

PHILADELPHIA INQUIRER
EDITORIAL BOARD

THE WHITE HOUSE

Office of the Press Secretary

For Internal Use Only

February 4, 1994

AN INTERVIEW OF THE FIRST LADY,
ACCOMPANIED BY SENATOR HARRIS WOFFORD AND
DR. C. EVERETT KOOP
CONDUCTED BY EDITORIAL BOARD OF THE
PHILADELPHIA INQUIRER

Q -- how you plan to reposition or regain the momentum or perhaps reposition the plan to (inaudible.)

MRS. CLINTON: Well, I don't think in general, but as a foot soldier I'll tell you how it falls. I don't know if I'm on a high enough hill or not to be aware of everybody is positioned.

I think we're just going through a natural kind of five and take, but I would not read too much into it. There's a lot of jockeying going on, which is understandable and will continue for a while because we're trying to move the action into the congressional (inaudible). And there's a natural concern on the part of all these interest groups about how to get their strongest negotiating position going into that congressional (inaudible).

So you look at something like the BRT thing you referred to, I mean, if you talk to every one of those guys and say to them, "Do you really support a health plan that removes your tax deductibility and forces your workers into the lowest cost plan?" they'd say, "Of course not, but we want to be in a negotiating position, and we think we'll have more leverage, both on the administration and the Congress, if we do this."

That's their choice, but that doesn't particularly concern me. That's kind of their decision about how they're going to position themselves.

From my perspective, I think that, based on everything I see out there, all the polls and focus groups and everything I'm looking at, there has been a steady support in the mid to high 50s for the plan, without any real description, and there's overwhelming support for the key

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features of the plan. Any time you ask people whether they feature getting rid of lifetime limits or whether they approve of the feature of having a shared responsibility between employers and employees, the range of support is from 60 on up.

So this battle is just beginning and the one thing I guess I've learned, watching legislative processes, is not to overreact, and wait until the situation gels a little and continue to marshall support for the basic parts of what we're trying to achieve. And that's what we're doing.

So I'm not at all concerned about where we are. We're about where I thought we would be at this point.

Q One of the things that I hear a lot from either my doctors or people, doctors I like, like my husband, is there's a real concern on the part of those practicing medicine and, to some degree, their patients, that a new kind of health care system (inaudible) is going to really affect the time that they can spend with their patients, that health care providers are feeling very forced to see more and more people. How do you respond to those kinds of concerns?

MRS. CLINTON: Well, that's exactly what's happening right now. I mean, the status quo is forcing more and more physicians into managed care systems. More employers are choosing such systems and eliminating choices for their employees. And if we do nothing, the outcome will be more and more closed panel HMOs, fewer choices for either the patient or the physician, and less time, with no increase in reimbursement for the clinical time you spend with somebody in your office, but a continuing downward pressure on the price paid for the procedure, for the test, that is the way we pay physicians, on a piecework basis.

So I say to physicians, if you're really unhappy with what you see happening in medicine right now, if you're tired of patients calling you up and saying, "Doctor, I'm sorry, but my employer just changed policies and I can't come to you anymore," then you have a lot to gain from changing the status quo, where the choices of your patients would be theirs, not their employers', where we will increase the reimbursement for primary care physicians because we know that they're underreimbursed compared to specialists, and where you will have incentives in managed care to provide preventive care as part of the basic benefits package, which

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will increase doctor-patient contact, not decrease it.

So I would just ask them where they heard that it was going to do all these things. They probably heard it from the advertisements by the insurance companies, which don't want any change.

Q So you think the administration will have to make "Mr. Smith Goes to Washington" call to energize and counteract the lobbying groups that are trying to serve their best interests? I haven't seen an appeal from you or the White House -- I guess that's you, too -- for the man in the street to come out and demand that their interests be served rather than the (inaudible).

MRS. CLINTON: Yes, I think that will happen but see, until -- here's the position we're in now, which is why I answered the first question the way I did. We don't have a bill yet because when we sent that up, we knew that it was going to be changed in the committee process.

We've got 5 different committees that are the major committees, and I guess probably about 10 more that are minor committees on these issues, in both houses, that are in the process now of marking up a bill. And there are going to be variations in how they put together the pieces, which is why we've created kind of a bottom-line mentality, which is what's overwhelmingly supported by the American public. They want guaranteed private insurance without the kind of limitations and costs that are associated with insurance now, and a comprehensive benefits package.

