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Children's Hospital of Philadelphia

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REMARKS AND Q & A BY THE FIRST LADY
AT HEALTH CARE FORUM SPONSORED BY DR. C. EVERETT KOOP
CHILDREN'S HOSPITAL OF PHILADELPHIA
PHILADELPHIA, PENNSYLVANIA

DR. KOOP: Thank you. They say you can't go back, but I did.

Before I introduce to you Hillary Rodham Clinton, I want to express my personal admiration and gratitude to her for her leadership in the President's health care reform effort. She has brought --

(Applause.)

DR. KOOP: She has brought to this assignment exemplary energy, unfailing diligence, a breadth of vision, attention to detail, care, and compassion. But I'm sure these words are not new to her. Ever since the Clinton health care plan became public and especially since her highly lauded testimony before Congressional committees, accolades have certainly come her way.

And, although the compliments for her accomplishment in producing a comprehensive reform plan are well-deserved, I must say that the tenor of some of the praise bothered me. There was too much oohing and aahing about how no First Lady had ever done such a thing before. And I think these folks miss the point, as well as missing the person.

It is my understanding that Hillary Rodham Clinton has presented this health care reform plan to the nation not as the First Lady, but as the American citizen whom the President decided he could best trust with this task in placing this on the top of his domestic agenda.

Now, I'm not saying it didn't help to say that she was a friend of Bill. But her chances, after all, were always good because the President has trusted friends to do important things in government. But I imagine, in this case,

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that Mrs. Clinton received that assignment as much in spite of her being the First Lady as because of it.

A highly educated woman, an accomplished attorney, a proven manager, a thoughtful analyst, a champion of children and the disenfranchised in our society, Hillary Clinton did not surprise anyone who knew her by producing a reform plan of such breadth and such depth. That kind of accomplishment was simply to be expected from her.

I also must say that I admire her and the President for their repeated statements that the plan they have offered is open to debate and amendment. They welcome suggestions to improve upon it. And, although the plan is complex, even complicated, I especially admire its breadth.

And I thank you, Mrs. Clinton, for raising all of the issues so that, no matter what finally emerges in the national debate and legislative process, you have forced us to deal with all of the issues, medical, financial, legal, public and private, as well as those of our personal responsibility for taking charge of our own health.

No matter what any of us here today think about some of the plan's particular points, we all owe you our gratitude and admiration for placing the issues and the ethical imperative for health care reform so clearly before us.

It is amazing to me to read in the press that we have no health care crisis. With 38.2 million persons without insurance all or part of the year and the knowledge that the quality of care and the outcomes of treatment in the uninsured is measurably less than in those with private insurance, I think we do have a crisis. Ask some of the 100,000 people who lose their insurance each month if they think there is a crisis. Ask the 250,000 people who filed bankruptcy last year because they could not face their medical bills.

Our system may function with compassion, with competence, at times, with sheer excellence, but not for enough Americans. For too many of your fellow citizens, our health care system is a tyranny. And that means, for them, it is more a curse than it is a blessing.

Let me illustrate from the world of children, which should be reasonably understandable to this audience. I don't know what happened in your life today, but I do know

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what happened in the lives of many of our children. Today, three children will die from injuries inflicted by abusive parents. Today, 90 children will be taken from abusive parents and forced into the already overcrowded foster home system.

Today, 2,200 teens will drop out of school, most of them without any kind of health care. Today, 100 children will take their first drink of alcohol, and 500 children between the ages of 10 and 14 will try another drug. Today, 1,400 teenage girls will become mothers; two-thirds of them will be unmarried. And now, in America, one child in five is at risk of becoming a teen mother.

About 2,750 children today will find out that their parents are getting divorced or separated. And that means that half of all white kids and three-quarters of all black kids in this country will spend part of their childhood in a single parent home.

Today, nearly 20 percent of all children have seen another year go by since they had visited a doctor. And the proportion of American nonwhite one-year-olds that are immunized against polio, measles, and other preventable diseases ranks lower than that of 55 other countries. That includes Iraq and Libya. One child in America out of every six has no health insurance.

Many of the problems faced by our children pinch hardest on those who live in want for those who are handicapped by the shameful prevalence of poverty in this otherwise affluent society. The millions of Americans who have these problems merely live on the fringes of our affluence.

And no one knows better than you, Mrs. Clinton, that children are the country's greatest resource, nor does anyone know better than the First Lady how good we all are at giving lip service to children and their needs and yet let a third of them live in poverty and a quarter of them be deficient in shelter, nutrition, or health.

The support system for children with special needs is complex. It has been cobbled together over the years by both public and private interests, and it is good in some areas and fragile in many others. During my tenure as Surgeon General, a lot was accomplished in addressing the predicament of special needs children in a series of Surgeon General's workshops.

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Indeed, the first such was held right across the street at the Children's Hospital back in 1982 and was followed thereafter by national, regional, and local workshops of the same nature for the next several years.

Out of these workshops, there evolved the principle of comprehensive, community-based, family-centered care for children. This meant programs to children and their needs delivered by multidisciplinary teams as close to the child's home as possible and in such a way as to reinforce the family's role as the child's primary caregiver. Indeed, Congress required just that from state maternal and child programs in OBRA of 1989.

We are concerned about the 15 percent of America's children who have a chronic health problem and about the 2 percent who have disabilities of special health care needs that severely restrict their ability to function in school and family settings. Title V of the Social Security Act provides the current safety net for maternal and child health.

For optimum care of children in the future, as well as for a system to provide accountability for maternal and child heath, there has to be some comprehensive coordination of the provisions of Title V and the President's health care reform package.

And, now, if you would come forward, Mrs. Clinton, I would like to give you my first question. Will these youngsters that I've been talking about with congenital problems be eligible for the therapeutic assistive technology and habilitative services that they desperately need, even if the services maintain limited function and the child's status could never be said to be improving?

MRS. CLINTON: Dr. Koop, this is an area that we have tried to address in the Health Security Act. And let me go through a few of the provisions and the coordination of services that we think will answer that question largely affirmatively.

As you know, the Health Security Act promotes comprehensive and accessible health care for all Americans, including children with disabilities and special health needs. The Act includes several provisions to ensure that a choice of care arrangements are available at the community level for all individuals.

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And, in addition, a well-designed quality system based on health plan monitoring using standardized performance indicators should assure that all populations receive quality care. For children with special health needs, as you clearly point out and as the research shows, quality care means family-centered, coordinated, and community-based approaches.

So, therefore, children who are currently eligible for Medicaid services will receive most of their services through a health plan that provides comprehensive benefits. Additional services will also be provided in a new federal program of wrap-around services to address any other needs the children may have.

This new program will have national standards developed to assure uniform benefits for children and will be coordinated with other programs for children, including parts B and H of the Individuals with Disabilities Education Act.

Additionally, Title V, which does mandate family-centered, community-based, coordinated systems of care for children with special needs will not be changed in the Health Security Act legislation as universal coverage is phased in.

The role of state, maternal, and child health programs will change, because resources currently expended on the actual provision of the purchase of direct medical services will no longer be necessary to the extent that these services are covered under the comprehensive benefits package. Therefore, state programs will be freed up to focus even more on the assessment, planning, evaluation, and assurance functions for which they are responsible.

Also, for the first time, the Health Security Act will assure that all children, including children with special health care needs, regardless of their income, diagnosis, or severity, have access to an affordable and comprehensive benefits package.

The current patchwork of coverage for families with disabled children will be streamlined into a uniform package for all children, backed up by the continuation and coordination of the other existing federal programs, including the ones I have already referred to, Title V and parts H and B.

Currently, disabled children are twice as likely to be publicly insured as nondisabled children. And, as Dr. Koop said, 500,000 disabled children are uninsured. When

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they do have private health insurance, which they would be guaranteed under the Health Security Act, they are more likely to see the cost of their coverage decrease and have the scope of their benefits increase, because the Health Security Act guarantees renewal of a consistent set of benefits.

