10/21/93
Children's Hospital, Chicago

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PRESERVATION

Remarks at Chicago Children's Hospital 10/21/93

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THE WHITE HOUSE

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REMARKS BY THE FIRST LADY
HEALTH CARE BRIEFING
AT CHILDREN'S HOSPITAL
CHICAGO, ILLINOIS

MODERATOR: We thank you for coming. And we especially appreciate the attention that has (inaudible) to the issue of health care and at the same time your acknowledgment of Children's Hospital. We have all been worried that that would be lost somewhere, but we are grateful for you to see -- that you've seen that it has not been lost in your shuffle of what to do about to about results.

We're thrilled to have you. For most of us, it's a rare (inaudible) dream to see health care at center stage of a national health care policy, and it's no surprise that you would be the leader (inaudible) long (inaudible).

And if you have anything to share with us, that would be great. Every single person here has 10 questions. (Laughter)

MRS. CLINTON: Only 10?

Q (Inaudible) before we begin, we should introduce Morris (inaudible) with (inaudible) Rock, as one of your very first campaign promoters here in (inaudible). So --

MRS. CLINTON: We try to export people.

(Inaudible) a little while, bring them to Washington and export them.

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Q Morris, every afternoon (inaudible) your husband (inaudible).

MRS. CLINTON: Thank you very much.

Well, I really would much rather listen and, to the extent possible, you know, talk through any of your questions.

And I really felt so lucky to have been associated with the Children's Hospital for so many years in Arkansas and one that particularly grew so rapidly and well over those years. And I never stayed on the board quite long enough to chair the board, so I recognize that kind of life-long commitment to Children's Hospital and the awards that people have? And it's so gratifying because it's so important to stay committed.

We have worked very hard to be sure that children's needs and children's hospitals' needs in particular are taken account, and we have worked closely in association and (inaudible).

But we're going to need your continuing guidance and support throughout this process, because for me, what I see happening as we go forward will be a real struggle between those of us who think that we need to end up with universal coverage and comprehensive benefits that stress preventive care and emphasize prenatal care and well-child care? And others will attempt to implement only marginal forms once again and often at the expense of the most vulnerable populations.

It's very easy to talk about capping Medicare and Medicaid. That's something that people in Washington talk about all the time. And it would have disastrous consequences for children and more children's hospitals if that were to happen without reform taking place systemwide.

So there's, I think, a great desire to come up with a positive reform, but I think there is a lot of maneuvering behind the scenes to try to both limit and undercut and marginalize. And so I'm hoping that we will continue to have strong support. We have children's needs (inaudible) areas of (inaudible). But I'd be happy to --

MODERATOR: Can you take a few questions?

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MRS. CLINTON: Absolutely.

MODERATOR: I know the doctors (inaudible) have some questions. (Laughter)

Q Welcome, Mrs. Clinton. I am (inaudible). I'm a resident of the medical staff. And I'm also a pediatric ophthalmologist, one of those hopefully not soon-to-be-extinct specialists. (Laughter)

You and I are of the same era, only you chose to go into law school and I (inaudible) medical school. And I chose to become a physician because I wanted to be (inaudible), and I wanted to make my contribution in that manner. And that's part of my career (inaudible).

As you know, healing comes not only from medications and technologies that you were experiencing when your father was ill, (inaudible) was a trusting relationship involving your physician.

My question is: What is President Clinton planning to do about preserving not only that relationship (inaudible) physician and (inaudible), but (inaudible) not become (inaudible) patients (inaudible)? And how do you see our (inaudible)?

MRS. CLINTON: Well, I feel very strongly about that, and this is an example of what we're up against. The President's health care plan actually will increase choice dramatically for both patients and for the number of (inaudible).

(Inaudible) association that represents independent insurance agents has been running ads nationwide talking about how choice may be taken away. Now why are they doing that? They could care less about choice. They care about the fact that under insurance reform, they won't have a job.

But their job is to eliminate people from insurance coverage by underwriting risk or to make it very expensive by making the risk factors as precise as (inaudible) possible. And when you have universal coverage, you eliminate all kinds of underwriting that goes on now and make sort of conditions on insurance disappear that are in the marketplace now.

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There will be a lot of independent insurance agents who will be out of work.