But Ways and Means may have a different approach than Ed and Labor, which will have a different approach than the Senate Finance Committee, and so forth. It's very hard to enlist people in the abstract.

This is the way we see what's happening. The sort of leadership of both houses, including the committee chairs, want us to continue doing what I'm doing -- coming to Philadelphia, talking about what we think the plan is about, positioning us in a way that is supportive of the best health care system in the world against the stupidest financing system in the world, which is what I said earlier, and to continue to build public support for changing the status quo in a certain direction.

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Once there is a bill, once we know what we can actually expect to get out of these committees, there will be tremendous public support. But right now, even the groups that represent large segments of the public are still jockeying. You know, the seniors group want to know the best deal they can get on prescription drugs. They think we've got the best deal but they're still shopping. That's all part of this legislative effort that's going on.

But I think that you can count on intense public pressure being generated once we can say, "Write your member and tell him to support Bill XYZ." We can't do that right now, and if we were trying to gin up that kind of support around the President's plan, when we know there will be changes in it, and we welcome those changes because we want there to be strong congressional ownership of it, we'd have to go through it all over again.

So the timing is --

Q So you're ultimately planning to do that?

MRS. CLINTON: Yes, absolutely.

Q (Inaudible) Don's question, the situation now is that the people who have the most to gain by health care reform are the sick and the poor -- no money, no organization. Those who have the most to lose by that are well organized and well funded. Now, that's got to be shifted. It's going to take something to enlighten the public to get hold of their congressmen and senators and talk about this.

But I think the kinds of things that happened today, with the First Lady presenting the issues and showing what the stakes are is (inaudible).

Q What is your response to the Specter chart that threatens, suggests that your preliminary proposals would create this monster bureaucracy that would be impenetrable and create all kinds of a presumably patronage hires and take it away from the private enterprise? What do you say to that?

MRS. CLINTON: Well, we've got a couple of alternative charts, if we want to get into a duel of charts. I have one big chart which says "Republican Health Plan" with

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a total blank on it that I like a lot. And I have another chart which tries to show the existing system, which is mind-boggling.

And then I have an accurate chart, which starts with real people and how they would navigate the new system, which is much simpler than the existing system.

I thought it was a very clever ploy. I mean, that's what they all are experts in, at clever ploys and diversionary tactics so they don't have to meet the real issues. The real message of that night was there's no health care crisis, which is patently absurd and is not a tenable political position. But if they want to have a duel over charts, we can come up with charts, too.

That's been, from my perspective, one of their more effective arguments, is to scare people that the government will take over the system and that the government will tell you who you can go to and they'll take away your choice. And we know we've got to counter that, and that has been something that we are working on.

Q What are your counterpoints today? One can adequately argue that you haven't nailed in the balloon very strongly today, that in one of the two major government-run programs, Medicaid, this proposal ends government-run medicine and it puts Medicaid constituents in private sector insurance, which is a huge step away from government-run medicine.

MRS. CLINTON: You know, I think that I went back and I looked at all the campaigns that were run against health care reform efforts, starting with Roosevelt, including Truman, against Medicare and against Medicaid, until it kind of fell of its own weight against Nixon's proposal. And it's always the same argument -- the specter of socialism, the specter of the government, it's the specter of people getting in there and taking over the system.

And this is not a government system. We're keeping private insurance. Some would argue we shouldn't, that it would be certainly more efficient in many ways to eliminate them. But we're keeping private insurance and we are building on the system that works, the employer system.

You know, any time your opposition has a lot of

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money, and there was one estimate that the opposition against Truman, which was primarily organized medicine and the commercial insurers, spent \$60 million, and that was real money back in '47 and '48.

Any time they do that, you've got to counter it. But I think we'll have more than enough ammunition to counter it. Lots of groups are organizing, raising money to run counter-ads and it's just going to take a while.

But most Americans -- you know, the press engages so fast and they watch the deals and they watch the nuance and they try to figure out who's on first -- most Americans are still digesting the State of the Union. I mean, this other stuff hasn't made any impression on them. And the support for health care reform has remained steady.