To gain access to the provider of their choice, families -- not employers, not the government -- will choose each year which health plan provides the best way to meet their needs. And we anticipate that many health plans will be specifically targeting children with special needs, because the act also requires that health plans contract with sufficient numbers of academic health centers and other centers of excellence to provide access to the specialty services required by the individuals in the plan.

In addition, children's hospitals may apply for and be designated as essential community providers. That designation would then require health plans providing services in the area where those hospitals like the one I just visited are to establish agreements for services.

We are also looking to expand the availability of long-term care services for severely disabled children. Eligibility for this program will be uniform across states, while services to be offered will be determined by states to assure appropriate tailoring of the program to community needs. Representatives of the disability community will be involved at each step of this state-based, federally matched program.

And, finally, we believe that the Health Security Act gives us an opportunity to reinvent public health and public health agencies at both the federal and state levels. Universal coverage and comprehensive benefits will free up many public agencies to focus now on the core services that should be provided by public health.

And, in addition, we believe that, through federal funds, we will develop the ability of public and private nonprofit organizations to reach those who most need additional assistance.

We will also be providing a federal program of support services for low-income children to try better to coordinate their needs, not only with Title V, but with other programs that are aimed at serving them.

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So we have tried to look at the full range of issues presented by our severely disabled children, those with chronic conditions, and better streamline the programs that already exist, use the new funding that will come to support universal coverage that will include every child that we believe will then free up resources to be available for those children. It is an issue that we care very much about.

(Applause.)

DR. KOOP: Mrs. Clinton, currently, Medicaid patients account for about 44 percent of the patient days in children's hospitals nationwide. And yet, Medicaid pays children's hospitals, on the average, less than 84 cents on the dollar, in spite of the improvements that have been made in Medicaid payments through disproportionate care providers.

The President's plan calls for community-based clinics serving low-income people to be labeled "essential providers." Now, this question has to do with part of your answer to the previous one: What can be done to assure that the concept of essential providers be extended to in-patient care, as well as primary ambulatory care?

This is of special concern as we attempt to sustain a fragile health safety net for low-income people during what will be a transition to an increasingly competitive market.

MRS. CLINTON: Well, first, the Health Security Act will eliminate the burden of lower payments to providers, including hospitals, for publicly-insured individuals. Once enrolled in a health plan, low-income individuals will be integrated into a single tier system of care for services covered in the comprehensive benefits package. And that means that there will no longer be a distinction between Medicaid recipients and the rest of us.

In fact, when I was at the hospital this morning in the primary care center that has been established there, one of the doctors told me that a patient who had been coming for certain services to the hospital but had been primarily cared for by her local pediatrician, had just been advised because their family's economic situation had changed and this child had spina bifida, that the Medicaid or the state assistance that would pick up much of her chronic care meant that her physician would no longer see her. And so she, then, was coming to the hospital for all of her services.

In the system we envision, there will be no distinction between those people who are getting a subsidy,

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such as Medicaid recipients do now for their health care and the rest of us, which we think will help better integrate into a better care delivery system.

Second, the Act's provision for essential community provider designation does allow for hospital inpatient services to be covered. Institutional providers who are located in an underserved area or who provide services to a medically underserved population are eligible for this designation.

And standards will be developed for additional designations, if required, to assure that every health plan does what we expect it to do, make available to its patients the full range of services in the benefits package, which includes access to centers of excellence and academic health centers and include inpatient hospital services.

DR. KOOP: Thank you very much. I have one more question for the First Lady, and then we'll be taking questions from you. There are two microphones in the aisles, one here and one over here. I would ask you not to make too long a line, because if you do, you will obstruct the view of the people of the platform.

My last question, Mrs. Clinton, is this: The President's proposed lowest cost sharing option has a mandatory $10 copayment per visit which includes physicians and therapists. Do you have any plans to subsidize low-income families who would not be able to meet their copayment requirements and, therefore, perhaps delay seeking prompt and necessary care?

MRS. CLINTON: Yes, we do. The Health Security Act includes provisions to assure the affordability of health services for low-income individuals. First of all, AFDC and SSI-assisted families will have their copayments reduced to 20 percent of the normal cost sharing in the lower cost plan. That means that they would be required to make a $2 copayment on office visits and a $1 copayment for prescriptions.

In addition, for low-income families at less than 150 percent of poverty in areas where there are no low-cost plans available, additional subsidies will be provided. This is part of our belief that everyone should be responsible for paying something, yet we want to provide the services to everyone who needs them. So we will subsidize the low-income patients, but we will expect some kind of payment, because we want to encourage that kind of individual responsibility

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wherever possible.

If I could, before we take just a few questions, just say a few words of thanks. I want particularly to thank Dr. Koop, who has been very helpful and very informative to me personally and at the forums that we have attended together. And I'm very grateful for his advice and guidance as we try to navigate our way through this process to achieve real health care reform.

I also very much want to thank the Children's Hospital of Philadelphia. I appreciated greatly my visit this morning and had a chance to talk with the physicians and the nurses and parents who are there. I also want to thank all of the sponsoring organizations which have been mentioned earlier for being able to come together to put on this forum.

And, in addition, because although I am greatly honored to be here with all of you, there is a special group that is of great importance to the President who is here. I want to acknowledge the members of Congress by name, because they are the ones who are going to be digesting everything they hear you say and me say to try to figure out how we're going to do this metamorphosis of the caterpillar to the butterfly.

And so, although you all know them, I want to particularly thank both of your senators. You know, Senator Wofford has been beating the drum for health care reform for a number of years, is a sponsor of the President's Health Security Act, and is an unabashed advocate for getting the job done. And I'm grateful to Pennsylvania for making it possible that he would be there.

(Applause.)

MRS. CLINTON: I also want to thank Senator Spector, who has been very interested in maternal and child health care, particularly for low-income families, and has had a number of conversations with me about how to make sure children's needs and pregnant women's needs are taken care of.

And I think he also brings a very personal perspective to this health care debate that I hope will be part of the conversation as we move forward. And I'm very grateful for both his personal and professional support for what we're trying to achieve.

(Applause.)

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MRS. CLINTON: And I also want to thank the members of the House of Representatives who are here. Congressman and Mrs. Blackwell here. And Congressman Blackwell has been with me every step of the way in Philadelphia every time I come, which I am grateful for.

(Applause.)

MRS. CLINTON: Congressman Foglietta, who handed me on the plane today an announcement of what the Urban Coalition and the Congress is going to try to achieve, so that the great hospital centers that I just visited will be fully taken care of as we move forward with health care reform. And I am very grateful to him.

(Applause.)

MRS. CLINTON: And I want to thank Congressman Borski for his being with me today and for caring about these issues and looking after the interests of the excellent medical facilities that are here in the City of Philadelphia.

(Applause.)

MRS. CLINTON: And I want to thank your neighboring Congresswoman, Marjorie Margolies-Mezvinsky, for --

(Applause.)

MRS. CLINTON: Actually, I want to thank her for two things. I want to thank her for her long-standing commitment to children and the way she has exemplified that in her own life through adoption and caring for children. And I want to thank her for casting that budget vote, which looks better every single day.

(Applause.)

MRS. CLINTON: So, Dr. Koop, I guess we're ready here.

DR. KOOP: For awhile, there were nine people on the right and no one on the left. And I thought there was going to be only conservative questions. But I see we're about even.

We'll take number one over here.

MR. GURRY: Mrs. Clinton, My name is Gary Gurry (phonetic), and I'm director of the Montgomery County Health

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Department.

First of all, I want to echo Dr. Koop's remarks thanking you for bringing health care reform to this nation and having the vision for the future. And I also want to say that we in the public health community welcome the debate.

But, at the same time, what I would like to know is, what can we do -- by "we," I mean the supporters of President Clinton's plan -- to counter much of the self-serving rhetoric that the public has been bombarded with by various special interest groups from the business community yesterday to the pharmaceutical community and some in the organized medical community and even some of my colleagues in the public health sector who are only looking out for themselves and not looking out for the future of our children?

What could we do, the people who support the plan, to make this plan or to make health care reform a reality?

