Which brings me to *Lesson Four: Pick the right battles and stay focused.*

There's a Yiddish proverb that goes: To learn the whole Talmud is a great accomplishment; to learn one good virtue is even greater. Similarly, there is virtue in not trying to do too much at once. Stay on message – as we like to say in American politics.

In the United States, one message was breast cancer. In 1993, working with the National Breast Cancer Coalition and other organizations, we started the National Action Plan on Breast Cancer. This public-private partnership awards grants for six priority areas – from research to tissue storage to ethics. At the same time we doubled discretionary spending for breast cancer research, prevention and treatment. The result of years of previous effort and this action plan is, breast cancer mortality is down – and the number of women getting mammograms is up by one-third.

The battle over breast cancer was just one part of a larger battle over research. Because women had often been excluded from clinical trials – we didn't know if the data we were getting applied to women. We didn't know if particular diseases strike women and men differently. We were doing science – but we couldn't say with confidence that it was good science for women.

So we picked this battle. We picked it. We fought it. And we won it. Now, there will never again be federally funded research – about diseases that strike women – which do not include women.

The victory for better research came in part because of *Lesson Five: Find a few good friends.*

Ecclesiastes says, "Woe to him that is alone when he falls."

Disease pays no attention to political affiliation. So we made women's health bipartisan – and went looking for good friends wherever we could find them. We looked first to Congress, where a handful of powerful voices – Democrat and Republican, male and female – agreed to lead the charge. Then we looked beyond Washington to state legislative bodies, the media, research institutions, the military and the clergy.

We didn't need to bring everyone on board – just a few people with clout. The newspaper editor who is willing to focus on women's health. The leading scientist who decides how research money will be allocated. The nurse or health care worker who interviews patients. The general who knows that the armed forces cannot function without healthy women. The rabbi, priest or minister who gives sermons about protecting women's lives.

Although women's health is bipartisan, in robust democracies like the United States and Israel – good health for women makes good politics. In our recent Senate race in New York, each candidate happily boasted that *he* had done the most for women's health.

On the other hand, women's health transcends politics. So the message is: Women's health can win votes at the same time it is winning a new chance at life for our sisters, mothers and daughters.

On to *Lesson Six: There's a woman's health angle for almost every issue.*

This lesson boils down to one piece of advice: Make your issue their issue, or as an old Yiddish saying puts it: If you want people to think you're wise, agree with them.

When someone asks me: "Secretary Shalala, aren't issues like Social Security; the economy; and national security more important than women's health?" I always answer: "These issues *are* women's health." By broadening the definition of women's health, you can actually recruit allies who might otherwise think that women's health has nothing to do with them.

There's another side to this coin. If you're working on issues that are not specifically about women's health – look for ways to build in a women's health component. For example, our Administration is committed to closing racial and ethnic health disparities in six major areas by 2010. But this is not just about minorities. It's about saving women's lives. African American women face greater exposure to HIV/AIDS. They have higher cancer rates, and a lower life expectancy than white women.

The fact is, every social or economic problem has a woman's component. How we solve these problems is answered in part by *Lesson Seven: Weave your way around the opposition.* There is a Midrash that says, "Even an angel cannot do two things at the same time."

If an angel can't, what hope is there for the rest of us – especially when opponents who are – let's face it – less than angels stand in the way? So we've learned that when it comes to women's health – go for what's attainable and build new successes on the foundation of old ones. That almost always means anticipating opposition and being ready to – deal it in, cut it off, or wait it out.

Our Administration believes that all women need information about reproductive health – including HIV and sexually transmitted diseases. We also believe that women are entitled to the full range of reproductive rights – including abortions, but that abortions should be safe, legal and rare. Many people believe that this is not the responsibility of government. We disagree, but we know this is a battle that cannot be won overnight. So we're focusing on different, but related, victories – and building partnerships to achieve them. For example, we're partnering with men's organizations – to teach young men to share in the responsibility for preventing unintended pregnancies. The same goes for getting birth control covered by insurance. For some reason insurance companies – which are still run mostly by men – are willing to cover the cost of Viagra, the impotency drug. But they won't cover the cost of birth control devices or pills. In other words, making sure men can have sex is considered a matter of public health. But helping women plan their pregnancies is not. We're weaving our way around this obstacle by requiring all federal employee health plans to cover prescription contraceptives if they cover other prescription drugs.

Tobacco is another area where there is strong opposition to protecting public health – and where women's health is particularly at risk.

So we focused on protecting children – with tough regulations designed to keep kids from ever lighting up. The tobacco companies are still fighting us. But even they say – at least publicly – that they don't want children to smoke. Our fight now is to make their actions fit their words.

On to *Lesson Eight: Think global, adapt local.*

There's a saying: Nine rabbis cannot make a quorum, but ten shoemakers can.

This saying is not about the power of shoemakers. It's about the power of numbers. We draw strength from our sisters around the world.

In 1994 we met in Cairo and reminded the world that the health of families, communities and nations all depend on the health of women. A year later we went to Beijing where Mrs. Clinton told the world that women's rights are human rights. At one point in Beijing, we literally had to push through a line of Chinese guards that tried to keep us out of an auditorium where Mrs. Clinton was speaking. The message to those guards – and the world – was: There will be no turning back. There will be no unlinking of arms. There will be no rest until victory.

We brought that spirit back to our own country and laid it at the feet of advocates for women's health in communities large and small. We said take this spirit. Adapt it to your needs. Adapt it to your cultures. Adapt it to your cause. Then your cause will be your sister's cause too.

That is *Lesson Nine: Support everyday heroines.*

For this lesson, I chose a wonderful observation from the Talmud. It says, "A woman of sixty runs after music like a girl of six."

This could be a statement about music. But I prefer to think of it as a statement about women – the lengths to which we're willing to go to achieve something of value. There's no greater value than saving the lives of women. That means those of us in government and the health professions must listen to the voices of ordinary women.

In the 1970s, women protested on the steps of our Capitol building demanding hearings on the safety of the Pill. Today, we have a National Women's Information Center. Women contact it by phone and over the Internet. The number one topic we're hearing about today is not reproductive health or heart disease. It's not cancer. It's not bone disease. It's *menopause* – which is linked to heart disease, cancer and bone disease. Women want to know what therapies work. And what are their risks. We don't know all the answers. But we're going to get them.

Now you're nine-tenths of the way toward institutionalizing women's health. But remember *Lesson Ten: Timing is everything.*

There's no resisting the words of Ecclesiastes again: "To everything there is a season, and a time to every purpose under heaven."

One of the reasons the United States has been successful in institutionalizing women's health – maybe the biggest reason – is that women seized the moment. In the 1970s, the Pill and *Roe v. Wade*, the case legalizing abortion, gave women their reproductive freedom – and the determination to never lose it. The next decade brought a boom in the health industry – better medications, better diagnostics, and more opportunities for women to enter the health professions.

Today we have cutting edge biomedical research; and a President who put women into positions of leadership in science and health – including his most recent appointment of the first woman to head the Food and Drug Administration. These changes brought opportunities to improve the lives and health of women. We didn't let a single one slip by.

Israel is a nation steeped in history and memory. You understand – perhaps better than anyone – what can be built when heroes say, "The time is now." Heroes like each of you.

Which brings me full circle.

Lesson one was, remember the past. But we must all *Build for the future.*

The Talmud says, "When you teach your son, you teach your son's son."

I don't believe I'm distorting the meaning of this beautiful text when I say, it's also true that when we teach our daughters, we teach our daughter's daughter. So part of building the future is focusing on prevention and healthy habits.

That's why we started our *Girl Power!* campaign – to help girls 9 to 14 make healthy choices about their future. We have many *Girl Power!* partners. Marlene Post of Hadassah is one of them.

That's why I agreed to be photographed with a milk mustache – to encourage young girls to consume enough calcium to protect themselves from bone disease.

That's why I'm willing to go anywhere – and talk to anyone – who has the power to reach our daughters. I've met with soap opera producers and talk show hosts about using their programs to get out good public health messages.

We teamed up with the great singing group Boyz II Men on an anti-smoking PSA aimed at young people, and with the U.S. Women's National Soccer Team to teach young women to "smoke" their opponents – not tobacco. We even have a partnership with the Women's National Basketball Association. So use soaps and talk shows. Use movies. Use magazines. Use MTV. Use the Internet. Make them all your allies in the fight to protect Israeli girls and young women.

Building for the future also means building for the nations we are becoming. Both the United States and Israel have large immigrant populations. Our faces are changing. Our cultures are mixing. And, in the United States, our population is getting older. We have to be ready for these changes with a blueprint for women's health that matches who we are – and who we will become. Both our nations will struggle to find that blueprint.

But perhaps the place to begin is with the words of another Jewish Sage, Ben Hei Hei, who said:

*We are here to do, and through doing to learn;  
And through learning to know;  
And through knowing to experience wonder;  
And through wonder to obtain wisdom;  
And through wisdom to find simplicity;  
And through simplicity to give attention;  
And through attention – to see what needs to be done.*

For women's health, it is time, again, to see – and *do* – what needs to be done.

Thank you

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\*REMARKS BY

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U.S. SECRETARY OF HEALTH AND HUMAN SERVICES

AMERICAN UNIVERSITY OF BEIRUT

BEIRUT, LEBANON

\*THIS TEXT IS THE BASIS OF SECRETARY SHALALA'S ORAL REMARKS. IT SHOULD BE USED WITH THE UNDERSTANDING THAT SOME MATERIAL MAY BE ADDED OR OMITTED DURING PRESENTATION.

It's a great honor to come to the American University of Beirut.

This is an important university for the Middle East and the world. It is not possible to go anywhere in the world without meeting proud AUB alumni. They are leaders in politics, medicine, business, government and education.

On my way here today, I was thinking about one of Lebanon's greatest national treasures – cedar trees.

Cedars are part of your noble Phoenician heritage of shipbuilding and trade. There's a cedar on your flag. And personally, I love the smell of cedar – because it reminds me of my Lebanese roots and my deep love for this magnificent country.

As I was thinking about the cedars of Lebanon, I couldn't help but think about my own country's great forestlands. There is none more beautiful than Yellowstone National Park.

Let me tell you something about Yellowstone.

About ten years ago, a terrible fire broke out in Yellowstone. Fed by high winds and a long period without rain, the forests of Yellowstone burned for weeks. Thousands of volunteers came to Yellowstone to fight the fires. Although these volunteers fought bravely, and at great personal risk, they had only limited success. Eventually the snows came, and the fires were put out. Still, many people feared that this great national park would not survive. But by the next spring, new plant life was already coming up through the ground. Wild and colorful flowers bloomed. Young trees replaced the old ones. And the vitality of Yellowstone proved itself to be eternal.

And so it is with the American University of Beirut – and all of Lebanon.

You suffered through many difficult years of civil war. But the vitality and spirit of Lebanon are as eternal as the forests of Yellowstone. Life springs from the ashes – and the future is born again.

I mentioned my Lebanese heritage. My grandparents left Lebanon at the turn of the century – and headed for America. My grandfather told me they left to avoid being recruited – involuntarily – into the Turkish army, and for the opportunity and promise of America.

They brought their Lebanese culture, cuisine, and spirit with them. I grew up in the large Lebanese-American community in Cleveland, Ohio. I was surrounded by family and friends who re-created for me the Lebanese community my grandparents knew when they were young.

I'm proud of the leadership role my family took in helping to forge a community for Lebanese in Cleveland and throughout the American Midwest.

I'm proud of the values they taught me -- and the opportunities they gave me.

I'm proud also of what my parents sacrificed to help me return to our native soil -- as a proud Lebanese-American, and as the U.S. Secretary of Health and Human Services, the highest-ranking Arab-American in the history of my country.

This is not my first visit to this university. I first came in 1963 -- 35 years ago. I came from Iran -- where I was serving in the U.S. Peace Corps -- to join AUB faculty to teach English as a second language to teachers in a refugee camp in Sidon. I can remember to this day -- the first time I walked across the AUB campus. It was exciting -- but not much like the villages in the "old country" my grandmother Shalala described.

My father loved the work of Lebanese poet, Kahlil Gibran, who once said, "The only way to help yourself is to help others." Those words echoed the words of President Kennedy -- who died the year I came here to teach -- when he said, "Ask not what your country can do for you. Ask what you can do for your country."

My generation of American leaders listened to both the Lebanese poet and the American President. We listened. We learned. And we did our best to follow.

You must too.

The Lebanese people have shown unbelievable strength of character in overcoming the challenge of war. Your faculty here, and in other colleges and schools, never abandoned their sacred duty to educate and enlighten -- no matter what dangers they faced each day. This university is like a special kind of birthday candle that is sold in the United States -- and perhaps here, as well. You think you've blown it out -- but it immediately comes back to life. The fire of education at the American University of Beirut is like that. It also refuses to go out.

The fact is, this is a great private university serving the public interest, and a great beacon lighting this city, this nation, and this region. Lebanon, too, is becoming a beacon lighting this region -- its flame of progress now proudly restored.

As I drove here today, I saw a booming city. A city of new buildings -- with more on the way. A city that is still the jewel of this nation and the Middle East. A city with an energetic people -- led by a dynamic new president. A city of hope and opportunity, where the next century will bring prosperity -- and we all pray, peace. But a 21st century vision for Lebanon will not arrive on its own. It will take hard work; collaboration among all of Lebanon's people; and the leadership of the graduates of the American University of Beirut. It will test the commitment and the character of this generation of young Lebanese -- Muslim, Christian and Druze.