So most Americans are just kind of waiting for Congress and the President to get it done, and when it's appropriate, they're going to be called on to stand up and express their support.

Q When do you think it will get done?

MRS. CLINTON: When do I think health care will get done? Well, I think we're going to try to have a bill by the August recess. That's the goal.

Q (Inaudible.)

MRS. CLINTON: Yes.

Q (Inaudible.)

MRS. CLINTON: Well, by the August recess, that we could have a bill by the August recess. That's what our hope is.

Q Moynihan said he expected the Senate to have a bill on the floor by the middle of the year, which is June.

MRS. CLINTON: That's what we're aiming for. It's a very ambitious schedule. I mean, part of what we're struggling with is there's never been a piece of legislation like that. I mean, as hard as the budget battle was and as hard as NAFTA was, there's only one committee in each house responsible, and we only had to deal and get it out of those

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one committees.

Now we've got a much more complicated situation, and it is unprecedented. The last huge piece of legislation they tried was the energy bill in the '70s and they created a supercommittee for it. They wouldn't do that this time because everybody wanted their piece of it because they see it as their legacy, you know. So every committee wants to have their mark on it.

So I'm not in any way underestimating the process difficulties of this, but I think we win either way. We either get a bill by the August recess, which guarantees private insurance and deals with the problems that people have in their heads about health care, or we have a midterm election about health care. I mean, either way is good for the country, in my view, and the latter is good for Democrats because if they filibuster, if they won't come with the votes to get this done in the right way, there's nothing like a campaign to focus public attention, much more so than any other way of doing it.

So I think it's a win-win situation.

Q One of the opponents, if I can remember who, of health care reform when it was initiated, said a factor that you don't hear in current debate is the cost (inaudible) cost and the impact on the deficit that's leaning over us. I was wondering, is it too early to refocus on that? I haven't heard much conversation about that, and what impact would it have on reducing the deficit? I understand we don't which version is going to come out, but what is your hope for that?

MRS. CLINTON: Well, we're doing a lot better with the deficit than we predicted. The latest figures from the OMB are considerably higher even than we thought they would be. So we've made a lot of progress, thanks to the budget and economic package last summer.

But there's no doubt that even though -- I wish I had all these charts; they're all in color because we did them on our Macintosh and they're beautiful -- but even with the charts, which show discretionary spending going down for the first time and where the deficit would have been and now where it will be, all that stuff, we run into a brick wall in about '98-'99 because of health care costs.

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If you do not control health care costs, you do not control the continuing reduction in the deficit. And the President has said that ever since last year.

What you've got is an interesting set of choices for the Congress. Our bill does reduce the deficit. There's no doubt about that. Even an independent study by Lewen (phonetic) and Associates, which is a health care analysis firm, concluded it does reduce the deficit, even though we're putting more money into the system.

The other plans that are out there either do not reduce the deficit or try to reduce the deficit by decreasing expenditures of Medicare and Medicaid without making comparable changes in the private sector.

So they reduce the deficit on paper in the short run; they increase it in the long run because if you just reduce Medicare and Medicaid, then what you're doing is throwing more uninsured into the system, which increases the costs to the private sector, because of the cost-shifting, which leads more employers to drop more employees, which puts them into the pool where they're government-assisted. I mean, all of this is part of the same unified system.

So the President's plan would reduce the deficit and it would reduce it considerably by 2002, but more important than that, because people can argue, "Well, would it reduce it \$50 billion? Would it reduce it \$35 billion?" There is no argument that the comprehensive approach we proposed would avoid having the deficit balloon back up. Cooper's bill, the deficit goes up. The Republicans, the deficit goes up.

So there isn't any other bill out there that can say it will control federal expenditures. And one of the great challenges for the Congress, as they deal with this, is to be honest about these other approaches. That's why I view this kind of boomlet around some of these other approaches as a negotiating position. I mean, these are being supported by people whose positions are mutually contradictory, and will be shown to be so as we move forward in the debate.

Q I guess a question I have parrots something that folks like (inaudible) all say, which is that -- and we can argue the merits of your (inaudible) bottom line is that you're not really talking about the critical savings that

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need to be made and probably not being as straightforward as you need to be with the American public, in terms of the kind of trade-offs we'll have to make. You're basically saying that we can have more research, we can have all of the new technologies, all of the new medical procedures, and the costs that go along with it, and not have to return something over here.