MRS. CLINTON: That's a wonderful question. I appreciate it very much.

(Applause.)

MRS. CLINTON: Well, let me just answer it by saying, the first thing you and others can do is to do what you just did, which is to speak out based on your personal experience, your observations, what you know works and doesn't work.

The second is to continually stress the point that Dr. Koop made. We do have a health care crisis, and those of us in this room who are well-insured today may not feel it, but none of us in this room, given the way our current system works, is guaranteed to have the same insurance that covers the same services at the same price this time next year.

So the crisis is not somebody else's crisis. The most extreme examples of the crisis are the millions and millions of people who not only are uninsured but the millions of more who are underinsured and the millions who pay more than they should because they have a preexisting condition of some kind and all of us who may wake up at any point and not be insurable, or insurable at a very high price. So the crisis is not just for somebody else, and we need to drive that point home.

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The other point is that we are confusing a lot of issues. And some of it, as you suggest, is deliberate confusion on the part of those who do not want any change. We are confusing the fact that we have the finest physicians, nurses, hospitals, health care in the world with the stupidest financing system for health care in the world.

(Applause.)

(End tape 1, side 1.)

MRS. CLINTON: Today's health care system is rigged against families and small businesses. And the insurance companies are in charge. They pick and choose whom they cover at what cost and for how long, and they also impose enormous burdens on those of you who deliver health care.

If you are a physician in private practice, you have seen your paperwork-related overhead explode. If you are in a hospital, you have watched as your hospital has hired four administrators for every physician to deal with the paperwork and the bureaucracy.

(Applause.)

MRS. CLINTON: We are basically taking the billions and billions of dollars we spend on financing health care and dropping it in a black hole as far as I'm concerned. Because having someone in the physician's office who is paid to be on a telephone all day to argue with insurance companies over how much you will be reimbursed is not delivering quality health care, as far as I'm concerned.

(Applause.)

MRS. CLINTON: So let's cut through the smoke screens. Let's cut through the expensive television advertising campaigns. Let's start talking some sense. Because every time we go out and talk to real Americans who are either physicians or nurses or hospital administrators or deans of medical schools or patients, they know what's at stake. They want a health care system that makes sense.

They don't want to be continually at the whim of some insurance company bureaucrat.

So what's really at stake here is preserving what most of us think of as the health care system -- our relationship with our doctors, the hospitals we go to, and

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thinking about how to change how we pay for it to eliminate the unnecessary costs. And that's what the struggle is about, because a lot of people have made a lot of money pumping that money through this system to go into the paperwork hospital and the paperwork health care system.

I want to get rid of that money. I want more money in the real health care system. And that's what the debate should be focused on.

(Applause.)

DR. KOOP: As a fellow supporter of public health, let me tell you how I answer your question one-on-one. Don't compare what you have now with what you think you'll have with the Clinton plan. Compare what you have now with what you'll have without it.

Question?

MR. HAYES: Mrs. Clinton, I'm Herb Hayes (phonetic), and I'm director of health services for the Philadelphia school district. And I want to add my thanks to those you've already heard.

And, clearly, all of the things we have talked about so far this morning are very, very important. But just as important, if not more so, are some of the things we haven't talked about. And those are the issues involving health promotion and disease prevention. And, as someone who works for a very large school district, that's obviously a very grave concern.

And, in my mind, at least, we won't have real, meaningful health reform in this country without a clear emphasis on health promotion, disease prevention. So what does the plan envision as the role of schools in health promotion and disease prevention, and how will the federal government take a greater role in supporting local school districts in those efforts?

Thank you.

MRS. CLINTON: Well, there is a role and funding for schools to be engaged in health promotion and disease prevention and also an opportunity for schools to provide primary care through school-based health clinics. So both of those are important features to ensuring that we have real coverage that is available to people and will be utilized.

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MS. MARX: I'm Leona Marx (phonetic), and I'm pleased to have the opportunity to present some highlights of a letter that I prepared for you today.

Like most Americans, my family has a great interest and concern about health care reform. And we're very pleased to have the openness of you and the President to constructive criticism of the proposal.

While we often considered writing to you about our health care reform ideas, recent events in our lives make us feel compelled to write to you at this time. In many ways, we are a typical suburban Philadelphia family, two working parents and two wonderful children. In other ways, our atypical background and experience with the health care, both professionally and personally, give us a different and somewhat more focused (sic) on meaningful health care reform.

My husband, after having worked for 17 years in a large Blue Cross plan, the last 5 years as CEO, is now a principal in an employee benefits firm which helps to design benefit designs and helps to control costs. I'm the associate director of clinical outcomes research at Jefferson Medical College, where I'm primarily involved in directing and designing studies on quality of medical care.

However, our induction into the real workings of the health care system started approximately 18 months ago when our son, Zachary, who was eight years old, was diagnosed with a particularly resistant form of leukemia, AML. If I was writing this letter just a month and-a-half ago, I would have been telling you about my son's remarkable recovery, his return to school, and his joyous time he would have playing soccer each Saturday morning.

Unfortunately, on December 30th, we learned during a routine checkup that his leukemia had relapsed. He is now hospitalized in Seattle, Washington, recovering from a second bone marrow transplant. My husband, David, and I are commuting alternate weeks from our jobs in Philadelphia so that we can both care for our son and attend to some of our business needs. And my husband wished that he could be here today, as well.

While much has been said about what is wrong with our health care system, not enough has been said about what works in our current health care system. I acknowledge that my family is exceedingly lucky in many ways. Our health insurance is covered through a large employer cafeteria plan,

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and we were fortunate enough to have selected the high option indemnity program. This gave us the opportunity to seek care for our son in the institutions that could best meet his needs without having these important decisions restricted on a network of services.

Our son's care began across the street in the world renowned Children's Hospital of Philadelphia, where a caring and professional attitude begins with the CEO, Edmund Notebar, and permeates to every level of the hospital, including the linen services manager, who tried to recover our son's lost baby blanket.

Our primary care oncologist, Dr. Beverly Lang, was fortunately so knowledgeable, respected, and self-confident that she could recognize that Zachary's unique circumstances would be better treated in another institution. We were able to receive care at the Fred Hutchinson Cancer Center in Seattle when research of ours and research by Dr. Lang, who discussed our son's condition with numerous colleagues across the country determined that the Hutchinson Center in Seattle was the most appropriate location for our son's transplant.

Along the way, we have met families from an insurance standpoint who have been less fortunate than us. Sadly, there were children who were never offered a transplant because they did not have adequate insurance. I applaud your goal for universal coverage. It is desperately needed.

Of equal concern to me are the families I met who had insurance but who could not select their transplant site because their managed care plan refused to pay for out-of-network services. I know of a family whose daughter died of leukemia because her managed care would not authorize out-of-network care.

This type of situation exists not only for leukemia but for a variety of other conditions where care is changing rapidly, and subspecialized care is required.

DR. KOOP: I wonder if we could have your question soon.

MS. MARX: I just have a few small comments.

I'm deeply concerned because the concept of regional alliance and managed care networks has become an infatuation of policy analysts. While most managed care

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plans will provide a full range of services, it is impossible for these plans to assure that high-quality care is being provided for all the services that they deliver.

I've spent most of the last eight years studying quality of care. I'm currently preparing a book for the Joint Commission on Accreditation of Health Care Organizations on public accountability of hospitals. I know that data is not available on whether quality of care is being rendered in restricted network services.

In addition, these networks are not formed on the basis of quality. They're formed when corporate needs of a given insurer match the corporate needs of a given provider to increase market share. And these networks particularly provide a one-size-fits-all array of services.

DR. KOOP: Ma'am, this is a question and answer session for this audience. Would you please ask us your question?

MS. MARX: I would like to know if the concept of regional alliances and the restrictions that can come about when you're forced to deal within a given region is something that the Administration will reconsider, in light of the --

MRS. CLINTON: Well, in fact, we have. We have a point-of-service option that will be required in plans to be made available to deal with just the problem you talked about, because we do not want to fall into the trap that you have described in which care networks try to restrict access beyond their regional area and do not provide that point-of-service option. So that is part of the plan.