I did not come here with simple answers to the challenges you face. That would be arrogant. But I know universities and their role in economic development – and the preparation of a workforce and leaders for the 21<sup>st</sup> Century.

What can Lebanon – and this university – do to make a successful passage into the next century? How do you assure Lebanon's rightful place as a world leader in commerce, education, art – and of particular interest to me – health and science?

On these questions I have some thoughts.

The place I'd like to begin is with words President Lahoud spoke when he was sworn in last month. He said, "The young want to see more interest in educational, social, health and environmental issues." President Lahoud is absolutely right. But I want to emphasize the importance of making sure that all Lebanese receive the blessing of a 21<sup>st</sup> Century education.

What now distinguishes the United States from almost every place else on earth is our firm commitment to build a nation using the skills of all our people. That means men and women. African-Americans, Latinos and Arab-Americans. Young and old. Rich and poor. Urban and rural. We strive to tap into the talents of everyone.

Call these talents the building blocks of nationhood. I don't mean roads, and bridges, and new office towers. I mean those who will construct a new world. Men and women -- their minds, bodies and spirits. So if I may, allow me to seize this opportunity to give back to the land of my grandparents, and offer three challenges to the AUB community.

Three challenges involving the mind, body and spirit.

First -- the challenge of the mind -- is to *never stop learning*.

After food, shelter and family, learning is a basic human hunger and requirement. It's the water of progress, the key to everything we want for ourselves, our nations and our world. This ancient value made this region the cradle of civilization. But centuries ago, learning was a luxury reserved for the few. Today it's a survival skill for all.

In this Age of Democracy, you need learning to be better, more informed citizens.

In this Age of Change – when half of all scientific knowledge will be obsolete in a decade – you need constant learning to adapt to change, to stay ahead of change, to harness change.

In this Information Age, you need learning to pull knowledge from the raging river of data flowing over the Internet and bouncing off of satellites. Already, 40 percent of the hits in the Middle East come from Lebanon.

In this Computer Age, you need computer learning to join the electronic web of nations, systems and people -- where isolation is impossible, and where we're all citizens of the world.

In this Golden Age of Science, you need learning to seize the opportunity to achieve new breakthroughs, and apply them to better people's lives. That's why I'm pleased today to announce that the National Institutes of Health, will begin offering two visiting fellowship positions to AUB faculty each year. They'll get to work on biomedical and behavioral research with some of the finest scientists in the world -- and we will be proud to have them.

Finally, in this Age of Globalization, you need learning to leap over the old boundaries of culture, tradition, religion and geography to embrace the world and its wealth of diversity. You must see diversity as Lebanon's strength. It's what AUB stands for. And it's certainly what your late President, Malcolm Kerr, stood for.

He was an American who grew up in Beirut. His parents taught at AUB. And he left Lebanon only to become a renowned scholar of this region. On the Western shores of America, he taught many young people about Lebanon, the home of his heart. When he returned to Beirut to become President of AUB, Dr. Kerr embodied the historic bridge between the United States and Lebanon. Even when an assassin's bullet took his life in 1984, as he stepped off an elevator in College Hall, Dr. Kerr's legacy refused to die -- the legacy of looking beyond borders, boundaries and barriers to the common humanity in every human.

In this and in so many ways, AUB gives you learning for life.

Here, you'll learn how to learn. Earn a respect for learning. And develop a yearn to learn, throughout your lives.

From a very early age, I was blessed with a love, respect and yearning for learning. I received these gifts from my remarkable late father, who had to drop out of high school during the Depression to help his sisters and brothers. I received these gifts from a very well educated, and very successful Lebanese-American woman. She was the first Lebanese-American woman from my community to go to college and to law school. In fact, in 1948, she was one of very few women in America attending law school. And as she went to classes, she also raised her family. Today, at age 87, this remarkable woman still practices law in Cleveland. And she's still teaching me lessons about life, almost every day.

That woman is my mother, Edna Haddad. Her parents were born in Saghbine. She's here with me today. By sharing her life experiences, my mother taught me something else about learning. My father too. Something that AUB can teach the world. That learning is crucial to the advancement of women. And the world.

My father was an unusual man for his time, because he believed deeply in the education of women. He urged his friends to send their daughters – as well as their sons – to college. AUB's commitment to educating women dates back 90 years. Today, there are almost as many women studying in this elite institution as men.

Women make every university stronger.

And women graduates of AUB enrich this nation and the world.

Why? Because the progress of humankind depends on the progress of women. And the progress of women depends on their progress in learning. We know that women make 10 to 20 percent more income for every year of education they receive – not just in the United States, but around the world. In the poorest countries of the world, every year of basic education for women translates into a five to 10 percent decline in the mortality of their infant children.

There is no question that better educated women help make healthier and better societies the world over. And, yet, the global gender gap in education persists. Nearly two-thirds of the illiterate people in the world are women. Of the 130 million children who lack access to primary school around the world, two-thirds are girls.

This is not an American woman pointing her finger at the world.

In my own country, women are still not equal in the halls of learning. We don't have enough women in medical schools or engineering programs. Or enough women from minority populations in college at all. Or enough women on faculties of our universities. Educational disparity should concern both women and men. Because in this era of rebirth and rebuilding, no nation can afford to squander the potential of any person. Neither should people squander their own potential.

That leads to my second challenge today -- a challenge of the body: *Respect the gift of health.*

There's an old Arab proverb that says, "Where there's health there's hope, and where there's hope there's everything."

That's true whether we sit in the shadow of the cedars of Lebanon or the pines of Yellowstone. It goes without saying that no nation can hope to rebuild itself, or sustain itself, or improve itself, without a healthy population. Health is the beginning of effective social and economic development. And the beginning of good health is preventing bad health.

In my country, there's an old saying, "an ounce of prevention is worth a pound of cure." That saying has new meaning today, because in the 21st Century, curing disease will only incur greater national costs.

In both our nations -- and indeed the world -- we will have more older people, higher health care costs, and more chronic diseases. And in both our nations, we lack unlimited health care resources. So we must focus more on prevention.

At least in my country, half of all preventable deaths are related to personal behavior. Throughout the world, the primary killer of older people -- cardiovascular disease -- is often related to poor diet, lack of exercise and smoking. Individuals have it in their power to protect their health, save their lives, and advance their national well being. They can simply get more exercise. Eat better. Have regular check-ups. And make sure children are vaccinated against infectious diseases.

Most importantly, stop smoking -- and avoid tobacco altogether. Smoking is the number-one preventable cause of death in my country and in much of the world. As many as 250 million children alive in the world today—children from Sidon to Singapore to San Francisco—will eventually die from tobacco related diseases. That's why I'm working with the new Director-General of the World Health Organization, Dr. Gro Brundtland, on a global campaign to protect people from tobacco.

But it all starts with you.

If you smoke, quit. If you don't smoke, don't start.

All of us who work in medicine, public health or scientific research also have a special role to play in any effort to ensure a healthy population.

This is the perfect forum to discuss healthy populations -- because AUB has long been a leader in medicine and research not only in Lebanon but in the entire Middle East. As I've told medical audiences in the United States many times, we must foster a dialogue between public health and medicine, a dialog that will foster a united front so that people can better understand the health effects of their behavior. And we must all work to help build—or as here in Lebanon, rebuild—a primary care infrastructure.

As we struggle with competing health care costs, scarce resources, and rigid bureaucracies, we must never allow dazzling cutting edge research to blind us to the fact that primary care is the basic building block of a healthy population. When it comes to ensuring the blessing of health for ourselves and our children, we all need to be involved.

That leads me to my third challenge today -- *a challenge of the spirit* -- captured in another Kahlil Gibran's maxim, "It is well to give when asked, but it is better to give unasked, through understanding."

This challenge is about who we are. About building a love for ourselves, for our community and for world peace.

Last year I went to the University of Mississippi – a school that 30 years ago was at the center of racial conflict in the United States. This is part of what I said: “I come as a stranger, but I am one of you. Because before region. Before race. Before age. Before gender. Even before history – there is humanity.”

Today, I want to expand on that idea and say that finding our common humanity and solving our problems together is not a dilemma for any one of us, it is a dilemma for all of us. Peace. Prosperity. Brotherhood and sisterhood. These will come – as Kahlil Gibran said – through understanding. By all of us working to make ourselves more tolerant, more educated, more open-minded, more compassionate.

When these become the qualities that mark our spirits – our spirits will become the tools with which we can build or rebuild great nations.

In 1800, when my country was not even 25 years old, one of our Founding Fathers gave a famous speech about national greatness. He said greatness is not measured in numbers, wealth or extent of territory. Nor in genius and excellence in the arts – or even liberty.

What constitutes national greatness, he declared, is national spirit – a high, generous and noble spirit.

You do not need to be Lebanese to recognize that kind of greatness in Lebanon. My friends, you have a great nation because you have a great resilient spirit. You see it in your rebirth after two decades of strife.

You see it in your kind and welcoming hospitality, known the world over.

You see it here in the promising minds and lives of AUB students.

And you certainly see the great Lebanese spirit in your diversity of cultures, traditions and religions.

So my final challenge today is to carry forward the spirit of Lebanon in whatever you do and wherever you go. Restore it. Renew it. Relive it.

I say that particularly to the students of AUB. Because remember, when you leave here, you will enter a world where you will no longer be judged by your grades, but by your character. By the promises you keep, and the changes you shape. By the love you give and the help you repay. By the examples you set, and the challenges you meet. By your guts and your heart.

These are the standards by which we will judge each graduate and ourselves -- no matter what profession or dream we choose.

At the end of World War II, as President Harry Truman reflected on all of the men and women who struggled, sacrificed, prayed and perished to free the world of tyranny and terror, Truman settled an age-old question: He said, "Individuals make history and not the other way around. Progress occurs when courageous, skillful leaders seize the opportunity to change things for the better."

Lebanon will thrive if it learns from history. Its own.

Thank you.

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\*REMARKS BY

HON. DONNA E. SHALALA

U.S. SECRETARY OF HEALTH AND HUMAN SERVICES

AT

FIRST NATIONAL SYMPOSIUM ON MEDICAL AND PUBLIC  
HEALTH RESPONSES TO BIOTERRORISM

ARLINGTON, VIRGINIA

\*THIS TEXT IS THE BASIS FOR SECRETARY SHALALA'S ORAL  
REMARKS. IT SHOULD BE USED WITH THE UNDERSTANDING  
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PRESENTATION.

It's my pleasure to welcome all of you to this first ever "National Symposium on Medical and Public Health Response to Bioterrorism." Over the past few months, many of you—like much of America—have probably been absorbed in Richard Preston's riveting best seller about bioterrorism—The Cobra Event. This haunting thriller—which Preston dedicates to public health professionals—weaves a chilling, but compelling, tale about a lone terrorist's attack on Manhattan with a genetically engineered virus.

It's true that this story of designer-made microbes on the rampage is a work of fiction. But it's also true that perhaps more than any recent news article or report, Preston's thought-provoking novel has helped shine the national spotlight on the shadowy threat of bioterrorism. And the book raises a logical question: How do we successfully contain and combat this emerging threat? To do so, I believe we must meet four important challenges. Four challenges that we cannot ignore. And four challenges that government cannot meet alone.

Our first challenge is to be aware that an act of bioterrorism could happen. The likelihood of an attack is entirely unknown—and it may never occur. But we've seen terrorism emerge as one of the thorniest problems of the post-cold war era. We've seen that terrorists are always searching for new weapons. And we've already seen sarin nerve gas released in the Tokyo subway. It may not happen immediately, but somewhere, sometime, in the future, terrorists may well threaten to use—or attempt to use—a biological weapon against the United States. But when discussing the possibility of a terrorist attack in the next few years, the President unequivocally stated that: "This is not a cause for panic. It is cause for serious, deliberate, disciplined, long-term concern." In other words, we must not be afraid—but we must be aware. That's why this National Symposium is so important—because it will help replace complacency with a new sense of urgency—And because it will help keep the national spotlight focused on the threat of bioterrorism.

Of course, once we're fully aware that a bioterrorism event could happen, then our second challenge is to do everything we can to be prepared. With the threat of bioterrorism knocking at our door, we can't afford to be caught off guard—because it's only in movies like "Outbreak" that we can save the world from a deadly virus in just 24 hours. That's why my Department is spending 158 million dollars this fiscal year to prepare for bioterrorism. And that's why the President has proposed increasing that investment by an additional 72 million dollars in his Fiscal Year 2000 budget.

This investment will fund our on-going "Anti-Bioterrorism Initiative." Devised to significantly raise our level of preparedness, this year the Initiative is expanding its activities in a number of key areas—these include surveillance; medical response; building a stockpile of pharmaceuticals; and research and development. We're working to improve and strengthen our nation's public health surveillance network—including detection and reporting, electronic communications, and laboratories. And, of course, we're also enhancing our epidemiological capacity—so we can quickly respond to a suspected biological agent.

We're enhancing our medical response capacity by spearheading an administration-wide effort to develop infrastructure at the local and national levels—by establishing medical response teams in major American cities—specifically designed to deal with the consequences of bioterrorism—and by expanding our capacity to provide immunizations, infection control and patient care on a massive scale.

We're creating—and maintaining—an unprecedented national “stockpile” of drugs and vaccines for civilian use in case of a bioterrorist attack.