I wonder if you can respond to that, as a general broadside against the plan.

MRS. CLINTON: You're right. We're not standing on street corners saying that decision X is going to be impossible to make in 10 years compared to decision Y, because the way we've tried to structure this is to push a lot of those decisions down to the local and regional and state level. And I've had this conversation with some of those people.

From our perspective, it is very difficult to engage the American public in a discussion about rationing the services, for example, in the absence of universal coverage. I mean, Oregon is always talked about as this great courageous state that went forward on rationing. Yeah, they did it for the Medicaid population. They weren't trying to ration for the non-Medicaid population.

So people could come together and very seriously in their communities say, "Well, what should those people on Medicaid get or not get?" They were saying, "What should I get or not get?"

Until there is universal coverage, so that everybody has a sense of security, you are not going to get that kind of discussion going in this country. But the way we've tried to set this up is get universal coverage and you provide services at the local level, within some kind of budget discipline, which forces people to make hard decisions. Do they need an MRI or don't they need an MRI? Well, they should decide, not somebody sitting in Washington.

So I see this all as an evolution in order to get to the point where those conversations can be had because right now when Dr. Koop and I go to medical groups, and I always say or he says later, I always say, "You know, right now we ration. The uninsured are three times more likely to die from the same ailment as the insured."

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And invariably, whenever I say that, I'm attacked by doctors who tell me it's not true, that's not the way the system works, and I must be mistaken. Or they say, "Well, that's true until they get to the hospital, but then survival is the same."

DR. KOOP: It's worse in the hospital.

MRS. CLINTON: And it's worse in the hospital. So we can't have that conversation now about the facts that are existing. So I think we need to get to universal coverage before we expect to have any sensible conversation.

Q How about the other aspect of what Gill was saying, about the fact that it would have a chilling effect on bringing around new drugs, a cure for AIDS, all that, on the biotech industry?

MRS. CLINTON: Were you implying that, because I didn't get that.

Q I don't think I was. If indeed we had a tough budget cap, it would force us make decisions (inaudible).

MRS. CLINTON: Well, there is so much money in the system right now that is misspent, poorly spent, that I don't think anyone who has really studied it, and I know Reinhardt (phonetic) (inaudible) would argue that we're going to undermine research or pharmaceutical development in this country if we try to have some kind of budgetary discipline.

I said earlier today at the Civic Center that all last year I was just hammered, day in and day out, by the biotech groups. I mean, they had everybody in the world calling me, saying, "You know, you're going to destroy biotechnology. Venture capitalists won't invest in us anymore. Wall Street's turning their back on us. We're going to have to go offshore for our money." You know, it was just, "The sky is falling," with all these people rushing around.

End of '93, I went and got the statistics. Investments in biotech firms were up 23 percent. Venture capitalists were pouring money into biotech firms.

So from my perspective, that fear, which in some cases I think is legitimate and in other cases masks other

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interests, is rebutted by the following.

Number one, we are pumping more money into the health care system. We are going from 14.5 percent of GDP to 17.5 percent of GDP by the year 2002. And we are going to be spending the money on more direct medical services, like research and prescription drugs and the like, and far less of it on paperwork, bureaucracy, insurance companies and the like. So the net increase and reallocation is huge for medical care.

Secondly, we are going to be putting at least \$15 billion a year into prescription drugs, which will go right into the pockets of the drug companies.

Thirdly, drug companies have a very hard justifying, except by scare tactics, the prices they charge. And they keep saying the same thing: "If you try to do anything to us, we'll go out of business and it'll be terrible for Americans."

Well, Americans fund most drug research, directly or indirectly. We fund it through the NIH. We fund it through academic health centers. We fund it in all different kinds of ways. And some may be independent and totally free-standing, but that is the minority.

And yet Americans pay anywhere from 2 to 15 times for the same drugs that are sold overseas, to people who've made no contribution to the research or the development because the prices are controlled.

We are not proposing price controls, although I have these arguments with the heads of all these drug companies all the time. We are proposing that we get information about their costs, which we then can make available to the marketplace. They will not open their books. They will not tell you what things have cost them. They're all of "The sky is falling" school, so that no matter what you ask them, they say, "If you make us do that, we'll just have to leave."