And it stands in stark contrast to some of the other plans that are being considered which would force people to make this choice: Either you go into the lowest cost plan in your region, or you lose your tax deductibility on your benefits.

We think that is terribly unfair. We want it to be a legitimate consumer choice, and we want to require plans no matter whether they're closed networks or however they describe themselves to offer a point-of-service option. And that would be available to families in the situation you find yourself in.

MS. MARX: Thank you, and I would like to give you a copy of this.

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DR. LONG: Hi. My name is Madalyn Long (phonetic). I'm a medical doctor from New Town Square, and I'm primary care. I want to say welcome to Philadelphia. We're thrilled to have you here. And I want to tell you that Philadelphia is the City of Brotherly Love, but also Sisterly Love. In that vein, I want to award you my hat so you can wear it on tour.

MRS. CLINTON: Thank you.

DR. LONG: But, seriously, I would like you to walk in my shoes just for a day, an hour, a week. We are in the trenches with primary care. We're getting killed by the insurance companies with their greed. And I wonder if you and our representative, which is Representative Mazinski (phonetic), could do that. We seriously welcome you to our practice. It is typically primary care.

And my question is how, in fact, can you not bankrupt us? Where are small businesses with this new tax? How can you create or think of creating 59 bureaucratic things to administer this new health care service and not put us out of business? I mean, we can't possibly, with this new entitlement, pay for these 59 new bureaus that you're about to create to administer this. How are we going go get through this?

MRS. CLINTON: Well, first of all, I agree with you that primary care physicians have been disadvantaged in the current system and have been particularly disadvantaged not just by insurance companies, but also by government programs like Medicare and Medicaid which have not paid primary care physicians for their clinical time with patients. So what has resulted has been a real financial burden on primary care physicians.

We are going to do several things. Number one, we're going to require that, at least through the government programs, primary care physicians will be reimbursed at a higher and fairer rate, because we think it is long overdue.

Number two, we are going to eliminate a lot of the paperwork and the problems you currently have with insurance companies. We have done some studying about the amount of money that physicians currently spend out of their gross income to support the paperwork part of their practice.

And a typical physician in private practice is spending between 40 and 50 percent on taking care of

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paperwork, adding more people to their back office doing the kinds of things that are just totally irrelevant to your taking care of your patients. We actually believe that by eliminating so much of that paperwork, your income will actually increase, because you will not be paying for the expenses to basically take care of the insurance company requirements.

So, from our perspective, both in terms of patient care, physician/patient time, reimbursement for your services, and elimination of unnecessary expenses for you, you should be better off today than you will be if we do not change the system which will continue to discriminate against primary care physicians.

DR. MARX: Thank you.

DR. KOOP: Microphone number one.

MS. BACRAC: Good morning. My name is Anne Bacrac (phonetic). I'm the executive director of Pennsylvania Healthy Mothers, Healthy Babies. And we have paid attention to this health care plan because we feel it represents a large range of benefits that many low-income families have difficulty accessing, even though they may have a medical assistance card.

My question has to do, in some ways, with more of the rural populations in this state rather than the urban ones. And one of the biggest concerns that we have in looking at the plan and its emphasis on primary and preventive care has to do with the emphasis on prenatal care and what we refer to as "enabling services" for that care, which include transportation.

And I know within the first version of the American Health Security Act, enabling services were available for rural populations. I'm curious as to whether it will also be available to other "medically underserved populations" in any kind of an entitlement.

MRS. CLINTON: No, it will not be a new entitlement. But funds will be appropriated and included to provide services, not only transportation, but translation services, which are often very important. And we think that is an essential part of actually getting the patient to the services. So we do intend to fund what we can of that to enable it to work better.

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MS. BACRAC: Thank you.

DR. KOOP: Microphone number two.

MS. SHLUCKNER: Good morning. My name's Juliette Shluckner (phonetic), and I'm here on behalf of my two children, a three-year-old and a one-year-old, who suffer from cystic fibrosis.

And first, I must tell you that every day, I enter into a dialogue with you across from my steering wheel and in my mirror, and it's much easier to debate these issues there.

All of my hope for my children right now is critically dependent on some life-saving technology that is being developed by, in some cases, some very small pharmaceutical companies. Last month, Jenitech (phonetic) received approval from the FDA for a miracle drug DNA that may extend my children's life.

I would like to know very specifically how the Health Security Act will impact the small pharmaceutical companies whose today incentive comes from Wall Street and from the price tag on their drug of $10,000 a patient per year. How will their incentive be affected by your plan to develop these life-saving drugs for my children?

MRS. CLINTON: Well, I can only tell you this, that all last year, 1993, there was a very big campaign put on by the biotech and pharmaceutical firms claiming that nobody was investing, that capital was drying up, they were having to leave the country because the specter of health care reform was such a burden. And I looked at the year-end figures, and investments in small biotech firms went up 23 percent in 1993.

Because anybody who really looks at what we're trying to do sees the following: First of all, we are going to be putting more money into the research that leads to breakthroughs at the federal level, which is often then the spinoff that enables other firms in the private sector to do their work.

Secondly, we are vastly expanding the market to buy pharmaceuticals. Under the President's plan, as part of the comprehensive benefits package, prescription drugs will be covered. As part of Medicare, prescription drugs will be covered. That will be an increase of at least $15 billion a year going in to the pharmaceutical drug company industry in

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this country.

So I think that any fair reading of what is likely to happen, both with our emphasis on research and with more dollars coming into research, is that pharmaceutical and drug companies will do very well, indeed.

Now, the other side of that is that it is absolutely true that we have the finest pharmaceutical companies in the world. They are doing the research that will lead to all kinds of advances. They also are charging Americans sometimes 2 to 3 to 10 to 15 times more to buy their drugs than they sell those same drugs overseas.

And I think the American taxpayer and the American patient and the American physician have to ask why, when we support it, when it's our tax money which pays for it, do we then get charged so much more for the products we helped develop? So what the Health Security Act --

(Applause.)

MRS. CLINTON: What the Health Security Act is trying to do is both encourage more research and development but also get more information from the pharmaceutical so that we can make fair judgements about what they should be paid for these drugs. They can tell you it's a $10,000 drug based on their research. They will not open their books to the government or anybody else for any of the rest of us to know whether that's true or not. It could very well be true.

But I will just close with this one story. There was a physician researcher at Mayo Clinic who determined that a particular medicine in pill form used for sheep was very beneficial in humans for certain kinds of colon cancer treatment.

He went to the drug companies, and he said, "I think my research shows this, and there ought to be some way to break the size down" -- because a sheep takes a lot bigger pill than we do -- "and be able to make sure in human trials there are no problems -- based on what I see, there aren't -- and then get this into the marketplace.

He is on the warpath now because he helped this company, he worked with this company, and then this company turned around, and for a pill that was being sold in feed stores in rural Pennsylvania for something like four cents a pill, it is now being sold for $4 a pill. It's the same

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pill. The same research had already been done. It is now being sold to human beings.

And he has gone on the radio and the television and has told everybody he can talk to, "I'm a physician. I respect our drug companies. I value their work. I use it every day. But their attitude needs to change about how much they charge people for the products they produce."

(Applause.)

DR. KOOP: I think all these things the First Lady has said are true, but I do also think that the pharmaceutical houses have seen the handwriting on the wall. As I told a group of them recently, if they confess their sins, I think Americans believe in redemption.

(Laughter.)

MS. ALBRICH: Good afternoon. My name is Bonnie Albrich (phonetic), and I'm a member of Children's Hospital Parents with Special Health Care Needs Committee. I'm also the mother of two children who have very special health care needs. One is severely retarded, and one has a cancer history with chronic illnesses.

Our committee has met a couple of times, and we have lot of issues and concerns about the health care plan as it pertains to our children. One of the concerns that I really don't hear too much about is it has taken me years to learn how to navigate the paperwork and how to advocate for my children through our health care plans that they have received the best health care that they have and that they need to survive.