Finally, we're accelerating our research and development in diagnostics and vaccines—so we can more effectively combat any threat. In addition, we'll be working to decipher and map the genetic material of microbes—so we can quickly identify biological agents, and develop new therapies. All of our efforts in surveillance, medical response, stockpile development, and research and development will help prepare us to meet—and beat—any bioterrorism threat.

Of course, if we want to be truly prepared, then our third challenge is for the public health and medical communities to take the lead in our fight against bioterrorism. With a conventional terrorist attack, it's the military and law enforcement that are the first line of defense. But with bioterrorism, it's the public health and medical communities who stand directly on the front lines. And how well we respond to a threat will depend on how well our public health and medical communities function. Think about it, if a specific bioterrorism threat is issued—perhaps someone claims to have released a deadly pathogen in a public place—then trained public health officials must first verify that an incident has actually occurred, and identify the biological agent. They may need to decontaminate the area; to determine the likelihood of secondary transmission; to identify exposed populations; and to provide preventive measures and treatments.

Of course, if a threat isn't issued—and no warning is given...the attack would be silent. Affected individuals might not develop symptoms for days or even weeks—and the victims would be visiting many doctors throughout a large area. Quarantine would not be a viable option—because only one biological agent—smallpox—is communicable. And even with smallpox, it would be impossible to know whom to quarantine—due to the long time period between infection and the development of symptoms. A strong communications network would be needed to piece together early reports and quickly determine what happened—so public health officials could promptly identify the deadly agent, the route of exposure, and the likely origin. The CDC, of course, would be an important part of this process—because of its particular expertise in infectious disease. And everyone—from the physicians who first see victims to the scientists who identify the infectious agents—must coordinate their efforts.

And that brings me to our fourth, and final, challenge: We must all work together. In the fight against bioterrorism, the Federal government—particularly HHS—has an obvious leadership role to play. Among other things, we need to support state and local planning efforts; to provide training at every level; to develop an infrastructure for delivering mass medical care; and to offer expertise to our communities.

But this is a fight we certainly can't win by ourselves. Across the board, we must forge new, working partnerships among health, public safety and intelligence agencies. We need unprecedented cooperation between the Federal government, state and local health agencies, and the medical community. And we must ensure that plans for managing the medical consequences of terrorist acts are well integrated—and coordinated—with other emergency response systems.

But there's also another aspect to working together. We know that microbes spread across boundaries of culture, language and territory. We know that an act of bioterrorism cannot be contained by any national border or barrier. And we know that when it comes to microbes, we aren't protected, in the word of Indian poet Tagore, "by narrow domestic walls." Since microbes recognize no border—in our battle against them—neither can we. The fight against bioterrorism must be a global fight. That's why I'm so pleased to see representatives from so many different countries here today. Because we share a common future, we must share a common ground. Or as Dr. Gro Bruntland, the Director-General of the World Health Organization has said, when it comes to public health and safety, "solutions, like the problems, have to be global in scope." And as we work together to defeat bioterrorism, we must also do one more thing. We must do what we are doing at this symposium—we must pool our wits and our will. It is precisely our restless intellects and soaring imaginations that are the most potent weapons and greatest resources in the collective fight against bioterrorism. Let's pit our wits and our will to the battle, and let's ensure that we meet our challenges—so that we are aware; that we are prepared; that we take the lead; and that we always work together.

FOR RELEASE UPON DELIVERY  
MARCH 16, 1999

\*REMARKS BY

DONNA E. SHALALA

U.S. SECRETARY OF HEALTH AND HUMAN SERVICES

AT

MANUEL F. COHEN MEMORIAL LECTURE

“NEW PERSPECTIVES ON PRIVACY”

GEORGE WASHINGTON UNIVERSITY LAW SCHOOL

WASHINGTON, D.C

\*THIS TEXT IS THE BASIS OF SECRETARY SHALALA'S ORAL  
REMARKS. IT SHOULD BE USED WITH THE UNDERSTANDING  
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PRESENTATION.

Thank you Professor Chh for your gracious introduction – and for inviting me to deliver this year's Manuel F. Cohen Memorial Lecture.

Manuel Cohen was one of the great legal minds of this century. Not only did he train a generation of lawyers, he helped build the safest, fairest and most profitable securities market in the world. Manuel Cohen cast a bright light on the American legal profession – and I'm honored to be able stand in that light today.

I'm not trained as an attorney; my academic background is political science. However, I did apply to GW Law School my senior year in college. You put me on the waiting list. I'm still waiting. But let me say, hardly a day goes by that I'm not talking to; taking advice from; or sharing a bottle of aspirin with – a lawyer.

For all I've learned about the law – including, lately, how to ID muggers – my core focus remains the health of the American people. When I was first named to the President's cabinet there was a cartoon in *The New Yorker* magazine. The cartoon showed a boy and girl playing. The boy makes the proverbial suggestion that they play doctor. The girl replies, "OK, you be the doctor and I'll be the Secretary of Health and Human Services." Today, that same girl might have answered, "OK, you be the doctor and I'll be the General Counsel of our HMO."

That's really the point. The healing arts – and the legal arts – are now intertwined as never before and certain to become more so. From food safety to managed care to clinical research – law and regulation help keep our rapidly changing health care system from becoming a runaway train.

Yes, we want to continue the spectacular revolutions in how medicine is practiced and delivered. But we don't want our science to get ahead of our ethics. We don't want our health care practice to get ahead of our health care governance. And we don't want caution about the future direction of health care to turn to fear – and fear to turn to paralysis.

There is no shortage of examples how the new world of high tech and managed health care threatens to trump the old world of Norman Rockwell and Marcus Welby health care.

But today I'm just going to focus on one example: Privacy.

As many of you probably know, in a famous dissent, Justice Brandeis wrote that our Founders, "conferred, as against the Government, the right to be let alone – the most comprehensive of rights and the right most valued by civilized men." To which I would add: "and women." Granted, Justice Brandeis was referring specifically to government interference with privacy. But as a broad statement of policy it is one that easily covers both public and private intrusions into our personal lives.

In that sense, Justice Brandeis was a visionary. On the other hand, not even Brandeis could imagine the minefield of privacy threats that now confront us at every turn. Just last week, the *New York Times* reported that Microsoft was going to modify Windows 98 to avoid creating a vast database of personal information that could be stolen or sold. Similarly, Intel agreed to modify its new Pentium III chip because of privacy concerns.

The Internet, microprocessors, cellular communications, eight gigabyte hard drives: This is the world we live in today. It's fast. It's informative. And frankly, it's a potential danger to privacy.

Still, I believe that Stanley Kubrick's vision in *2001 A Space Odyssey* of rebellious computers saying, "Sorry, Dave, I can't do that," was meant as a warning, not a prediction. So I'm not here to tell you that we have to put the genie of modern technology back in the bottle. We don't – and we shouldn't.

Technology will remain our servant, provided we build the necessary safeguards – and preserve the belief of Justice Brandeis – and the heroic Justice Blackmun – in the fundamental right to be let alone. All this means that one of the great challenges of the next century will be to continue our technological progress – while holding on to our privacy, especially the privacy of our medical records.

Since this is Oscar time and all the nominated movies will soon come to a video store near you, let me tell you something you might not know: There is a federal law that protects the privacy of your videotape rentals.

If you like Denzel Washington better than Bruce Willis, or Gwynneth Paltrow better than Sandra Bullock, that information is protected.

But if you have a family history of breast cancer. Or if you've been treated for heart disease. Or if you've been prescribed anti-depressant drugs. There is no federal law telling health care professionals and payers what they can – and cannot – do with that information.

It's true that the landmark Federal Privacy Act does limit what federal agencies can do with health records; but in almost all other cases, control over health care information is left to a patchwork of state laws. That means the potential for abuse is enormous.

Today, we have a burgeoning volume of health care records.

We have a system where information can be passed in real time across hospitals, doctors' offices, state lines – and even international borders.

We have countless Americans reluctantly signing blanket consent forms to have their records released – or refusing to sign them and not getting served.

We have abuse. And we have fear of abuse.

What we don't have are national standards for protecting the privacy of our medical records. That must change.

The time has come to give all of our citizens the right to control and protect their medical histories – no matter where they live, and no matter who pays for their care. So the fundamental question is this: Will our health records be used to heal us or reveal us?

The American people want to know. And as a nation, we must decide.

As I was preparing this speech, I couldn't help but remember that this Administration is not the first to wrestle with the problem of privacy. Twenty-five years ago, one of my predecessors, Elliot Richardson, appointed an advisory board to help the government figure out how to protect the privacy of data in the newly born Computer Age. The report outlined a code of fair information practices – including the need to eliminate secret data bases and give people more control over their personal information.

This report laid the foundation for the Privacy Act, and it established the principle that we must balance our age-old right to be left alone with our desire to fulfill the promise of new technology.

But it is not just government that is working to build practical safeguards for our medical records. Health professionals are speaking out on this issue. Leading academics are also contributing important ideas about protecting privacy. One of them is right here at George Washington University. Professor Amitai Etzioni, just published a book about privacy. In it he notes that reducing health care costs, medical research, public health and quality can all be served, "even if medical privacy is greatly enhanced." Our Administration completely agrees.

That's why the President in his State of the Union address called on Congress to pass legislation this year protecting the privacy of medical records. The President spoke with real urgency – and for good reason. If we don't act now, public distrust could deepen to the point where citizens stop disclosing vital information to their doctors, stop getting needed treatment for mental illness, stop going in for genetic tests, and stop participating in clinical research trials.

Under the Health Insurance Portability and Accountability Act – also known as the Kassebaum-Kennedy law – Congress has until August to pass a comprehensive medical privacy bill. Congress must not let this deadline pass. Protecting medical privacy is a national priority that affects every single American. That means we should act – and we should act through our elected representatives.

Still, if Congress fails to live up to its responsibility, Kassebaum-Kennedy gives our Department the authority to issue regulations. And we will. However, that authority is not comprehensive, so what I said last August bears repeating: "We need to finish the

bigger job and create broader legal protections for the privacy of medical records in all forms."

I want to be clear: We are not passing the buck to Congress.

We want to work with Congress. That's why in September 1997, we made extensive proposals to Congress for protecting the privacy of all medical records. The proposals we gave to Congress will not only maintain privacy, they'll enhance public health without tying the hands of law enforcement or reducing our ability to fight fraud and abuse. Our recommendations to Congress were guided by five key principles. I'm going to describe each one briefly.

*Principle One: Boundaries.*

With very few exceptions, a health care consumer's personal information should be disclosed for health care and health care only. Our goal is to make it easier to use information for health care purposes and tough to use it for any other purpose. For example, we recommend that a hospital be able to use personal health information to teach, train, conduct research, provide care, and ensure quality.

On the other hand, employers who get health care information to pay claims must not use that information for non-health purposes like hiring, firing and promotions. The same goes for third parties that are hired to do billing and other services. They must be bound by the same tough standards in the handling of medical records. Even if they don't collect them, they must protect them.

*Principle Two: Security.*

When Americans give out their personal health care information, they should feel like they're leaving it in safe hands. At every juncture -- from doctor to hospital to insurer -- there is the potential for both greater care and graver privacy violations. If we are going to block this leakage, Congress must pass a law that says: If you receive health information legally, then you must take real steps to keep that information out of the wrong hands.

*Principle Three: Consumer Control.*

No one should have to trade in their right to privacy in order to enjoy their right to quality health care. That's why we recommend that Americans be given the power to ask hardball questions: Who's looking at my records? What's in them? How do I get them? How can I change incorrect information?

Let me give you an example of why this is important. According to the Privacy Rights Clearinghouse, a physician in private practice was having trouble getting health, disability, and life insurance. She ordered a copy of her report from the Medical

Information Bureau – a clearinghouse used by many insurance companies. The report included information about her heart problems and her Alzheimer's disease.

There was only one problem. None of it was true.

With electronic data, mistakes can multiply and end up on the desks of employers and insurance companies. That's why consumers must be able to know – and control – what is in their medical records.

#### *Principle Four: Accountability*

Our recommendation is simple: If you're using medical information improperly, you should be severely punished. We can't just tell hospital workers to stay away from private medical records. We can't just tell private investigators not to lie about their identity in order to see a patient's records. We need to enforce our policy against abuse with tough criminal penalties. That is especially true now that AIDS has created the real – and justified – fear of health care discrimination.

For example, we believe in voluntary AIDS testing. But people will avoid being tested if they don't think their records are secure. The only way to make sure they are secure is to have stiff penalties. As for people living with HIV/AIDS, they don't just worry about their health. They worry that information about their health will lead to assumptions about their sexual orientation – as well as discrimination in jobs and health insurance.

That must never happen. That's why we are fighting to enforce the Americans with Disabilities Act. And that's why we continue to support ending genetic discrimination in health insurance.

But, as we work to protect Americans from breaches of privacy, we must recognize that we have other critical – and sometimes competing – goals.

Which brings me to *Principle Five: Public Responsibility*.

Just like free speech rights, privacy rights can never be absolute. We must balance our protection of privacy with our public responsibility to support other national priorities. For example, public health agencies use health records to warn us about – and protect us from – outbreaks of infectious diseases. Our Inspector General uses health records to zero in on kickbacks, over-payments and other fraudulent schemes. Researchers have used health records to help us fight childhood leukemia and uncover the link between DES and reproductive cancers.

Other researchers are using health records to make sure that the care patients receive live up to the highest standards of quality based on the best available science. In these cases, it's not always possible to ask for permission, and doing so can create major obstacles to fighting crime and protecting public health.