So what we're trying to do is to strike a balance. We're putting more money into these guys, huge amounts of money, but we'd like not to control their prices, but we'd like some better information so consumers and providers can make better decisions because if we get that prescription

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drug benefit in, Medicare will become the largest drug purchaser in the world. And we think we ought to get things like discounts and we ought to get some other breaks that we should get for that kind of trade-off.

SENATOR WOFFORD: The R&D cushion that the pharmaceutical houses (inaudible). I talked to a group of 11 pharmaceutical houses that are very altruistically (inaudible) concerned about health care in the Third World. Those 11 companies have \$30 million (inaudible).

So a lot can happen to (inaudible.)

Q You've made some strong points on the (inaudible) budget issue coming up on the plane.

DR. KOOP: I'll tell you the facts of the matter, because there are some personalities. John Kitzhoffer, (phonetic), who is president of the senate, put this thing through in the beginning (inaudible). So am I and we have people up there who were very much interested in (inaudible).

And he invited us out and we looked at it and we found that if Oregon had reallocated its present resources, they could have given everything to the Medicaid people without taking from the poor to give to the poor. And I tried to make this point today at the forum.

The medical profession and the states have to reallocate resources because the federal government can't force them to do that. But the federal government eventually will force them to stop doing things that would back to having necessary permits for planning and so forth, which you don't have to have if people will take charge of their own responsibilities.

MRS. CLINTON: I just want to follow-up because this is one of the key arguments we're going to have in Congress. Our plan calls for premium caps. We adopted that approach, as opposed to either a totally free market approach, which we believe will bust the deficit and lead to escalating costs, or to a heavily price-controlled approach, where you have set the price for every treatment that anyone gives, because we wanted not do what Dr. Koop was saying.

We wanted to be able to say to a state or a region, "Here are the budget parameters, and they will be a very

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comfortable cushion in which you will make these decisions."

You go make the decisions. I mean, Philadelphia may decide, through its medical community and whatever local decision-makers are at the table, that they want to limit the number of MRIs and CAT scans in Philadelphia because they have more than they need. Pittsburgh may decide they're short, and so they want that within their budget.

Q Why won't the caps become ceilings?

MRS. CLINTON: Well, I think because we've got the competition under the caps. I mean, part of what we think makes this workable is that you've got competing health plans, each of whom are going to try to get our business, each of whom is going to have to offer competition based on both price and quality for the first time, but each of whom is going to have to price its services within some kind of budget discipline.

And what we're finding, in what we consider to be analogous situations, is that just as Dr. Koop pointed out about Oregon, there is so much fat in the system that once health plans really have to compete and have to make the hard decisions, they're coming in below what the projected budgets are, in places like Florida which have set of purchasing plans. And we have no reason to believe that won't happen in the entire country.

But as a backstop, these premium caps will be there in the event that a health plan exceeds what should be a reasonable amount. They're not going to be put out of business but they're going to be told that they've got to go through and take a hard look again about how to reallocate their resources.

Q One problem that I've come across, the whole issue of cost-effectiveness (inaudible). And underlying the whole issue is the question of: what is cost-effective? And most of the experts agree that the (inaudible), and yet in this plan you're relying heavily on someone determining cost-effectiveness, and generally that tends to be the companies who have the financial incentive to try to show cost-effectiveness in favor of their own product.

How are you going to deal with that? You have one small agency now that's trying to learn something about cost-

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effectiveness. How do we trust the studies and what will be trade-offs?

MRS. CLINTON: Well, that's where we agree with those who want to give a role to the marketplace. I mean, we want this to be worked out through the marketplace. And let me just give you a couple of examples about where we see this going.

If you look at the way we reimburse physicians today, it is largely done on a piecework basis. I mean, we stopped paying people who made clothes that way 50 years ago in many instances, but that's what we still do with doctors.

There is, therefore, no incentive to be cost-effective because you have to keep gaming and building up your services to be able to get paid.

Now, that is just a financing cost-effectiveness that we think, if properly changed through other incentives, could make a huge difference, and that has nothing to do necessarily directly with quality --

(End of Side 1.)