How will the health care plan help parents like us who have already learned how to navigate and advocate for our children learn to do it all over again? It's a fear that we have.

Thank you.

MRS. CLINTON: Could I ask you, are you fully insured for your children's needs?

MS. ALBRICH: No, not completely. We have lots of copayments, and it's very expensive when you make numerous trips. But I do have private health care insurance, yes.

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MRS. CLINTON: And do you have lifetime limits on your policies?

MS. ALBRICH: Most definitely. One of my children will most definitely reach it pretty soon before she's probably 16 or 17. Right now, she'll be 12 next week.

MRS. CLINTON: Well, let me say that under the Health Security plan, some of the things that you've had to worry about you will not have to worry about. You will not have to worry about lifetime limits. You will not have to worry about the kinds of maneuvering and navigating you've had to do over these years to try to make sure your children got health care.

The way that this will work is that through your employer or your husband's employer, you will, every year, be given a wealth of information about the plans that are available to you. It will not be your employer's choice; it will be your choice. And, in your case, you will look particularly as to how your children will be taken care of.

What we anticipate is that under the comprehensive benefits package, many of the needs that your children have on a routine basis will be taken care of. Their acute and chronic care will largely be taken care. And the cost of that will be much reduced for your family, so that in the event there is some specialized care that you need for your children, if you want to buy and additional policy or go into a market to try to make sure that you've got all that you need, it will be much, much less.

And the absence of lifetime limits means that your children will always be cared for. And the guarantee of private insurance means that your children, when they are no longer technically your dependents by age, will be insurable. So I think that the system we're moving to is going to be much simpler. And the amount of time and money and energy and frustration that parents of special needs children have dealt with trying to navigate this system is just outrageous.

And when I was in Cleveland at the children's hospital there, I had the parents of two cystic fibrosis children say to me that they couldn't get insurance anywhere and that what finally happened in their last effort with a broker of insurance is he looked at them, and he said, "Look, we don't insure burning houses, and that's what your children are."

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And this mother told me this. This is, you know, a family that is a middle, upper-middle income family. They exhausted their limits quickly. They can't get back in the insurance market. And they spend -- she spends every day, personally caring for the children and dealing with medical providers, insurance companies, and others. And you just will not have to do that.

No other country that provides universal health care coverage makes you spend the time you would like to spend taking care of your child filling out forms, and we shouldn't, either.

MS. ALBRICH: Thank you.

(Applause.)

DR. KOOP: Microphone number two.

MR. KIRSHNER: Hi. Good afternoon. I was going to say, the people in line in front of me made this look so easy.

My name is Andrew Kirshner (phonetic). I'm a junior medical student at the Philadelphia College of Osteopathic Medicine which, I'm sure you're aware, is responsible for turning out a huge population of primary physicians in the Delaware Valley. It's a good place.

Additionally, I'm also the creator of the Russian-American medical student and physician exchange program. My experiences here and in Moscow have really made me appreciate what we have here. While there are some problems with our health care system, it's arguably the best health care system in the world.

My question is going to sound somewhat selfish, and I hope it really doesn't strike it down. It's pretty certain that we live in a litigation-happy society, and we really kind of abuse a legal system that was designed to protect us in the first place. And, since I was trying to get a real grasp on what malpractice reform was going to mean to us, I've been met with various conflicting and very circuitous responses.

I have friends who are spending 30 to 40 percent of their yearly income on malpractice insurance. And these are people who have never had any kind of litigation trouble whatsoever. Like I said, I know this sounds selfish, but I

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would really like to know your concrete assessment of how this issue's going to be addressed how me, as a future physician, how I am going to be protected from a public which has really seen physicians vilified expertly by the media.

MRS. CLINTON: I don't think that's selfish at all. I think it's a very real concern that we try to address in this legislation, because there are two problems. One is the out-of-pocket cost, paying for the malpractice insurance, which keeps going up, unfortunately, in many areas and the impact on your practice of the fear of being sued, which often means you run more tests and do more things in order to be able to say you did them when, in your clinical judgement, you don't think you needed to do them. So there's really two parts to this.

With respect to the first part, we are doing a number of things which we believe should lower malpractice costs to physicians. One is that we're going to require alternative dispute resolution before you go to a court. We're gong to require that there has to be some qualified expert who says that the case that the lawyer is trying to bring is a worthwhile case. We are going to limit --

(Applause.)

MRS. CLINTON: We're going to limit attorney's fees in malpractice cases.

(Applause.)

MRS. CLINTON: And we're going to do some other technical things that have to do with who the insurer really is and how they all have to pitch in so that you don't have this game that goes on where you've got one insurance carrier pitted against another insurance carrier all driving the cost up. So we are going to try to limit access to the courts. Now, you can't eliminate access to the courts. Obviously, that's a Constitutional right. But you can certainly limit it.

The second thing, which I think, in the long run, will be even more important, is working with medical specialty organizations to develop guidelines for practice that will insulate physicians from any lawsuit. Because, if you can say, "I did what the state-of-the-art in anesthesiology or radiology or whatever is," we want that to become an absolute defense to lawsuits, so that you can begin to try to use the expertise of the medical community to deal

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with these problems.

But then, there is something that the medical community also has to do. There was a study done in the last several years of Pennsylvania which showed that most of the malpractice cases were brought against the same physicians or the same kinds of physicians doing the same procedures. And, in fact, it was striking to me that there were a number of lawsuits brought against the very same physicians.

So it would be very helpful for the medical community to begin to deal with whatever the legitimate problems within its community are, because every time there's even one case, the insurance companies use that as an example to increase everybody's rate. So, even if you've never had a claim, or you've had a bogus claim, they come in and they say, "Well, there was a big jury verdict in York and, therefore, we're going to raise your rates."

The medical society needs to do what it can both to weed out those that should not be practicing medicine and to help control the circumstances in which these kinds of claims can arise. So we're going to do what we can from the legislative position to try to prevent frivolous, unnecessary lawsuits to lower the costs and to come up with guidelines that will insulate you from such malpractice claims.

(Applause.)

DR. KOOP: Mrs. Clinton, I think the medical profession is ready to police itself better. But if they do, there has to be some federal protection against what we now call "whistleblowers," because, in the past, the courts have not dealt kindly with these people.

MRS. CLINTON: And that is absolutely right. We also need antitrust protection, so that physicians and hospitals can cooperate together instead of compete against one another, and we need other kinds of legal support, so that you are protected when you engage in this.

But I had an example given to me by a hospital that I visited which was an interesting example, because a surgeon had been accused of a criminally negligent act. And the hospital suspended his privileges. The surgeon went to court. The court reinstated him, because they said until his trial was finished, he was innocent till proven guilty, and they couldn't deprive him of his income.

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Now, in many multispecialty clinics and in many other practice settings, that would not have been a problem, because you could have suspended the person with pay. Like the Mayo Clinic, for example, they would have been on salary. So they wouldn't have had to keep doing surgeries to get paid. They could have been suspended and then, when this man eventually was convicted, terminated.

So part of what will help on this, too, is reorganizing how we deliver care so that more physicians have a stake in policing and holding accountable their own colleagues and then, as Dr. Koop says, giving you the legal protection so you can do it right.

DR. KOOP: Number one.

DR. KATZ: Good morning, Mrs. Clinton, Dr. Koop. I'm Warren Katz (phonetic). I'm chairman of the Department of Medicine at the Presbyterian Medical Center just a few blocks away.

And I'm very concerned about the overuse and abuse of medical technology. Physicians, for many reasons, order too many tests. And you just gave one of those reasons, the fear of a malpractice suit.

Does the health security plan address the high cost, the high ticket medical technology as a cause of the rapidly rising health care costs? And what do you think we can do to balance out what really is the wonder of modern technology with its exorbitance?

MRS. CLINTON: I think that's a very important question, because nobody wants us to lose our technological edge in medicine. I mean, it has been a remarkable accomplishment for us. On the other hand, the number of expensive machinery and other equipment that we have in all of our communities far exceeds the reasonable expectation of their usage.