I'm not arguing for a free pass for research or law enforcement. But I am arguing for balance and reasonable safeguards. Take the case of research.

Institutional review boards already limit access to personal information. These boards determine when it is advisable to waive informed consent. But our new recommendations go further. They require all researchers to carefully protect the privacy of the personal information they receive. And we recommend penalties if they don't.

That's important – not only to protect privacy, but for less obvious reasons too. For example, protecting normal trade relations. Under the European Union's Privacy Directive, if we don't protect health records soon, we might lose the right to share valuable research data with Europe.

All five of these principles are important. But to bring them about we need more than legislation.

We need a major commitment to educating Americans about privacy. Without exception, every health care professional, every insurance agent, every researcher, every public health official, every pharmacist, and yes, every lawyer who comes in contact with health care records must understand why it's important to keep them safe, how to keep them safe, and what the consequences will be for not keeping them safe.

Similarly, we need to educate consumers not just about the privacy risks in this new health care world, but also the rewards. We need to help them understand that in addition to privacy rights – they have responsibilities. That means asking questions, demanding answers and becoming active participants in their own health care.

To help ensure that consumers have the privacy protection tools they need, we're again calling on Congress to pass a comprehensive privacy and confidentiality law. Congress failed to get the job done last year. We will work with Congress. But if they do not act, we will move forward with regulations – not only because the law requires us to, but because it is the right thing to do.

Finally, we need an informed public because, as the National Research Council has pointed out, there are many tough privacy questions that still need answers. Those answers cannot be imposed from the top down. They must be worked out from the bottom up. That means we must have nothing less than a national conversation about privacy.

Since I'm talking to an audience that includes many future lawyers, let me start with some of the unanswered questions surrounding law enforcement. I'll use what I call "Socratic method lite." I'll ask questions, but I won't call on anyone for the answers.

Should auditors be allowed to examine your medical records looking for fraud committed by a doctor? Most people would say, yes.

Should law enforcement officers be able to search through emergency room records looking for someone who has just fled the scene of a crime? Again, most people would say yes.

But, suppose law enforcement officers are looking through insurance records for fraud and stumble upon evidence of an unrelated crime – say drug use. What then?

Similarly, what happens if researchers stumble upon information about someone who may have exposed you to HIV? Is their obligation to your safety? Or the other person's privacy?

What happens if drug companies know you suffer from heart disease and send you information about their new treatment? Is that helpful or offensive? Does your answer change if the disease is depression? What about sexually-transmitted diseases?

These are tough – even wrenching – questions. But they are not going away. And they are not going to be solved overnight. We need to be flexible. We need to be open to all views. And we need a national commitment from government, the health care industry, ordinary citizens – and the legal profession – to find the answers.

I mentioned Stanley Kubrick's 1968 classic, *2001: A Space Odyssey*. Sadly, Mr. Kubrick died earlier this month. But when his film first came out over 30 years ago, 2001 really was the future. Not any more. Now it's just two short years away. But what about the next 30 years? Do we face a future of great medical breakthroughs undiminished by misuse of our medical histories? Or do we face a nightmare where seeking health care means giving up our cherished privacy?

The answers depend on all of us working together to make sure that our health care information is held within established boundaries. That our health care information is secure. That those who fail to protect our health care information are held accountable. That each of us retains control over our health care information. And that we figure out how to balance the use of our health care information with other core public responsibilities.

We can do all of this – and when we do, we'll harness today's revolutions in biology, medicine and communications, while breathing new life into Justice Brandeis' profound vision of personal autonomy and privacy. Yes, we can achieve that vision. And if we act today, we will. Thank you.

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\*REMARKS BY

HON. DONNA E. SHALALA

U.S. SECRETARY OF HEALTH AND HUMAN SERVICES

AT

PORTLAND STATE UNIVERSITY COMMENCEMENT

PORTLAND, OREGON

\*THIS TEXT IS THE BASIS FOR SECRETARY SHALALA'S ORAL  
REMARKS. IT SHOULD BE USED WITH THE UNDERSTANDING  
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PRESENTATION.

President Bernstine, Provost Reardon, faculty, guests, and fellow graduates—it's a pleasure for me to be here with the Portland State University Class of 1999, your families and friends. And I hope you don't forget your other supporters—the hard working citizens of Oregon whose taxes make this fine university possible. Each of you has also worked very hard to be here today. As President Clinton noted at last year's commencement—some of you have managed to hold a full-time job, carry a full course load, and raise a family. I applaud your achievements—and your obvious stamina.

Being here with all of you, I'm reminded of my own college graduation. I'll never forget it. In the air you could almost feel the excitement, the anticipation, and—above all—the fear that the commencement speech would never end. But don't worry. I promise to remember Franklin Roosevelt's formula for a successful speech: Be sincere. Be brief. Be scared.

That's good advice—and giving advice is really what graduation speeches are all about. So with that in mind, let me offer you Donna Shalala's top ten pieces of advice for Portland State graduates: Number Ten. Be diplomatic. When your families ask if you've finally finished school—lie. Nine. Be direct. When an interviewer asks, "What is your long term goal?" Say: Early retirement. Eight. Listen to the voices of experience. Robert Frost said, "By working faithfully eight hours a day, you may eventually get to be a boss—and work twelve hours a day." Seven. Be good Americans. Pay your taxes, repay your student loans and—above all else—rewind your videotapes before you return them. Six. Don't procrastinate. Order your tickets now for next year's NBA Championship—because the Trailblazers are going all the way in 2000. Five. Be honest. If anyone asks you how you got through school while working or raising a family, tell them the truth—you have no idea. Four. Be Patient. Wait 24 hours before telling your families that you're taking a vacation—alone. Three. Be optimistic. When you think your stress level has reached an all time-high, remember the old maxim: Things can always get worse. Two. Don't neglect your personal life. Because as Lily Tomlin once said, even if you win the rat race—you're still a rat.

But in all seriousness—and without the David Letterman drum roll—my number one piece of advice is: Always be true to your heritage—to the pioneer spirit. The pioneer "spirit of the west"—of rugged individualism and restless imagination, of self-reliance and selflessness—is very much the spirit of this extraordinary state—and this remarkable city. It's the spirit of service that's celebrated in Portland's "Pioneer Courthouse Square." It's the spirit of courage that's commemorated by the mast from the battleship *Oregon* that stands on Oak Street. It's the spirit that sustained the settlers as they trekked the Oregon Trail—and the spirit that guided Lewis and Clark to the Pacific. Regardless of where you call home—or what work you choose—as graduates of Portland State you are now heirs to this spirit—and it's your responsibility to infuse the spirit into your communities—wherever you land on this earth.

Historian Frederick Jackson Turner was the first person to speak about the importance of the "pioneer spirit," at the Chicago World's Fair in 1893. In his famous speech, Turner asked: "[now that the frontier is closed] what of American energy...continually demanding a wider field of exercise?" Turner was saying that if Americans weren't to become self-absorbed and indifferent, we need great goals—"a wider field of exercise." Americans need great things to do—things that get us beyond our immediate selves. We need great goals to stir our hearts and our imaginations. We need great goals to channel our energy. We need great goals to bond us together as a nation. And we need great goals to demand the pioneer spirit.

For decades—the settling of the frontier provided that great goal. And being here in Portland—shadowed by the majesty of Mount Hood in the lushness of the Willamette Valley—it's easy to see why the frontier would have such a grip on the American consciousness. But the closing of the frontier meant that America no longer had a great goal or a grand cause—and many people—including Turner—were afraid that this meant the pioneer spirit, the spirit of the west, the spirit of courage and service, would be lost.

We find ourselves in a similar situation today—we've conquered the heavens; we've won the world wars and the cold war; and we're now the only global superpower. It would appear that—once again—there are no more great goals, no more grand causes. The flame of our pioneer spirit is once again being extinguished. And the results? One of America's leading sociologists spent the last two years speaking with middle class Americans all across our country. Many told him that the end of the cold war has left America without a sense of purpose—and this lack of purpose is causing many people to become indifferent to anything that doesn't personally touch them.

If that's true, then perhaps Turner was right and we do need a grand cause to rally around. Fortunately, I think we have one. We have a cause that's just as great, just as grand, just as good—as settling the prairies or sending a man to the moon. That cause is for each of us to be a good citizen—and being a good citizen is based on the foundation of service. A recent national poll showed that more than any other group in America, Generation Xers—the very generation represented by so many of you graduates—hunger for a revitalization of community spirit. The only way to rekindle that spirit—some would argue the true pioneer spirit—is with the spark of service. Now I realize that I may be preaching to the choir. After all, the very motto of this university is "Let Knowledge Serve the City." And the theme of service runs through your entire curriculum. I also know that many of you graduates have freely given your time and talent to community service. For example, C.J. Martin founded "Kids Helping Kids", an organization that raises money for the Children's Miracle Network. Linda Humphrey is a dedicated AmeriCorps member. Tony Silva is very involved with Special Olympics and PAL, and has worked on disaster relief projects. And Dan Overbay mentored minority students, while also volunteering with the Humane Society.

I hope all of you continue this kind of investment in your local community and your nation—and continue to make a difference—after you leave Portland State. Now I realize that as you begin—or continue—to struggle with the competing demands of professional and personal life—this won't be easy. When you're already trying to balance career and family responsibilities, it becomes all too easy to overlook your community responsibilities—but we can't overlook them if we want to be good citizens and build a civil society. Engage in public service; join community organizations; stay involved; do pro bono work; make a contribution; and carry the American dream to every corner of our nation—and the world. Don't get caught up in the usual excuses—that it doesn't matter; that you can't be bothered; that you already have a full time job; that you don't have the time. Strive to be a good person—as well as a great professional. Because—ultimately—you won't be judged by your college degrees—but by your character. You won't be judged by what you earn—but by what you contribute. You won't be judged by who you know—but by who you are.

Undeniably, service is the foundation of citizenship and the civil society. But it is also something more. It is the ultimate expression of the true spirit of Oregon, of the west, of the pioneer. As I said at the opening of my remarks, as graduates of Portland State, this spirit is now the proud inheritance of each of you—regardless of where you call home, or what work you choose. And whether you realize it or not—each of you is also a pioneer, a pioneer of a new century. One of you may discover new paths to better health. You may find a new route to understanding the origins of the universe. Or you may blaze new trails in the global struggle for peace and equality.

But before you leave to chart new worlds, to map out a civil society—and to continue your service—I hope you'll take a moment to look at where you are right now. And as you do: May the natural beauty of Oregon—from the soaring Cascades to the brooding headlands of the coast—remind you that you can always find beauty in life—if you look for it. May the pioneer heritage of the “City of Roses” remind you that there is always more to discover, always more to explore, and always more to learn. May the values you've been taught at Portland State University—a pioneering institution—remind you that what's important is not how you make a living—but how you make a life. And may the example set by Ruby Clancy and Tukata Ninneman remind you that you can overcome any obstacle in the pursuit of a dream.

More than anything on this earth, I believe in each of you. So, to all the members of the class of 1999—the final class of this century—god speed on your wondrous, joyful, miraculous journey as great citizens. I wish you good health and great success along the way—and may the force always be with you. Congratulations.

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\*REMARKS BY

DONNA E. SHALALA

U.S. SECRETARY OF HEALTH AND HUMAN SERVICES

BUDGET PRESS CONFERENCE

WASHINGTON, D.C.

\*THIS TEXT IS THE BASIS OF SECRETARY SHALALA'S ORAL  
REMARKS. IT SHOULD BE USED WITH THE UNDERSTANDING THAT  
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PRESENTATION.

This is my eighth budget since becoming Secretary of Health and Human Services, and we have saved the best for last.

When it comes to old black and white movies and the 15-cent stamp, I can be as nostalgic as the next person. But I'm not nostalgic for where we were seven years ago. Record deficits and predictions that the red ink would flow forever. Growing Medicare fraud. Teen pregnancy rates going up. AIDS deaths on the rise – with very few services and fewer treatments. I could go on and on because for millions of Americans the pain went on and on.

Simply put: The gaps in our public health system and social safety net seven years ago were real and unworthy of a great nation. At this moment of what the President calls profound promise and possibility we are within sight of closing these gaps. We have the means. I'm convinced that we have the will. History bears me out.

Each budget we have presented to Congress has been in the spirit of the third of President Franklin Roosevelt's Four Freedoms: The freedom from want.

Our 2001 budget will help make us a nation free from the want of affordable, accessible and high quality health care.

Our 2001 budget will help make us free from the want of lifesaving prescription drugs.

Our 2001 budget will help make us free from the want of trustworthy child care, and the ability to care for our aging parents and grandparents.

Our 2001 budget will help make us free from the want of a research infrastructure strong enough to unlock cures to our worst killers.

Our 2001 budget will help make us free from the want of safe food and protection against infectious diseases.

This year's budget builds on seven years of progress and leaves us where we should be at the dawn of a new century: A nation pledging allegiance to: Expanded health care coverage. Renewed support for children and families. Greater scientific advancement. And the creation of a healthier America.

All – and I want to emphasize this – all in the context of fiscal discipline.

Here are the numbers: Our proposed outlays of 421.4 billion dollars for Fiscal Year 2001 is 9 percent above last year's budget. The discretionary portion of the budget is 48.6 billion dollars– a program level increase of 8 percent over last year. But, as always, our budget is about more than numbers on a ledger. This budget is about people.