MRS. CLINTON: -- physicians in that position every day. Or integrated delivery networks, through a model like Mayo, which is a multi-specialty clinic, which, when it started, was called socialism by the American Medical Association, where physicians are on salary, very good salaries, but they're not paid by the procedure.

You actually can be more cost-effective and quality-driven. That's one of the out-growths that we think will come from reorganizing the way we finance health care, so that cost-effectiveness, then through competing health plans and people making some hard decisions, will be joined with quality to give us a better outcome.

Q I (inaudible) concerned, at least from my research, I think that there is a great gap in our ability to distinguish the study of what people seem to (inaudible). You can take two drugs, and drug A will appear cost-effective in one study and the company will go ahead and tout it that way, and then drug B will be touted by the other company.

A perfect example has been the debate over TPA

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(inaudible) in the blood clot arena. And I think that there is great room there for a lot of manipulation.

MRS. CLINTON: But let me go back to what I said about the drug companies, and what we want from them, which is information. You said it exactly right. Where do doctors get their information about drugs? Initially from the drug companies, and often unrelated to cost-effective or quality, but who put on the best seminar or gave the best brunch at the medical society meeting, all of which is sponsored by big drug companies.

We want more and better information, and that can come through clinical trials and through other kinds of research, but a lot of that is done before the drug goes to market, but it's not readily available except in the way the drug company wants to present it initially. And then you've got to go through kind of real world practical clinical trials to acquire a new base.

If drug companies were required, as we're asking them to be, in the health care plan, to come to a health board not to get their price set but to give information that that then be made available, we will be further along towards determining cost-effectiveness than we are now, where we start basically from zero with competing propaganda from drug companies.

So none of this is going to happen overnight. I mean, we have to change imbedded attitudes and practice styles and behaviors of people. But right now, we need to change the incentives initially that will move us in that direction and then watch it carefully to make sure that it unfolds correctly.

DR. KOOP: (Inaudible) is it shouldn't even be considered until you know what works and doesn't work, in the theory and practice of medicine. We don't know that yet. Now, if you knew that, then you can say, "Here are two things that work. Which is cost-effective?"

And one of the little-discussed things in the President's plan is the provision for professional foundations, which are totally professionally operated, the purpose of which is to study utilization, informed decisionmaking on the part of patients, and outcome research.

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And I would think 10 years from now, that there's no transaction a doctor will do in his office that doesn't automatically become a unit of evidence in outcome research, so that what he can pull up on his computer in January is quite different than he does in March, but he has contributed to it all during that time. It takes it completely out of commercial hands.

MRS. CLINTON: I just want to make one last point, which is that Dr. Koop, who's been extremely helpful during this process -- he's given us lots of good advise and actually read early drafts of the plan to advise us -- has said over and over again that many features of this plan that are getting no attention whatsoever, like the use of technology, like the professional foundations -- I'm never asked about them and people are not paying attention to them -- have, in the long run, the possibility of huge pay-offs for the entire system.

And what I worry about is that we will narrow the debate and we will make marginal changes that are in the absence of this kind of systemic reform, and we will therefore lose a lot of what's in this plan that kind of is leading edge, like the technology and some of these quality outcome things that in the absence of it, we will not be able to do effectively under the budget, as we currently have it at the federal government, and we will lose an opportunity to get ahead of both the price and the quality curve.

So that's why we went with a comprehensive plan, and people say it's long and it's complex, but everything's in there. I mean, some of the competing plans are 400 or 500 or 800 pages long and they don't have anything except the financing and a few other features.

So we've tried to look at every issue and put it out there. And what we hope is that we can keep the focus on comprehensive reform and not have it narrowed too soon.

But I wanted to say, before I'm dragged out of here, that you all have done a great job covering this. I think that both the reporting and the editorials and the cautions and the encouragements and all that you've done in your coverage has been among the best in the entire country. So I'm grateful for what you've already done and feel like I'm preaching to the choir in terms of what you all know and what you've already communicated.

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But I can't stress how important that's going to be for now, going forward. And I wish I could get other papers to go at it with the kind of depth and understanding that you've brought to it because this his going to be hard enough to do, and not having accurate information will make our job even harder.

Q Just among the best? (Laughter.)

(The interview was concluded.)

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