And so the costs of these machines are then put into the base of the cost of medical care, and they are paid for by raising premiums and raising tax money that goes into health care. So there is a problem there. So trying to balance how do we keep our technological edge and make it available with the costs of it, we have made several suggestions.

One is that there ought to be more cooperation

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among hospitals in a community so that they all don't have to go out and buy the same machines, because what we have seen is an explosion of CT scans or MRIs or other advanced technology as a competitive device. Every hospital had to have their own, because the hospital down the street did, and there has been no way to cooperate across those kinds of lines.

And the antitrust laws have stood in the way of that cooperation. Hospitals which have tried to ban together and to say, "Let's build a joint high tech center where we'll put the community CT scan and the community MRI, and we'll all share the cost" have been forbidden to do so by their hospital lawyers, who have said that will violate the antitrust laws. So we're trying to change the antitrust laws so there can be more real cooperation.

We also believe that we ought to be creative on how we use this machinery. We ought to be using it 24 hours a day. You ought to give people a discount if they'll come in at 11 o'clock at night to get their CT scan instead of 8 o'clock in the morning. And, that way, you've got more use out of these machines over a longer period of time, which we think makes a lot of sense.

And then, finally, one of the big debates in this whole health care reform is, how will we control costs, and who should make those decisions? Up until now, the decisions have been made, on the one hand, by the federal government through Medicare and Medicaid and, to a lesser extent, by state government and on the other by insurance companies.

And what we have found is that that idea that we could control the cost of procedures, that we could come up with these complicated systems for you to determine how much you could charge for a particular diagnostic test and all of that has added billions of dollars of cost to our system.

The President's approach is very different. He says eliminate all of these interfering, overly regulating kinds of price controls, so you can only get so much if you do a certain procedure. Instead, set up in each state and in each large urban region a budget for health care. And then, you all make the decisions. If you need another MRI, the people of Philadelphia, through a planning effort, should decide that they want another MRI. It shouldn't be determined by an insurance company or the government.

So let's make better use of the systems we have

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got. Let's try to promote their use in a more efficient way. Let's share them. And then let's have that decision about technology made at the local level, where you know a lot better than somebody else does.

DR. KATZ: Thank you.

MR. FASTMAN: Mrs. Clinton, my name is Alan Fastman (phonetic). I am chief of staff for state Senator Artie Williams, who is the chairman of the Senate Public Health & Welfare Committee in Pennsylvania.

As you must know, while you and your husband have worked so hard to advance the national health care reform plan, there is a plan in Pennsylvania that has been advanced by Governor Casey and is now under consideration in our committee.

And, as you have traveled across the country, Senator Williams and the committee have traveled across Pennsylvania gathering information and learning all that we can on these issues. And we are committed, regardless of what happens at the federal level, to addressing the problem of health care reform in Pennsylvania.

My question is, as we are moving independent of the federal government, we feel that we should also be taking with the federal government. And we believe it would be productive for our committee to be talking with you or your staff on these issues. And I wonder if you agree with that. And, if you do agree with that, I wonder if you would tell me how to facilitate that.

MRS. CLINTON: Well, I do agree, and I also agree that Pennsylvania has been a real pioneer in a lot of health care reform. All during my Congressional testimony, I held up the Pennsylvania cost containment studies, because what you have done to try to really understand the costs of certain procedures and be able to make comparisons on quality outcomes is rather unusual. It hasn't happened in many other states.

And I'm very grateful to Governor Casey for his leadership, because I think the plan he has come forward with is in line with what we are attempting to do at the federal level. And we will contact you, and we will set up a time for a meeting so that you can meet with the people in the Administration who are working on this.

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There have been, I know, many meetings between governor staffs and administration, personnel but, you're right, not as many between state legislative staffs and representatives and Senators. And so we should move on that, and we will.

DR. KOOP: Number one.

A PARTICIPANT: I was wondering why such an important issue with children's health care wasn't addressed sooner.

MRS. CLINTON: Very good question.

(Applause.)

MRS. CLINTON: Well, let me just say a word about this that was referred to earlier. You know, 46 years ago, way before you were born, slightly after I was born, Harry Truman, in this very hall, accepted the Democratic nomination for President, and he did not mince any words, as President Truman didn't.

He said, "The nation suffers from a lack of medical care. But that situation can be remedied any time the Congress wants to act upon it." And that was exactly his attitude. And he tried to get health care reform. President Nixon tried to get health care reform through an employer-based system. President Carter tried to get some health care reform.

But at every time we tried, the voices of children, the voices of people who work in children's hospitals, the voices of parents with children suffering from leukemia or cystic fibrosis or other chronic diseases were way overwhelmed by the voices of commercial insurers, by the voices of independent insurance agents, by the voices of all other kinds of interests who, frankly, liked the system just the way it is.

And so, this time, we feel a special obligation to try to do all that we can to take care of this problem, so that when you grow up, you won't be able to ask that question again. So I want to thank you for reminding us what this is really all about.

(Applause.)

DR. KOOP: Microphone two.

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DR. MEVIN: I am Bill Mevin (phonetic). I'm a pediatrician, a family physician, and a family physician educator. And we want to thank you, Mrs. Clinton, for what you're doing down there in Washington. And most of the people in this room support you completely.

And thank you, Chick Koop. You were one of my teachers when I was a student across the street.

I have some concerns about the availability of generalist physicians to take care of the people that we're going to cover with universal access, which I applaud completely and totally. I'm also somewhat concerned about the health of the academic institutions.

Right now, the system is rigged -- certainly, terribly rigged against generalists. We have way too few physicians going into primary care, internal medicine, pediatrics, or family medicine. Many of the residents across the street that start out in pediatrics end up subspecializing, so that fewer than 25 percent of the physicians now in the training programs will end up as generalists; the other 75 percent may be termed "partialists."

I didn't make that word up. It's one of the current buzzwords in, at least, family medicine education. We have some real concerns --

(End tape 1, side 2.)

DR. MEVIN: -- so that we can take care of the folks out there in the trenches.

Thank you.

MRS. CLINTON: That is a very important question. I want to say a word about it. Then, I would like Dr. Koop to address it, as he has in my presence many times in the past months.

You're absolutely right. If we don't change the mix, both the existing mix and the pipeline mix that is in our medical schools, we will not be able to deliver on our promise of universal coverage for every American. If we do begin to change that mix, then, it will still take a number of years, but we'll be able to get into a better balance.

So we're going to try to change the incentives for

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the funding of residence programs to try to begin to fund more generously those that train primary care physicians. And we're going to try to do what we can to encourage the placement of primary care physicians in underserved urban and rural areas, which will be at least something of a financial incentive which doesn't currently exist.

And we're going to do a lot with loan forgiveness and other kinds of financial assistance for generalists. And, through technology, we're going to be linking those generalists with academic health centers, so that they aren't isolated, but they will have the backup that they need.

But Dr. Koop is eloquent on this subject.

DR. KOOP: I think that your figures were even generous. In 1992, the number of graduates of our medical schools heading for generalist practices was only 19.4 percent. I think that you have to think about how we got in the situation we are. Why don't we have more generalists?

I think, first of all, when those people who would like to be generalists look forward, they see very poor pay, and they see no prestige. And when they look behind them, they see an overwhelming debt.

Now, actually, all of those things are addressed by the President's plan, because the plan mandates that, before long, 55 percent of graduates of residency programs will be headed for primary care. And "primary care" is defined as general medicine, family practice, pediatrics, but also OB/GYN.

Secondly, the academic medical centers, I think, are quite well-protected. And, as a matter of fact, when it comes to numbers, there's $5 billion more available to them in the future than there has been in the past. And there are incentives to turn our primary care physicians. There is also a provision which makes it possible for those who choose primary care to have forgiveness up to a point of their accumulated debt.