The President noted recently that he was pleased that access to health care is part of this year's campaign debate. So am I. But let me be very clear: We don't have a year to think about this. The time to move ahead is now. That's why our budget makes a record investment in health care coverage. In access. And in quality.

Last year our State Children's Health Insurance Program, like a great Clipper Ship, caught the wind in all fifty states. Today, two million children are enrolled. Now we want to make sure this new program – and Medicaid – carry millions more children – and their parents – into the safe harbor of quality health care.

For parents, the President unveiled FamilyCare – an idea first proposed by the Vice President. It says to parents: If your children are eligible for Medicaid or the Children's Health Insurance Program, you should be too. FamilyCare is a partnership with the states. States that cover children up to 200 percent of poverty will have the option to cover parents with an enhanced federal match. That's a 50 billion dollar investment over ten years.

For children, we are proposing new ways to step up our efforts to enroll them in these vital programs. One proposal is to allow school lunch programs to share information with Medicaid workers. This is just plain common sense because any child eligible for a free lunch is likely to be eligible for one of these programs. We're also going to give states the option to extend coverage under the Children's Health Insurance Program up to age 21. In the spirit of federalism, we have one more option for states. Under these programs states will be able to cover children and pregnant women who are legal immigrants – regardless of when they came to our shores.

Together, these new approaches to expanding coverage build on our successes last year: President Clinton's landmark legislation making it possible for millions of Americans with disabilities to join the workforce while retaining their Medicaid and Medicare coverage. And a second new law giving states the option to extend to age 21 Medicaid benefits for young people who "age out" of foster care.

Even as we take these steps, we recognize that many low income adults still work in jobs that don't offer health insurance. These workers frequently rely on what Tennessee Williams called, "the kindness of strangers." Those kind strangers are local health institutions and professionals who provide services at a reduced or at no cost. Last year, Congress approved our proposal to invest 25 million dollars to help these community service networks build a seamless system of care for workers with no other place to turn. This year we want to increase that funding to 125 million dollars.

Most twenty year-olds think fifty year-olds are settled and financially secure. I know I did at that age. But the reality is that workers 55 to 65 are the fastest growing group of uninsured. Let's face it: There is nothing worse than losing your job, losing your insurance and knowing that Medicare is still years away. So for the last two years we have proposed allowing displaced workers 55 to 65, and their spouses, to buy into Medicare.

We also proposed that former workers, 62 to 65, without insurance, be allowed to buy into Medicare. Although Congress has so far refused to see the wisdom of helping displaced older workers buy affordable health insurance, that has not stopped us from continuing to champion this good idea.

Groucho Marx famously quipped: Who are you going to believe, me or your own two eyes? On the subject of Medicare, too many members of Congress have been playing the role of Groucho – while the rest of us see with our own two eyes that the system needs to be strengthened and modernized.

First and foremost, that means dedicating 300 billion dollars of the surplus over 10 years to extend the solvency of the Trust Fund until at least 2025. The question is: What are we going to put in the hands of the next generation? Something they can hold and carry into the future, or an empty promise? We have a moral obligation to protect Medicare. But extending the Trust Fund is only the beginning.

Does anyone seriously believe that if we were building a Medicare system today, we wouldn't include a prescription drug benefit? That's like saying if we built a car today, we wouldn't include seatbelts. Not only would building such a car be illogical – it would be immoral. Even as I speak, three in five seniors do not have dependable drug coverage. The longer we wait, the worse this problem is going to become – and the more expensive it's going to become.

That's why we're again proposing a voluntary – I repeat, *voluntary* – prescription drug benefit. The cost of this new benefit will be 38.1 billion dollars over 5 years. The benefit will have no deductible and will pay half of all beneficiaries' drug costs up to 2,000 dollars in 2003 – and 5,000 dollars when the program is fully in place in 2009. Medicare beneficiaries with incomes below 135 percent of poverty will pay no premiums or cost sharing, and we're going to help employers that offer their retirees prescription drug coverage that is at least as good as the benefit we're proposing. We also want to eliminate all coinsurance and deductibles for preventive tests and screenings – saving lives by stopping disease before it starts.

Part of modernizing Medicare is making sure it operates more like a business. That means using state of the art purchasing and quality management tools to improve care while constraining costs. We propose to save 15.4 billion dollars over ten years with a modernization package that includes using Preferred Provider Organizations, expanding our Centers of Excellence, and paying competitive prices for disease management services.

Also – the days of Medicare as a blank check are over. We've dramatically cut overpayments – and now demand that our costs reflect market realities. We've also proudly become anti-fraud gumshoes. We've taken more than 1.8 billion dollars out of the hands of cheats – and put it back in the hands of taxpayers.

And we're not finished yet. We're proposing another 7.9 billion dollars over five years in cost savings from proposals that fight waste and abuse, and we will work with our contractors to put in place strong management controls – and to assign financial specialists to each contractor.

As for nursing home care, our message to the bad apples is simple: If you're only in business to make a quick buck, we're going to put you out of business. This year's budget adds 71 million dollars to the President's Nursing Home Initiative to fund ongoing activities. This is 29 percent more than last year. These funds will strengthen state and federal oversight, speed up investigations of complaints, and pay for more enforcement tools.

Thirty years ago we were reading the *Greening of America*. Now we're seeing the graying of America. Millions of families want to care for their chronically sick or disabled loved ones in their homes. We should do everything possible to honor that wish.

Imagine this: You have two parents, both in their nineties, one with Alzheimer's and the other in a wheelchair. Too terrifying to think about? Maybe so, but we need to anyway. Between 1996 and 2010, the number of Americans over 85 is expected to double. Many of these older Americans will be living at home with informal caregivers. That's why our budget includes 125 million dollars for family caregiver support, and why we want to let states provide Medicaid services to qualified beneficiaries without seeking a complicated and time-consuming federal waiver. Last year the President proposed a 1000 dollar tax credit to help families who care for – and house – sick or disabled relatives. This year we propose to raise the credit to 3000 dollars.

I don't know if any of you read or saw *The Cider House Rules*. If you did, you know that part of the story takes place in a 1940s orphanage. The movie reminded me that millions of working families rely on the love and support of other adults to keep their children safe.

Government cannot – and should not – step into the shoes of parents and communities. But government does have a supporting role in what for many families is a daily drama: Balancing work and children. This is not our opening act. Federal funding for child care has more than doubled in the last seven years. Still, one recent study notes that in 1998 only 10 percent of the 14.7 million children eligible for federal child care subsidies received them.

Two years ago the President proposed a Child Care Initiative designed to give a "yes" answer to these three questions: Can I get it? Can I afford it? Can I trust it? Yet, when Congress was asked: Will you fund it? The answer was "no." Now millions of parents – many fresh off welfare and trying to move from first job to first career – are searching for affordable, accessible, high quality child care. As part of the President's Child Care Initiative, this year's budget adds another 817 million dollars to the Child Care Development Block Grant. This discretionary money brings the total Block Grant to 2 billion dollars.

The budget also includes 600 million in mandatory dollars for a new Early Learning Fund. We will use this Fund to help vulnerable children in the critical pre-school years build a foundation for reading and learning.

Which brings me to one of the most successful programs ever created for children: Head Start.

Head Start has traditionally enjoyed bipartisan support – and for good reason: Research shows that Head Start helps children learn. Funding for Head Start has gone up each of the last seven years, and in 1995 we began Early Head Start for children ages zero to three. But we're not resting on our laurels. This year we're requesting 6.3 billion dollars for Head Start. That's 1 billion dollars more than last year – and the largest increase in the history of Head Start. The additional funds will allow us to enroll over 70,000 more children in Head Start, for a total enrollment of almost 950,000. That keeps us on track to meet the President's goal of enrolling one million children in Head Start by 2002.

Child support enforcement is another bipartisan success story. The reason is simple: For every 1 dollar we invest, we collect more than 4. Our message to delinquent parents is even simpler: You can run but you cannot hide. We'll track you down through the IRS. We'll track you down through motor vehicle records. We'll track you down through the National Directory of New Hires. One way or another – we will find you. In 1999, child support collections reached an estimated 15.5 billion dollars. However, next year we plan to do even better because of a new set of proposals that are self-financing and get more money to families.

I can't talk about children without talking about drugs.

We know marijuana use has leveled off among teens. We also know that there are teens in every corner of this country that are still saying "yes" to drugs and alcohol. But we're not giving up. That's why our budget includes over 3.3 billion dollars for substance abuse treatment and prevention.

Two more quick items under support for children and families: We're proposing to invest 100 million dollars over two years to help states test innovative asthma management techniques for children enrolled in Medicaid. Our budget also provides 80 million dollars for training at free standing children's hospitals that are also teaching hospitals. These hospitals train over 25 percent of all pediatric residents in the country. The 80 million dollars doubles our investment last year.

*2001 A Space Odyssey* was utopian fiction. But our FY 2001 budget is designed to make great scientific advancements – from biomedical research to disease prevention to quality health care – a national fact. In the last two years, the budget for the National Institutes of Health grew by over 30 percent. This year's NIH budget is 18.8 billion dollars – that's a 1 billion dollar increase over last year.

Why the increase? Because we now know that sustained public investment in basic and clinical research pays undeniable dividends. So this is truly a case of throwing good money after good. From detecting genetic disorders, to AIDS to new prevention strategies – the National Institutes of Health is the master goldsmith in the golden age of biomedical research.

Our budget request for AIDS-related research at NIH is 2.1 billion dollars, a 5.2 percent increase over last year. NIH will also focus on the human genome, neuroscience, clinical research, teaming up with other disciplines – including chemistry and computer science – and reducing health disparities.

Let me note – and I'll return to this subject in a moment – every Institute and Center is working on a strategic plan that will lead to a better understanding of health disparities and how to treat them.

No trip to the grocery store or a restaurant should be hazardous to your health. Yet every year, an estimated 76 million people get sick from the food they eat – and 5,000 will die. We intend to strengthen the President's Food Safety Initiative by adding 40 million to our interagency food safety program. Ten million will go to CDC to expand its award winning PulseNet system for identifying disease-causing bacteria. FDA will use the other 30 million dollars to inspect 100 percent of high-risk food establishments. Those funds will increase the FDA's total food safety inspection program to 109 million dollars. Overall, our budget for the Food and Drug Administration is almost 1.4 billion dollars – 13 percent more than a year ago.

We're going to respond vigorously to the Institute of Medicine's recent report on preventable medical errors. I'll have more to say about this when our review of the issue is complete. In the meantime, we're requesting an additional 16 million dollars for FDA to reduce these errors – and to make sure they're properly reported. Similarly, the Agency for Health Care Research and Quality – "ARC" – the lead agency on quality – will invest 20 million of its 250 million dollar budget on research into medical errors and what can be done to reduce them.

There's been so much talk lately about the health of the American economy, I sometimes want to stand on my soapbox and say: Let's not forget the health of the American people.

As the Deputy Secretary noted, we've made tremendous progress over the last seven years in improving the health of Americans. But we still have a lot of work ahead of us. That's why our FY 2001 budget puts a premium on fostering healthy living and better health services.

That is especially true for HIV/AIDS. I want to be clear: Stopping AIDS the way we stopped smallpox is a top priority for this Department – and our budget reflects that. From HRSA to CDC to NIH – every agency's AIDS-fighting budget is going up in prevention, treatment and research.

I've already mentioned what NIH will spend on AIDS in FY 2001. But our total AIDS budget this year is 9.2 billion dollars – which is 8.4 percent above last year. The best way to fight HIV/AIDS is through prevention. That's why our budget proposes to spend an additional 75 million dollars to help prevent the spread of this disease. As part of our strategy of bottom up – not top down – decision making, the CDC will direct 40 million dollars of the new funds to local communities, including prevention services targeted to minority populations. CDC will also expand funding for fighting AIDS around the world by 26 million dollars.

Prevention is critical, but we have no intention of pushing to the sidelines the 750,000 Americans living with HIV. Our budget for Ryan White – which is administered by the Health Resources and Services Administration – is 1.7 billion dollars, a 125 million dollar increase over last year.

Late last year, the Surgeon General released a new report on mental health. The numbers were a wake up call: One in five Americans will experience a mental disorder during their lifetime. Perhaps worse: Sixty percent of people with a history of mental illness do not seek – and do not get – help. At the same time, our knowledge about mental disorders has increased dramatically – as has the number of available treatments.

We need to narrow this disconnect between what we know and the help that mentally ill people receive. To do that, our budget increases the Mental Health Block Grant by 60 million dollars. That's a 17 percent increase. This is money that goes from the Substance Abuse and Mental Health Services Administration to states to treat people with mental illness.

For any parent with school children, 1999 must have been a year like no other. The statistics tell us that school violence is down. But the pictures from Columbine and other schools tell us something else: We need to reach young people with words – and in ways – they truly understand. And we must be prepared to wage this battle day in and day out. That's why our budget includes 78 million dollars to stop youth violence, including 50 million dollars to increase school safety and for mental health prevention and treatment.

There is another battle that requires constant vigilance: Defending against the threat of infectious diseases and bioterrorism.

Every year I talk about this I mention the latest movie where a virus threatens civilization. But this is no movie. And our determination to protect the American people from terrorism and emerging infectious diseases is no passing fancy. We're going to do what it takes – starting with an almost 50 percent increase in CDC's funding for national disease surveillance. We want make sure that if there's an outbreak of disease – that information leads to immediate public health action. As for bioterrorism – which may be the biggest threat of the 21<sup>st</sup> century – we're proposing to spend 265 million dollars to prepare for, and respond to, a biological attack.

This year we are making a major investment in our public health infrastructure – the bricks and mortar, and in our public health information systems. CDC proposes to spend 127 million – 70 million more than last year – to modernize and expand three laboratory sites. Some of the funds will go for facilities designed to handle the most lethal pathogens – such as Ebola. The remaining funds will go toward completing the Edward R. Roybal infectious disease lab, and construction of a new environmental health lab. We further propose to invest 73 million dollars – over two years – to build a National Neuroscience Research Center at NIH. This will put all NIH brain research under one roof.

We're also investing 20 million dollars in a "Health Informatics Initiative." In plain English, we are going to establish health data standards aimed at making the data more uniform and easier to transmit – while also protecting confidentiality. The goal is to improve patient care and health outcomes through better use of data.

I try to treat the HHS budget the way a grandmother treats her grandchildren: Don't show – in fact, don't even have – favorites. So I won't say that I saved the best for last. But I did save what may be our greatest moral imperative for last: Closing the gaps in health outcomes between minorities and the majority population.

In 1998, the President set a goal of ending health disparities in six major areas: Infant mortality, cancer screening, cardiovascular disease, diabetes, HIV/AIDS and childhood immunizations. Almost every operating division is making a contribution toward closing these gaps. That includes an additional 35 million dollars at CDC for community based research and demonstration projects to reduce disparities.

The Indian Health Service, whose proposed budget is 229 million dollars more than last year – the largest increase in two decades – will similarly focus on health disparities, and unique health problems among our First Americans, the 1.5 million American Indians and Alaska Natives.

This year's budget request presents annual performance information required by the Government Performance and Results Act. I believe strongly that government must be accountable. Setting goals isn't enough. We have to achieve them.

On the other hand, we must never be self-satisfied. We must never say: Set the bar this high and no higher. So the most important question is: How are we performing – not by our own standards – but in the eyes of the American people?

We believe our 2001 budget gives us the tools we need to help the American people live longer and healthier than ever before. That may sound like a great ending. But for this Department – this year – it is only the beginning.

Thank you.

FOR RELEASE UPON DELIVERY  
FRIDAY, APRIL 7, 2000

\*REMARKS BY

HON. DONNA E. SHALALA

U.S. SECRETARY OF HEALTH AND HUMAN SERVICES

AT

COVERING KIDS NATIONAL CONFERENCE  
WASHINGTON, D.C.

\*THIS TEXT IS THE BASIS FOR SECRETARY SHALALA'S ORAL  
REMARKS. IT SHOULD BE USED WITH THE UNDERSTANDING  
THAT SOME MATERIAL MAY BE ADDED OR OMITTED DURING  
PRESENTATION.

It's a pleasure to participate in this "Covering Kids National Conference," because all of you here today truly care about our most valuable—and vulnerable—citizens. You also remind me of another person who cared about our children, and the child in all of us: Charles Schulz. The unassuming creator of the Peanuts gang—who died in February—left behind a 50 year legacy of wit and wisdom that includes one of my favorite anecdotes.

It seems that one beautiful April day, Charlie Brown and his friends were lying on a baseball mound, looking up at the sky, and describing what they saw in the clouds. Lucy said, "I see Madame Curie in her laboratory making a life-saving discovery." Then Linus added, "There's Aristotle contemplating the nature of the universe." And Schroeder remarked, "That's Beethoven penning the ninth symphony." Finally, they all looked at Charlie Brown. He muttered, "Well I was going to say a horsey and a doggie, but I've changed my mind."

One of the things that distinguishes Peanuts from all other cartoons about children is the complete absence of caring adults. But in the real world, children certainly can't take care of themselves. In the real world, children get sick and have accidents. And in the real world, children need adults to provide the healthy foundation for their dreams.

Providing a healthy foundation—that's exactly what insuring eligible children is all about. That's why the entire Clinton-Gore Administration has been working hard to find and enroll children in Medicaid, and in our newer program—the "State Children's Health Insurance Program"—or SCHIP. It's why we created a 500 million dollar Medicaid fund for states to conduct aggressive outreach. And it's why we partnered with the National Governors' Association, to launch a nationwide "Insure Kids Now" outreach campaign that includes a web site and a toll free number. To date, that number—1-877-KIDS-NOW—has received nearly 250,000 calls...250,000 requests for information...for help...for answers. We also formed a federal "Task Force on Children's Health Insurance Outreach" that's implemented over 150 innovative and successful activities.

But at HHS, we certainly didn't stop there. Last year, my Department teamed up with other federal agencies—and many of the organizations here today—to launch a major "back-to-school" campaign that enlisted over 1,500 schools to conduct local outreach activities. We created a paid radio campaign to reach parents and other caring adults. We've been training grantees; meeting with State Medicaid Directors; encouraging Head Start programs to become active in outreach; even enlisting the help of grandparents. And I'm happy to announce that the Health Resources and Services Administration is offering new grants to help states develop plans for providing even more families with access to affordable health insurance. Fifteen million dollars will be available to fund one-year studies in up to 10 states.

Thanks, in part, to all these efforts, nearly two million children—more than the combined population of Montana, Vermont and North Dakota—were enrolled in SCHIP as of last September. That's nearly double the estimate for December 1998, and it includes both children enrolled in new, state-designed, programs and in Medicaid expansion plans. Additionally, the number of states covering children up to 200 percent of poverty with SCHIP has increased seven-fold—from only four in 1997 to thirty today.

These are significant accomplishments... Accomplishments we can all be proud of... And accomplishments that never could have happened without the commitment, compassion—and leadership—of all of you who are in the trenches and on the frontlines in the campaign to insure eligible children. As part of the "Covering Kids" initiative, you've written enrollment success stories in every corner of our nation—from enlisting Naomi Judd as the spokesperson for KCHIP in Kentucky... to generating over 100 news stories that aired on 41 T.V. stations. Of course, none of your efforts would have been possible without the continued support of the Robert Wood Johnson Foundation. Today, I'm pleased to announce that the Foundation will be providing up to 26 million dollars more—26 million above their original 47 million dollar commitment—to "Covering Kids." I've no doubt that these funds will help intensify efforts to aid uninsured children... and complement the work of the Clinton-Gore Administration.

But despite all of our efforts—to paraphrase Robert Frost—we still have miles to go if we want to reach the millions of uninsured children... If we want to give every child a healthy foundation for her dreams... And if we want every child's story to have a happy ending—an ending like the one I first heard about at a children's health event sponsored by the First Lady.

At the event, a father told the story of his young son—who had suffered repeated ear infections that left him hearing impaired. The father couldn't afford health insurance. He couldn't get the medical care his son required. And he didn't know that the boy was eligible for Medicaid. But thanks to the President's outreach efforts, the family learned the boy was eligible. At first, they were reluctant to apply... and they needed help with the enrollment process. But soon, the boy was enrolled and he received the surgery he needed. A short time afterward, the toddler was exploring his familiar yard, when he was struck by something decidedly unfamiliar—and he began to cry with fear. That little boy had never heard the wind before... he had never heard the wind. And as he comforted his son, I know the father would have agreed with Tennyson that "sweet is every sound." Because in that small cry, I'm sure the father also heard something very different—the sound of the opening of doors... doors to a world of beauty, opportunity and possibility that had previously been closed to his son.

I tell that story here—not because we're all unfamiliar with such cases—but because I believe it reflects five challenges... five challenges that government cannot meet alone... and five challenges that are also barriers to enrolling every eligible child.

Our first challenge is the challenge of awareness. Many states have already found innovative ways to spread the word about Medicaid and SCHIP. Utah placed a full-time outreach worker in its Primary Children's Hospital to target and enroll eligible children who visit the emergency room and clinics. Georgia hired people to distribute Medicaid flyers in pizza boxes, and on the weekend before public schools opened, outreach workers stationed in K-Mart stores completed applications for families to enroll in PeachCare.

It's up to all of us to support, enhance and further these efforts. After all, too many parents—like the father of that young boy—still don't realize that their children are eligible for SCHIP or Medicaid. Too many parents still don't know that Medicaid eligibility isn't linked to welfare—now known as TANF...and that their children can qualify for Medicaid, as well as SCHIP, even if the family earns too much to qualify for cash assistance. And too many parents still don't understand that working doesn't disqualify their children from Medicaid or SCHIP. Right now, the families of 4 million uninsured children probably don't know they're eligible for Medicaid coverage.

We must do more to educate low-income families—and their employers—about Medicaid availability for children outside the welfare system. And we must find new ways of reaching SCHIP and Medicaid eligible children. For example, we know that the uninsured rate for Hispanics was 35 percent in 1998—more than twice the national average. My department is continuing to look at ways to address this issue—but a first step would be to make sure that—where appropriate—our outreach efforts are culturally sensitive and language appropriate. After all, no one should be unable to complete the route to enrollment—simply because they can't read the signs along the way.

Above all—if we really want to reach these children—we must go where their families live, work, learn, pray and play. That's why, six months ago, the President instructed HHS, and the Departments of Agriculture and Education, to prepare a comprehensive report on school based outreach. That report will be released later this year—and it will tell us what we can do to make school-based outreach an integral part of regular school business.

Of course, if we really want to maximize our outreach efforts, then we must simultaneously address our second challenge: the challenge of perception. For too many people, a stigma surrounds Medicaid—and even SCHIP. This stigma may partially stem from Medicaid's historic ties to welfare—and the negative public image sometimes associated with cash assistance. Also, not everyone understands that public health is really like public education—it's every child's right and a benefit for our entire society. Nebraska has the right idea. It organized focus groups that found that a colorful, positive, upbeat image for the state's Medicaid expansion plan—known as Kids Connection—would reduce any stigma associated with the program.

No family—like the one in my story—should be reluctant to enroll...and open the door to a better life for their children. We all need to spread the message that these programs are not hand-outs—but a helping hand. And they're an important work support for parents who are struggling to be both good workers and good caretakers for their children.

Our third challenge is the challenge of simplification. We know that many families—again, like the one in my story—find the enrollment process difficult. And we know that in some states enrolling in SCHIP is much easier than enrolling in Medicaid. Fortunately, many other states have already started efforts to make the application and enrollment process for both programs as user-friendly as possible. Ohio has just reduced verification requirements for both Medicaid and SCHIP. And Nebraska developed a one-page Kids Connection/Medicaid application that's available in Spanish, Russian, Arabic and Vietnamese.

These are important accomplishments—but we need to do even more. Today, we're taking further steps to explain and clarify the enrollment process for Medicaid families moving on and off cash assistance—because we all know that the delinkage of cash assistance and Medicaid eligibility has meant both new opportunities and new challenges for states. We're asking all states to review their computer systems and eligibility processes—in order to ensure that all families that are eligible to keep their Medicaid benefits really do keep them. We're asking states to review their own records—and to be sure that no one who was entitled to keep Medicaid after leaving cash assistance lost out. And we're asking them to reinstate anyone who was improperly terminated from Medicaid.

Of course, we're partners in this with the states, so we'll match all costs for reinstatement. And we'll offer to match any state dollars used to reimburse families for medical bills that would have been paid by Medicaid during the time these families were terminated from the program. We'll also continue to work with all the states to simplify application and enrollment procedures—and in the summer, we'll be holding a "best practices" conference to share our success stories. Additionally, the President's Fiscal Year 2001 budget would require states to make their Medicaid and SCHIP enrollment equally simple. And it would also allow states to determine presumptive eligibility for Medicaid, as well as SCHIP, at more sites—such as child care centers, homeless shelters, and schools.

But as we simplify the process, we also need to improve coordination. That's our fourth challenge. A recent study by the Urban Institute found that approximately 60 percent—almost 4 million—of America's uninsured children are enrolled in school lunch programs. But federal law prohibits these programs from sharing enrollment information with Medicaid.

The President's Fiscal Year 2001 Budget would allow school lunch programs to share application information with Medicaid—and to use enrollment in school lunch programs as the basis for presumptive eligibility for both Medicaid and SCHIP. Sharing information should become common practice because it makes common sense. After all, health insurance promotes access to health care—which promotes academic success. That means—just like the school lunch program—health insurance prepares children to learn.

Our fifth, and final challenge, is the challenge of expansion. As you may be aware, the President has proposed creating a new "FamilyCare" program. Under this initiative, parents of SCHIP and Medicaid eligible children would be covered by the same health plan as their children. Additionally, states would have the option of covering young people ages 19 and 20—the age group with the highest uninsured rate in the country—through SCHIP and Medicaid.

Now I do realize that the mission of "Covering Kids" is to find and enroll children that are currently eligible. But we know that family enrollment promotes both the enrollment—and the use of medical services—by children. And after all, isn't that really our ultimate goal?

Our children will be the architects of society in this new millennium. The future is very much in their hands. But right now, their future is very much in our hands. That's why we must work together to meet all of our five challenges...To endow each child with a healthy foundation...To enable every child to open the door to a world of opportunity, beauty and possibility...And to convince everyone that providing our children with health insurance isn't only good for them...it's good for us. After all, healthy children—today—means a healthier...more productive...more prosperous nation, tomorrow. So just like Charlie Brown—who never gave up trying to kick that football—let's never give up fighting for our children.

FOR RELEASE UPON DELIVERY  
MONDAY MAY 15, 2000

\*REMARKS BY

HON. DONNA E. SHALALA

U.S. SECRETARY OF HEALTH AND HUMAN SERVICES

AT

WORLD HEALTH ORGANIZATION ANNUAL MEETING

GENEVA, SWITZERLAND

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REMARKS. IT SHOULD BE USED WITH THE UNDERSTANDING  
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PRESENTATION.