And then, finally, the thing is not just attracting young men and women into primary care but keeping them satisfied when they get there. This, I'm spending an awful lot of my life on now, because the Koop Institute at Dartmouth is trying to make primary care more exciting, more rewarding, and more fulfilling. And what we want to do -- and we have the technology -- is to take the medical center

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to the primary care physician when he wants it or bring him into the medical center when he wants to come without moving a single body.

And the nice thing about all this is that the imperative by the Vice President, in reference to high tech communication, fits beautifully with this. I would go so far as to say the most important part about health high tech communication is the generalist. And I would go further than that and say, unless we do have that high tech communication, health care reform cannot succeed.

MRS. CLINTON: And I would just add that internists are also -- there's five groups, that internists will also be included in the primary care physician definition.

And I just think it's so important what Dr. Koop is pointing out about how all these pieces fit together. And one of my fears is that the debate in the Congress will get bogged down, and people will say, "Let's do the easy parts. Let's just pick out what we can get through the Congress," and these huge issues, like workforce makeup and technology, which are really the cutting edge, will get just shunted aside because they're a little more complicated, and they'll take a little more changing to get done.

Many people told us, "Just send up, you know, a 20-page bill, and let the Congress fill in the blanks and claim victory." And what the President really wants to do is to have a system that will work. And this workforce issue is critical to making it work. So thank you for raising that.

DR. KOOP: Microphone number 1.

MR. NORRIS: Hello. My name is Bill Norris (phonetic). I'm an information systems specialist, and I recently completed work on a managed care system for a large chemical firm.

My question deals more with cost. Skeptics argue that any governmentally administered health care plan will merely increase the bureaucratic overhead and drive up health care costs. I look at the current government administered programs of Medicare and Medicaid, and they are fraught with waste and mismanagement. And it becomes hard for me to imagine a streamlined, efficiently-run government program which will drive down the cost of health care.

I know you've presented us with several ways of --

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it's going to reduce paperwork, et cetera, et cetera. However, if it's going to be as instrumental as is being touted in helping to reduce the eventual budget deficit and the budget crunch that we're experiencing right now in this country, are you planning to provide any provisions in this that we won't pull money from future revenues to pay for current health care problems?

MRS. CLINTON: Yes.

MR. NORRIS: You are? Do you have that as part of the proposal, that when the money runs out, it's out?

MRS. CLINTON: But that's not going to happen. I mean, if you know anything about how the system is funded and costs are derived, as you do from your description, you know that the vast majority of money comes from the private sector and that the private sector is also rife with fraud, abuse, and waste, some of which I have alluded to.

And what we are doing is trying to build on the private sector. This is not a government health plan. This is a plan that requires all individuals and employers to contribute to what already works for most individuals in America who are well-insured. And that money, then, is pooled together not to deliver health care, but to bargain with health insurers to get better prices than are currently available to most Americans.

The very largest of our companies can bargain effectively on their own. But small businesses, medium-sized businesses, self-employed people, families, they cannot. So we pool them together. But the pooling arrangement, which we call an "alliance," does not deliver health care.

It bargains with and makes available to all of its subscribers the various plans that will deliver health care. Then, it will be up to the individual to make that decision. So the vast bulk of the money is private sector money.

Now, at the same time, we are going to be reducing the rate of growth -- not the amount spent, but the rate of growth -- of Medicare and Medicaid, because even though Medicare can claim to have very low administrative costs -- it runs at about a 2 to 3 percent administrative cost in Medicare -- it is still spending more money unevenly around the country for various services that seem reasonable, when you compare how those services are paid for in competing parts of the country or even within a state like

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Pennsylvania.

So, by reducing the rate of growth, we are taking that money and providing new services to Medicare patients, namely, prescription drugs and long-term care. But it is within the amount of money that was already budgeted to be spent. And under the President's plan, there is no automatic entitlement. You have to appropriate new funds in the future if, for whatever reason, as unlikely as it seems, there is not enough money.

The alternative is to continue doing what we are doing, which, even though we have a very good year economically now in the country, and we're grateful for the economic package. We're getting better deficit reduction than we even predicted. The deficit is, for the first time, on a true downward slope. Discretionary spending is on about a 45 degree downward line.

If we don't control health care costs, then the deficit starts building up again, because the baby boomers will start getting old and start being eligible for Medicare. And the poverty level, which has increased, will put more and more people into the Medicaid population.

So, if we do nothing, then what you're describing is exactly what will happen. We will continue to have to spend more and more money for the same health care. If we reform the system and control costs, we will not have to make those kinds of decisions.

So the status quo is our real enemy. As Dr. Koop said about the public health system, you can say it about the entire medical system. The real enemy is the status quo. And the very large businesses will continue to make their best deals, and everybody else will pick up the cost. And the federal government will then have to come in through Medicare and Medicaid, deficit spend to be able to pay for that. That's what we're trying to avoid, and we think we can.

DR. KOOP: For all the bashing that Medicare takes, I think we should realize that it has done a tremendous amount to take a lot of the fear and the anxiety out of the frail years of elderly life. And it should stand as a monument, I think, to the basic decency of the American ethical core.

And the First Lady mentioned a figure of 2.6

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percent administrative cost. The administrative cost of private insurance companies is exactly 10 times that, 26 percent.

MRS. CLINTON: So when you talk about waste and fraud, don't just point your finger at the government programs. Point it at the commercial insurers who are raking that money off at everybody else's expense.

(Applause.)

DR. KOOP: Number two?

MS. FALCONE: Thank you. My name is Christina Falcone (phonetic). I'm the self-pay inpatient collector at Children's Hospital. I'm in the back room, and my job may go out the door. I don't mind that. Actually, I'm glad that that might happen, because I accept the issue, I think it's a real issue, and I think we need change.

My question is, why can't we develop a system that eliminates Medicare/Medicaid? Why don't we have a universal system for everyone? Why can't we create that?

MRS. CLINTON: Well, we are going to eliminate Medicaid. Medicaid will be integrated into the universal system. Medicare is already a government-funded system.

How many of you know how Medicare is paid for?

MS. FALCONE: By us.

MRS. CLINTON: Right. Every paycheck, a certain percentage comes from your employer and from you to pay for Medicare. Most people don't know that. I don't know how they think Medicare is paid for, but it is a payroll tax on every working American to support health care for people over 65.

MS. FALCONE: Excuse me. I was only talking about the medical aspect, not the entitlement, not the cash --

MRS. CLINTON: I'm not talking about that, either. That's how Medicare is paid for. That's where the money comes from for the federal government to reimburse your hospital when you bill Medicare.

As Dr. Koop says, we have actual done something right with Medicare. We take care of people over 65. And,

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when Medicare was passed 30 years ago, those were the most medically needy people in our population. We don't want to do anything that undermines or in any way harms Medicare, because Medicare is working for older Americans.

What we would like to do is to provide an opportunity for older Americans to decide if they want to get their Medicare through managed care or through the traditional fee-for-service network, because managed care, if they move into the universal system, as many are now doing in places like California, will provide them more services at less cost.

But we also don't want to mandate that until we get the rest of the system up and going and see if it works. I mean, I can't go home and tell my mother, who has got Medicare -- and most Americans don't have anything, at this point, that is guaranteed like Medicare is -- that we're going to change Medicare unless we can see how it can work.

So we hope that in the years to come, Medicare recipients will actually get their health care through alliances and through managed care and that, eventually, it will be a moot issue, we'll be able to integrate it. But we're going to actually integrate Medicaid to start with.

MS. FALCONE: Thank you.

DR. KOOP: There are two traits in our American cultural personality that can either impede or accelerate health care reform. That's altruism and individualism. I think back in the heady days of the Great Society in the early 1960s, it really was altruism that brought about Medicare.

I'm not so sure now that it isn't individualism that is propelling most of the concerns of the American people. And that is a bother, because we are essentially saying we are no longer our brother's keeper. It's a difficult plan to look forward to if we don't share some of the problems with those who are in real need.

And a poll taken by Gallup about a year and-a-half ago indicated that 70 percent of Americans were deeply concerned about those who did not have insurance, deeply concerned enough to want to do something about it. But when they were asked if they would be willing to pay as much as $200 per year in additional income taxes, 70 percent shrank to 20.