Madam President, Madam Director-General, distinguished delegates: It is an honor to once again address the World Health Assembly. As we witness the dawn of the 21<sup>st</sup> century, I'm reminded of the words of U.S. President Teddy Roosevelt nearly 100 years ago: "A new century is a time for both celebration and reflection."

We certainly have much to celebrate: Led by WHO, over the past decades we've consigned smallpox to the history books...we've eradicated polio from most of the world...and we've put health firmly on the global agenda—and now, thanks to its dedicated staff and its able Director-General, Dr. Gro Harlem Brundtland, WHO has become the pre-eminent global force for health. I also find myself reflective—because today marks my eighth, and final, speech to this body as the Secretary of Health and Human Services of the United States. I will leave with President Clinton at the end of his term in January, 2001.

Last year, I said that we can only guarantee a future of health for all if we address the challenges of infectious disease; non-communicable disease; and emerging public health threats. Reflecting on that, I want to discuss with you the five commitments we—the international health community—must make to meet those challenges in this new century.

First, we must vigorously fight infectious disease. That's especially important as we near our goal of eradicating polio. Finishing the job won't be easy. We can't become complacent. Donor nations must do more to overcome the financial, political, security and other barriers to polio eradication. Let me be clear: No nation is free of polio—until every nation is free of polio.

As we continue to battle infectious disease, we must always pursue new, more effective, weapons. That's the second commitment. That's why President Clinton has proposed a one billion dollar tax credit for pharmaceutical and biotechnology companies to accelerate vaccine development. This powerful incentive will help move vaccines out of the halls of science and into the hands of those who need them...including those with TB, malaria and AIDS.

Confronting the global epidemic of AIDS must be our third commitment. Up to one quarter of southern Africa's population may die of AIDS—and the potential for explosive epidemics in Asia and Eastern Europe is just as threatening. Besides the toll in human lives and human suffering, these numbers endanger fragile democracies...fragile economies...fragile health systems—and international political stability. That's why the President of the United States considers AIDS a threat to our regional and global security...why we're supporting a significant increase in funding to combat the AIDS epidemic around the world...and why we must reaffirm our support of UNAIDS. We must all recognize that AIDS is a threat to every Member State—and act accordingly.

Our fourth commitment is clear: We must protect our children from a very different epidemic: tobacco. As we approach the tenth anniversary of the World Summit for Children—which challenged all of us to reduce child and infant mortality—let's pit our wits and our wills to this task. By the middle of this century, tobacco is predicted to be the leading global cause of non-communicable death and disability—responsible for one in eight deaths. We have a tremendous opportunity to prevent many of these deaths by supporting WHO's Tobacco Free Initiative. I also believe that the proposed Framework Convention on Tobacco Control can be the strongest multinational effort—ever—against tobacco. The debate on the Convention must be open, transparent and inclusive—and we urge that the framework itself be sufficiently broad to permit universal signing by member states. The only way to defeat the tobacco epidemic is through global cooperation.

That brings me to our fifth, and final, commitment: We must continue to work together for positive change. WHO must lead the way. But this isn't a job for WHO alone. Madam President: World health problems require world health solutions. It's up to all of us to expand worldwide access to immunizations, safe blood and health services—including mental health services—for all...To support partnerships like WHO's "Roll Back Malaria;" "STOP TB;" and the new "Global Alliance for Vaccines and Immunization"...To ensure that women and girls share equally in health and education services...To vigorously pursue prevention strategies for all our citizens—women, men and children...To develop the evidence base for health systems so that we know how to deal effectively with the major causes of death and disability...And to escalate our global fight against infectious disease, non-communicable disease and emerging public health threats.

Madam President: If we truly want to reach the goal of ensuring health for all, we must continue to form global partnerships... strengthen global systems... harness global communications... and—above all—chart a common course in our common cause.

FOR RELEASE UPON DELIVERY  
WEDNESDAY, JULY 12, 2000

\*REMARKS BY

HON. DONNA E. SHALALA

U.S. SECRETARY OF HEALTH AND HUMAN SERVICES

AT

35<sup>TH</sup> ANNIVERSARY OF THE MEDICARE PROGRAM  
HUBERT HUMPHREY BUILDING  
WASHINGTON, D.C.

\*THIS TEXT IS THE BASIS FOR SECRETARY SHALALA'S ORAL  
REMARKS. IT SHOULD BE USED WITH THE UNDERSTANDING  
THAT SOME MATERIAL MAY BE ADDED OR OMITTED DURING  
PRESENTATION.

Standing here in the Hubert H. Humphrey Building, I'm reminded of the well-known words that Vice-President Humphrey himself spoke—in this very hall—when this building was dedicated in 1977. In the presence of his sister Fran Humphrey Howard—who's every bit the voice for good...the voice for change...and the voice for the voiceless that Hubert was—he noted: "the moral test of a government is how that government treats those who are in the dawn of life—the children; the twilight of life—the elderly; and the shadows of life—the sick, the needy, and the handicapped." Throughout his distinguished career as mayor, senator, and vice-president, Humphrey always strove to pass that moral test—especially when it came to our country's elderly and disabled.

In 1949, he introduced into Congress the very first national health care bill specifically targeted to senior citizens—called "Post Hospital Care for the Aged." Unfortunately, the landmark bill received little support, and Humphrey would have to wait many long years to see his dream become reality...and his vision become law. He would have to wait until America was immersed in the promise and potential of President Lyndon Johnson's "Great Society." He would have to wait for victory in a slow—and often difficult—political battle. He would have to wait until July 30, 1965. On that date, President Johnson traveled to the Truman Library in Independence, Missouri to sign the Medicare Bill into law...to change forever what it means to be elderly and disabled in America...and to prove that our nation can be good as well as great.

Although Humphrey's dream of medical care for the elderly and disabled culminated on that humid July day, the story of Medicare—its journey from idea to institution—is deeply rooted in the politics and policies of the twentieth century. So it's only fitting that on this, Medicare's 35th Anniversary, we briefly pause to reflect on the journey that we celebrate today.

During the darkest days of the Great Depression, President Franklin Roosevelt understood that too many Americans were not only ill-housed and ill-fed—but just plain ill. That's why, during the 1930's, FDR supported the principle of national health insurance. But it was Roosevelt's successor—Harry Truman—who truly raised the banner of national health insurance by becoming the first President to publicly endorse—and passionately fight for—such a program. To paraphrase what President Johnson said during the signing ceremony, Harry Truman did more than give his opponents hell—he gave the American people hope. Unfortunately, the time wasn't right, and Truman would later recall that his biggest disappointment as President was his failure on national health insurance. But if he had lost the battle—the war was far from over.

Social Security expert Wilbur Cohen—a future Secretary of Health, Education and Welfare—and other Truman Administration officials, began to focus on the needs of the elderly. Back in 1934—when Cohen was only out of the University of Wisconsin a few months—he had helped draft the original Social Security Act. Cohen speculated that many seniors—who had the least resources but the most health care needs—were facing a gradual decline into a twilight existence of illness and isolation. Under his leadership, the Truman Administration came up with a new and fairly radical idea: Guaranteed hospital care for everyone on Social Security. Cohen called it “America’s form of national health insurance.” A bill—which certainly would have passed Hubert Humphrey’s moral test—was drafted and filed in Congress in 1952. The road to Medicare was now paved.

Over the next twelve years—with Wilbur Cohen serving as its faithful guardian—the Medicare bill evolved and changed. Both President Kennedy and President Johnson dedicated themselves to its passing—and to ensuring that not a single elderly person suffered the indignity and infirmity of an untreated illness. Finally, with the support of compassionate and courageous individuals in Congress—including another future HHS Secretary, then Senator Richard Schweiker—the spark that Harry Truman and Hubert Humphrey first ignited became a beacon of hope for every senior citizen.

It must have been a bittersweet victory for the “Man from Independence” when President Johnson signed the Medicare bill in Truman’s presence—and handed him and Mrs. Truman Medicare Cards Number One and Two. Musing about the long road that brought them to that day, Johnson would remark during the signing ceremony that, “We marvel not simply at the passage of this bill...what we marvel at is that it took so many years to pass it.”

The difficulty of Medicare’s journey can only be matched by the difference Medicare has made in the lives of the elderly and disabled. The phenomenal difference it made reminds me of a story about the famous writer, Somerset Maugham. Maugham was asked to address a group on his 80<sup>th</sup> birthday. When the author was introduced, he began by saying, “Old age has many benefits.” And he suddenly stopped. Maugham looked around. He fidgeted. He sipped some water. At last, he said slowly and dryly, “Old age has many benefits...*I’m just trying to think of some.*”

Maugham was trying to be funny. But when he made that remark a half century ago—as many of our centenarians can attest—there was a sad ring of truth in his words. At the time, growing old meant poverty. Growing old meant disability. And growing old meant going without health insurance. In 1964, only 50 percent of America’s seniors had insurance for hospital care. Too many had to choose between saving their health—or spending all they had saved. Too many had to watch the spark of hope fade as they sank into the darkness of poverty. And too many had to bear the pain of an untreated illness—and a seemingly uncaring nation. They were members of our “Greatest Generation”—the one that restored the American dream and destroyed the Nazi nightmare—yet our country seemed to quietly forget about their sacrifices and service.

At the time, the lives of millions of older America seemed scripted for an unhappy, undignified ending, but, then—with a stroke of President Johnson's pen—the script was totally re-written. As Senator Russell Long of Louisiana commented during the Congressional Medicare debate on July 6, 1965: "...the pending [Medicare] bill will be the largest and most significant piece of social legislation ever to pass the Congress in the history of our country. It will do more immediate good, for more people, who need the attention of their government, than any bill that Congress has ever enacted." He couldn't have been more right.

Since 1965—largely thanks to Medicare—access to health care for seniors has increased by one-third...the poverty rate has dropped significantly...and older Americans are enjoying not just more years in their lives—but more life in their years.

Additionally—since 1972—the promise of Medicare has also included Americans with disabilities, and those with end-stage renal disease. By improving access to health care, financial security, and overall quality of life for the disabled, Medicare helped ensure that no American was left out...left behind...or left on the sidelines...it cast the light of national concern on those who—for too long—had lived in the shadows of our national consciousness...and it made the American dream more accessible for those with disabilities. The number of the disabled enrolled in Medicare has grown from two million in 1972—to more than five million today. And over the life of the program, more than 93 million Americans—including almost 10 million with disabilities—have been able to access the humanity and healing of modern medicine...and bring our nation a little closer to passing Humphrey's moral test.

But anniversaries are not only a time for celebration—they're also a time for reflection. So today we need to examine not only Medicare's past—but its future. The great *New York Times* reporter, Max Frankel, happened to be present at the signing ceremony in 1965. Shortly after Johnson put down his pen, Frankel approached the President and said, "My mother thanks you." "No," Johnson replied, "It is you *who* should be thanking me."

Johnson was referring to the fact that—thanks to Medicare—young families and young people would no longer have to bankrupt their own savings—and dreams—providing for the medical needs of older family members. But I think Johnson meant something more. He understood that Medicare is a living program—one whose promise will be just as important for each succeeding generation of Americans.

But if we are to keep that promise for future generations—for our children and grandchildren—then we must continue to strengthen and modernize Medicare. My extraordinary predecessor, John Gardner—HEW Secretary during the height of Johnson's Great Society—certainly understood this when he noted, "Medicare was a great turning point...but it has to be continually revised."

A program designed for the 20<sup>th</sup> century must be reinvented for the 21<sup>st</sup> century. That's exactly what we've been trying to do for the past seven-and-a-half-years. Because of President Clinton's economic and health care policies, we extended the life of the Medicare Trust Fund for 26 years—until 2025. We launched the biggest crackdown on fraud, waste and abuse in Medicare's history—and restored over two billion dollars to the Trust Fund. In October, the Work Incentives law the President signed lets people with disabilities work and keep their Medicare for eight-and-a-half-years—This is a good first step—but we've proposed to extend their benefits for life. We've strengthened Medicare's management...we've modernized our payment system—and—perhaps most important—we've added new preventive benefits.

We all know that disease prevention and early detection can substantially reduce life-threatening illness. That's why the President worked with Congress to add several new preventive benefits to Medicare, including mammograms; bone density measurements; flu and pneumonia shots; colorectal cancer screenings and glucose monitoring for diabetics. These new benefits are helping prevent and detect diseases at early stages—when they're most treatable...and they're helping to reinvent Medicare for the 21<sup>st</sup> century.

To complement these benefits, today I'm pleased to announce our new "Smoking Cessation Project." This program will test specific strategies to help older Americans in selected states quit smoking—and the information we gather could lead to a smoking cessation benefit in the Medicare program. Additionally, I'm also happy to kick-off the second year of "Screen for Life"—our national colorectal cancer action campaign. Colorectal cancer is the second leading cause of cancer deaths among Americans. The ultimate message of our campaign is that it doesn't have to be. Colorectal cancer screening saves lives—and Medicare can help pay for the test.

Of course, if we truly want to ensure the promise of Medicare for future generations—if we truly want to modernize the program—then we must still add the one benefit that has become an essential element of high-quality medicine: prescription drugs. When Medicare was created, no one could have imagined the role that prescription drugs would eventually play in modern medicine. I don't have to tell you that medications are as important today as hospital care was in 1965. We need an affordable, accessible, comprehensive prescription drug benefit—and we need a drug benefit now. I can think of no better—no more fitting way—to honor Medicare's 35<sup>th</sup> anniversary...and to fulfill Hubert Humphrey's moral test.

The addition of a prescription drug benefit will undoubtedly enhance the promise of Medicare. It's a promise that we—as a nation—cannot break. Harry Truman himself certainly understood the importance of Medicare to our country when he commented, "this signing of the Medicare bill...puts this nation where it needs to be—to be right."

Truman, and the heroes of '65 knew that Medicare—along with Social Security—would be the twin pillars supporting the true equality of all Americans. Truman and the heroes of '65 knew that Medicare proved not how good we are—but how good we can be. Truman and the heroes of '65 knew that Medicare—by promising the best health care in the world for older and disabled Americans—advanced the very promise of America itself. And, above all, Truman and the heroes of '65 knew that Medicare confirmed the greatness of America. It confirmed that we, as a nation, would never turn our heads away from those who were sick or suffering... That we would never refuse to extend a helping hand to the helpless... And that we would heed the words of Hubert Humphrey and never harden our hearts to those who are living in the dawn, in the twilight, or in the shadows of life.

To Hubert Humphrey, Harry Truman, Lyndon Johnson and all the heroes of Medicare, my mother thanks you—and I thank you.

FOR RELEASE UPON DELIVERY  
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\*REMARKS BY

HON. DONNA E. SHALALA

U.S. SECRETARY OF HEALTH AND HUMAN SERVICES

AT

ALF M. LANDON LECTURE  
KANSAS STATE UNIVERSITY  
MANHATTAN, KANSAS

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Being here today, I'm reminded that, at the turn of the last century, historian Carl Becker wrote that the Kansas spirit is the American spirit—double distilled. The spirit Becker spoke of is the spirit of rugged individualism and restless imagination...of self-reliance and selflessness...of good will and good faith...of heart and humor. It was the spirit that guided the Pony Express Riders across the plains...and that sustained George Washington Carver when he homesteaded here in Ness County. It's also the spirit inherent in the state motto of Kansas that tells us, "To the stars through difficulties."

I can think of no one who better personifies this true American spirit than the person we honor in this lecture series, Alf Landon. The unassuming Landon demonstrated that spirit when he modestly described himself as "an oilman who never made a million...a lawyer who never had a case...and a politician who carried only Maine and Vermont."

Landon also demonstrated that spirit—in the words of another former Kansas governor, John Carlin—"by not being a partisan." For example, while Landon undertook the daunting challenge of running against Franklin Roosevelt in 1936—he also supported many of FDR's views on the role of government. Running under the campaign slogan of "Life, Liberty and *Landon*," he succeeded in getting his party to go along with many of the New Deal's social welfare programs, to recognize the rights of labor unions, and to support civil rights.

And when the 1936 race was over, Landon—who actually coined the phrase "New Frontier"—also demonstrated the true spirit of America by his equanimity—and good humor. In a frequently played snippet of a radio interview, he dryly observed that the most remarkable aspect of his 1936 defeat was "the completeness of it all." And he liked to add that "As Maine goes—so goes Vermont." He even gave his grandchildren two ponies—and named them "Maine" and "Vermont" for the only states he had won in the Presidential contest. As Landon once explained to an interviewer, "With me, politics was not a vocation—but an avocation."

Alf Landon not only set an example—he also set a benchmark for politicians who want to be both great and good. I can't help but wonder what Alf Landon would have made of our last two weeks of political excitement and uncertainty. One thing I know for sure is that the pragmatic, good humored and fiercely independent Landon would have agreed with another pursuer of the impossible—the Man from La Mancha. The main message of *Don Quixote* is that the most important thing is what we do after we decide. That is certainly true for America in the 21<sup>st</sup> century.

Because I believe that no matter whom we elect as our Presidents throughout this new century—regardless of their politics or parties—they must be guided by a vision that recognizes that the common good is the highest good. It's a vision that Alf Landon who, in the words of President Reagan, "was motivated by a genuine desire to help his fellow man," would have supported. And when it comes to health care, it's a vision that requires that we meet five challenges.

First, we must focus on the problem of the uninsured. Today, over 42 million Americans—including 10.5 million rural residents and 11 million children—still have no health insurance. When this administration took office, our original goal was to insure all Americans at one time. This turned out to be politically unfeasible—not because Americans don't believe that everyone should have health insurance. They do. There is just simply no consensus on how to do it. Experience taught us that the best way to achieve universal coverage is to get political agreement—step by step—on, first, the problem and, second, the solution.

Thanks to the leadership of Senator Kassebaum—and her colleague Senator Kennedy—we began by making health care portable. Now, changing jobs or having a pre-existing condition doesn't mean losing health insurance coverage.

In 1997, the President and Congress worked together to fashion the States' Children's Health Insurance Program, or S-CHIP. The program was designed for families who earn too much for Medicaid...too little to afford private insurance...but just enough to fall through the cracks. Working in partnership with the states, almost 3 million children—more than the entire population of the cornflower state—now have good health insurance.

More recently, Congress and the President made it possible for millions of Americans with disabilities to join the workforce—and access the American dream—without fear of losing their Medicaid or Medicare coverage. Similarly, children who age out of foster care can now keep their Medicaid coverage until they're 21.

Yes, we've made very important progress over the last eight years, helping the uninsured get health care. And I'm happy to say that, for the first time in a decade, the number of Americans without health insurance has declined! In 1999, 1.7 million more Americans had insurance than in the previous year. Still, as a nation—when it comes to health care for all—we still have miles to go to ensure that no one is left behind...left out...or left on the sidelines...and to ensure that the poet was right when he said, "America is a willingness of the heart."

Of course, as we work to help the uninsured access health care—we must also work to eliminate racial, ethnic—and geographic—health disparities. That's our second challenge. Comedian Chris Rock once said, "Why should I pay taxes. I won't get the money until I'm 65. Meanwhile, the average black man in America dies at 54." Behind the joke lies a tragedy. Consider this: If you're an African-American woman, you're over 20 times more likely to be diagnosed with AIDS than a white woman. If you're an American Indian, your rate of diabetes is 3 times the national average. If you're a Chinese American, you are 4 to 5 times more likely to have liver cancer.

While in rural America, more than 20 million citizens have inadequate access to health services...ten percent of all rural hospitals closed in the 1980's...and while only 25 percent of our nation's children live in rural areas—they account for 85 percent of all oral or dental disease. We may have the finest health care system in the world—but too many of our citizens enjoy less years in their lives...and less health in their lives.

When it comes to improving health, America can never move ahead—if anyone is left behind. We've worked hard to lift the shadow of health disparities that falls across minority communities—as well as to close the gaps between urban and rural areas. My department's "Office of Rural Health Policy" is specifically working to improve access to primary care and preventive services in rural America through a range of programs. For example, over the past decade, the Office has provided incentives for medical professionals to work in rural areas...it has supported relevant research on rural health services...and it has awarded over 170 million in grant funding for demonstration projects that served more than 300 rural communities—and improved health care access for at least 2 million needy rural citizens. Additionally, my department's "National Advisory Council on Rural Health"—which is chaired by Senator Kassebaum—recently issued a set of guidelines to help ensure that rural concerns are included in any debate on reforming the Medicare program.

These are significant accomplishments. But we all know that there's still much that needs to be done. And while we're working to close the gaps, we also need to ensure the highest quality health care for all Americans. That's our third challenge. Americans know that our health care system has no equal. They know that we have some of the finest doctors, medical schools and science in the world. But they know that it's not the best for everyone—everywhere—everyday. Patients want to see a specialist whenever needed. They want to know all medical options. They want to go to an emergency room when necessary. They want their medical records kept confidential. That's why we must continue to press for a strong, enforceable Patient's Bill of Rights—a Bill of Rights that will ensure access, choice, privacy and recourse against shoddy care for everyone. It's what health care needs—and what patients want.

Patients also want their medical privacy protected. That's why I will soon issue the very first federal privacy regulations for all health care records. The guiding principle is that health care information can only be used for health care purposes.

But ensuring health care quality is much more than a patient's bill of rights or privacy regulations or any single measure. At its crux, quality is doing the right thing, for the right person, at the right time, and in the right way.

Four years ago, the Health Care Quality Commission—created by the President and co-chaired by myself and the Secretary of Labor—identified three overall problems. Above all, there are simply too many errors being committed. The Institute of Medicine's Report on medical errors—*To Err is Human*—indicates that between 50,000 and 100,000 hospital patients in the United States annually die from medical errors. It's the eighth leading cause of death in this country. Additionally, there's a great deal of over and under utilization of health care services. For example, about 80,000 women get unnecessary hysterectomies every year...while an estimated 180,000 Americans die because they don't receive beta blockers after their first heart attack. Finally—as I discussed earlier—there's a tremendous variation in national, regional and local health care services offered in this country.

If we want to ensure an America where the common good is the highest good, then we must ensure the highest quality health care. Similarly, we must also ensure that no American is denied access to the miracles of modern medicine. That brings us to our fourth challenge: Reforming our Medicare program for the elderly and disabled.

The difference that Medicare has made in the lives of the elderly and disabled reminds me of a story about the famous author, Somerset Maugham. Maugham was asked to address a group on his 80<sup>th</sup> birthday. When the author was introduced he began by saying, "Old age has many benefits." And he suddenly stopped. Maugham looked around. He fidgeted. He sipped some water. At last, he said slowly and dryly, "Old age has many benefits...I'm just trying to think of some."

Maugham was trying to be funny. But when he made that remark some 50 years ago, there was a sad ring of truth in his words. Old age meant poverty. Old age meant disability. And old age meant going without health insurance. In 1964, only 50 percent of seniors had insurance for hospital care. By improving access to health care, financial security and overall quality of life, Medicare—which Alf Landon supported—changed all of that.

But a program designed for the 20<sup>th</sup> century needs to be modernized for the 21<sup>st</sup> century. We need to improve its delivery—and we need to update its benefits. No one would create a Medicare program today without including the one benefit that has become an essential element of high-quality medicine: prescription drugs. Medications are as important today as hospital care was in 1965 when Medicare was inaugurated. They can prevent, treat and cure illness. And their prudent use can help older Americans not only avoid doctor visits—but even lengthy hospital and nursing home stays. But 13 million seniors—including 50 percent of all rural beneficiaries—have no prescription drug benefit.

We need a 21<sup>st</sup> century drug plan that is voluntary, accessible and affordable. It must provide meaningful protection and bargaining power for seniors, offer competitive prices and be easy to administer through the private sector. And it must maintain, strengthen and further Medicare's historic promise of providing the best health care available for America's seniors.

Our fifth—and final—challenge is to keep our science strong—but our ethics stronger. From the human genome to vaccine research to food safety, this century's blockbuster discoveries will come from American scientific genius—but only if it continues to receive support and assistance from policymakers, Congress and future administrations.

We've seen it recently in the case of genetically modified foods. As we know, scientists have been improving plants by changing their genetic make-up for over a century. But today—as our outstanding FDA Commissioner, Dr. Jane Henney, said when she delivered the "Enloe Lecture" here in March—a scientist can actually insert one or more genes into a plant and produce a new plant with entirely new, advantageous characteristics. For example, about a quarter of the corn planted in the United States last year carried a gene that produces a protein which is toxic to caterpillars—so reducing the need for chemicals. Besides reducing pesticide use, we know that genetic modifications may enhance the nutritional value of foods, and in the event that something unexpected does occur, the testing that developers generally conduct should identify a problem long before the product goes to market.

But let me be perfectly clear: Our testing and evaluation so far has shown that—in terms of food safety—the genetically engineered foods currently on the market are not significantly different from traditionally bred foods. That's why we've continued to work closely with great research institutions like Kansas State—and with farmers—to help reap the benefits and minimize any risk that may arise from genetically modified foods. No group of Americans have a bigger stake in this debate than the farmers of the Midwest. We know that we can count on our farmers—who have led the way in reducing pesticides and in expanding production to feed the world—to keep our food supply bountiful and safe. We also know that we can count on the students, faculty and researchers of Kansas State's outstanding College of Agriculture to help us find our way in this brave new world of biotechnology. And we know that we can count on Kansas State to continue to fulfill the mandate—and rich tradition—of a land grant college by increasing and promoting knowledge of the agricultural sciences.

But—let me add one word of caution—as much as I love and support science, I recognize that our revolutions in research and technology and health care can raise serious ethical questions. Woody Allen once joked, "I was thrown out of college for cheating on a metaphysics exam...I looked into the soul of the boy next to me."

Metaphysics is fine, but what we really need is some soul searching about science and medicine. For example, we must not have a 21<sup>st</sup> century where food science ignores food safety...where scientific breakthroughs widen the gap between the haves and the have-nots...where our genetic map is used to deny health insurance or jobs...or where our science gets ahead of our ethics and eclipses our fundamental sense of humanity, fairness and values.

Alf Landon once remarked that, "It's a sin to throw a soft punch in politics." Similarly, I think he would have also agreed that it would be a sin to tackle these five health care challenges with half-measures or half-hearted support. All lie at the very crux of a vision that celebrates the common good as the highest good. It's a vision that will confirm the greatness of America. It's a vision that will prove not how good we are—but how good we can be. It's a vision for the 21<sup>st</sup> Century that moves beyond politics and parties. And—I think—it's a vision that Alf Landon—the "Grand Old Man" of the Grand Old Party— would certainly support.