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MS. GARLAND: I'm Amy Garland (phonetic). I'm a research technician at Children's Seashore House across the street. Sometime in the next five years, I would like to be a part of that 55 percent of a graduating medical school class going into primary care. I'm happy to be able to say that I won't know a time before the Clinton plan as a physician.

Listening to you and everyone's questions, it's clear to me that part of the point of this plan is to make the medical care system easier for more people to use and available to more people. At its simplest, it seems to me that health care is a physician or a community of physicians and their facilities and a patient.

MRS. CLINTON: That's right.

MS. GARLAND: As the system is now, there are all kinds of things going on in between these two participants in the health care system, a lot of them motivated by profit-mongering interest, perhaps. Perhaps someone only as uninitiated into the system as I could ask this question. Why are we letting the insurance companies still play this game?

(Applause.)

MS. GARLAND: Obviously, they have demonstrated that their interests in the past haven't been the same as the interests of the health care needing public or as the interests of the health care providing physicians. What checks will there be in your plan to make sure that the interests of the insurance companies, which will still be deciding what options are available to doctors and to patients will be the same as the interests of the public well-being?

MRS. CLINTON: Well, one of my hopes is that other entities besides insurance companies get into creating health plans. Like this medical center that you've got across the way with all of its many parts could come together as a health plan and offer its services.

And so, in order to achieve that, we have got some seed money in the plan for doctors and hospitals and medical societies to actually use to help them create health plans to compete with insurers, because we fear what you're saying and want to be careful about that.

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On the other hand, insurers have a lot of experience in managing the financing of health care. And, if we level the playing field, and we prohibit them from doing what they have historically done and, instead, ask them to go back to being what insurance used to be, which was everybody pays a little bit, and everybody's in the big pool and then, when somebody is sick, they're taken care of, we think that will create an atmosphere in which innovation and all kinds of new ways of delivering medicine will be encouraged.

So that's what our thinking is about. You know, those who favor the single payer system make your argument, which is cut out all the middle men, have a big tax raise, which will save many Americans money, because you'll no longer have to buy insurance, and have the government, basically, run the system.

We rejected that. Not that we don't believe that the ultimate goal of universal coverage in a single payer system is the right goal, but we believe that in our system, in the American health care system, having different points of view about how to deliver health care and how to do it better so that there is some competing ways of getting the job done is, in the long run, better for us.

But you're right. We have to be very careful. We have to watch what the insurance companies do. And that's another point I would ask you to pay attention to in this debate.

The President's plan would move us toward what's called "community rating." That means everybody would pay the same. It doesn't matter whether you've ever been sick or how old you are. Everybody would pay the same. That's how we think insurance should operate.

Many of the other competing approaches would permit insurance companies to still determine whether you could get insurance at what price based on your age or your preexisting condition. So if we get community rating, we will solve a lot of problems that the young woman referred to with insurance companies.

And I know we have to close. I saw Dr. Koop get the signal. But I just want to end with this one last thought, since there's a lot of researchers in the audience and a lot of highly trained medical professionals.

At the rate we are going with medical research, we

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are soon going to discover that every one of us has a preexisting condition. Every day, there is a breakthrough. We now have 81 million Americans who have some kind of preexisting condition. By the end of the decade, I think the genetic research that's being done will include all of us. We'll be able to see what that gene is for cancer or for diabetes or for whatever, and none of us will be insurable.

So it is my fervent belief that we need to move now before we know any more about how sick we really are to make sure every American has the cheapest affordable health insurance.

Thank you very much.

(Applause.)

MR. NOTEBAR: Mrs. Clinton, we have several mementos for you. The first is a set of books that is available nationwide. It emanates from the Children's Hospital and its affiliated institutions, the Children's Seashore House and the Philadelphia Child Guidance center, along with our colleagues at ten University of Pennsylvania Medical Center. And it's our privilege to present them to you. They're particularly distinguished because each has a forward by Dr. C. Everett Koop.

(Applause.)

MR. NOTEBAR: We also have a plaque. And recall that our original visit was scheduled during the worst weather ever to hit Philadelphia in the winter. So this plaque reads, "This commemorative plaque is presented to Hillary Rodham Clinton in appreciation for her visit to our nation's first children's hospital, the Children's Hospital of Philadelphia on the occasion of her anniversary as our nation's First Lady."

(Applause.)

MRS. CLINTON: Thank you very much. And I want to give to you a copy of this little book called "Health Security," which explains the President's plan in very easy to understand language. And we'll leave some copies at the hospital for all of you who didn't get to ask your questions.

Thank you very much.

(Applause.)

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MR. NOTEBAR: Thank you, Mrs. Clinton.

I think her point about learning about all of our preexisting conditions through molecular biology is one that we need to pay attention to.

At this point, I would like to introduce Dr. John O'Donnell (phonetic), executive director of the very distinguished College of Physicians at Philadelphia, who will close our program.

Doctor?

(Applause.)

DR. O'DONNELL: Thank you, Ed.

Mrs. Clinton, Philadelphia is a bookish city, and so we have two more volumes for you. The first is the "History of the College of Physicians of Philadelphia" by Whitfield Bell (phonetic), which, in many ways, is the history of Philadelphia medicine. I'm sure that when its sequel is published, your visit here will not go unrecorded.

The second volume, which is more lenient of what we suspect to be minimal amounts of time available to you for leisure reading, is the college's portrait catalogue. We have taken the liberty of inscribing this to the President, as well as to you, and it comes with a standing invitation to visit and inspect the originals whenever you happen to be on 22nd Street.

On behalf of the College of Physicians of Philadelphia, we present these mementos of your visit with our highest esteem and very best wishes.

(Applause.)

DR. O'DONNELL: In case anyone is wondering why Dr. Koop is leaving the podium here empty-handed, we checked throughout the city and discovered that he already had one of everything. Actually, he gave us this gift of this wonderful event today, because he was able to bring together the White House and our institutions, for which we are profoundly grateful.

(Applause.)

DR. O'DONNELL: Mrs. Clinton, Dr. Koop, to extend

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the metaphor of health to politics, let me just say how refreshing it is, how therapeutically refreshing it is to listen to you and to understand that American political discourse in this critical area has gone beyond the sound bite to sound prescription.

We thank you very, very, very much.

(Applause.)

DR. O'DONNELL: Don't go away.

In 1887, when the College of Physicians of Philadelphia was founded -- tell me if she goes away, please. I'm not going to look back.

(Laughter.)

DR. O'DONNELL: And when the idea of Children's Hospital was a gleam in no one's eye, Philadelphia was the center of reform in American medicine.

Two centuries have transpired since that time. And history, as we all know, has a very annoying way of making yesterday's reforms today's status quo. But every so often, and usually in a moment of crisis, a voice emerges from some special arena of human endeavor with the courage to call for needed change and, more rarely, with the wisdom and with the persuasiveness to forge a new consensus.

At first glance, Philadelphia does not seem like the place to launch a new reformation. Today, one of the largest medical health care centers in the nation and, certainly, one the finest in the world, Philadelphia mirrors microcosmically the competitive tensions that confront health care reform nationwide.

But look closer at how we have recently been coping with these sorts of complexities in this city. We are witnessing how good will, forceful will, and intelligent cooperation has led to a political reformation in this city, which is the basis of its economic revitalization.

We have seen, also, how that same combination of leadership traits has led to a cultural Renaissance. We Philadelphians know that there is no reason why health care reform cannot be rekindled in the place where it began.

Mrs. Clinton, Dr. Koop, the Children's Hospital of

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Philadelphia is dedicated to practicing the most perfect medicine. The College of Physicians of Philadelphia exists to promote a better understanding of how that medicine relates to the rest of society.

Together with the many institutions that are so well-represented here today, we pledge to face head on the challenges you have prompted America to confront. We admire you, we thank you, again, for your visit.

And, ladies and gentlemen, now, we are adjourned.

(Applause.)

(Whereupon, the forum was concluded.)

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