So they did a survey which showed them that the most vulnerable part of the President's plan was to try in some way convince people they were going to lose their choice of physicians. That's the kind of thing we're up against.

Now, the facts are that in today's current environment, every day people are losing their choice of physicians. This hospital has seen, as it was in Arkansas, that as employers make choices and deals with insurance companies, the children's hospitals are being written out of policies because the cost of care is more expensive. And employers make the decisions, and insurance companies make the decisions, not the consumer, not the patient.

But in contrast, what we are proposing puts the decision-making authority in the hands of the consumer. Every year the individual may choose what health plan they intend to enroll in.

It eliminates the increasing practice of physicians being told if they belong to one network, they cannot belong to any others. It guarantees the existence in every area of a fee-for-service network, so that even if you're in an HMO, you have the right also to practice in a fee-for-service network. It does all of these things to try to reverse the trends that are diminishing choice in the medical system right now.

But because of a very clever advertising strategy, I have go around answering this question in every group of doctors that I ever encounter.

And I said, "Well, who told you that?"

"Well, I don't know. Somebody told us that."

But I think it's a -- I think it's a serious issue.

Now, it's also hard for me to say that when someone comes to me and they say, "Look, I have an ophthalmologist whom I love. I have a gynecologist whom I love. My husband has a cardiologist who he loves. And we all have an

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internist whom we love. Can we be guaranteed to see all four of them?"

The answer is yes if you enroll in a fee-for-service network, which is the traditional indemnity kind of insurance. But it will be more expensive, just as it is now. It costs more for that kind of policy than it costs to join an HMO or a PPO. That's not going to change.

But you will always -- assuming that all four of those doctors wish to be in the fee-for-service network, it will have to take every willing provider.

And finally, we are mandating that every network, whether it's a closed-panel HMO or a PPO or anything, has to be created (inaudible), has to have a point of service so that specialists, children's hospitals, cancer centers, others, will be available for referral.

So we have done all that we can think of to do to create choice and to enhance choice. But I imagine that we will be, you know, struggling with that issue quite a bit, because it is something that's going to be used as one of the primary scare tactics in (inaudible).

Q When is the next (inaudible) this?

(Inaudible.) One of the jobs that the President has had that (inaudible) there's some preference where children with congenital defects will have access to physical and occupational therapy and speech therapy. And (inaudible) appears to imply that congenital defects are not (inaudible) as the acceptable reason to have these therapies. Is that the case? Or can we assume that children such as ones who saw the (inaudible) Arkansas will have access to this kind of treatment?

MRS. CLINTON: Yes, I'd have to see exactly what you're referring to there. I'm not aware of that. I'm not -- I don't know what -- what that means. I will check into that.

My understanding is that the kind of therapies that are medically necessary or appropriate on either an outpatient or an inpatient basis that are being provided now would continue to be provided, and the funding that currently

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exists for low-income children who are not eligible for Medicaid but who now receive what are called in many states wraparound services for all kinds of occupational and rehabilitative (inaudible), I'd have to look specifically at the reference, because I don't know that.

Q Well, (inaudible).

(Simultaneous discussion.)

MRS. CLINTON: It was not -- as far as I know, unless there is some, you know, technical (inaudible) that nobody spoke to me about. But we'll check into that, and I'll give you a -- you know, a reference to (inaudible).

Q I'm Mark Meyers, and I'm the chairman of (inaudible) and actually (inaudible) that most of the people in the room probably won't know, because (inaudible) health care (inaudible) one-third of the (inaudible) that (inaudible).

MRS. CLINTON: Oh, you're kidding.

Q (Inaudible.)

MRS. CLINTON: Well, that's very reassuring.

Q We think you made a wonderful (inaudible). (Laughter)

MRS. CLINTON: Well, I guess then I -- how did you survive the beginning of ninth grade? (Laughter)

Q (Inaudible) as a response.

MRS. CLINTON: Oh.

Q (Inaudible.)

Q (Inaudible) became a psychiatrist, so -- (Laughter)

MRS. CLINTON: So you're working on it, too.

Q It's -- I just have to echo what everyone else has said. It's just a delight (inaudible) health care plan (inaudible) important part of the population (inaudible).

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You could probably, given what I do, anticipate what my question is, and that is (inaudible) nutritionists (inaudible) order that we're training in children's hospitals (inaudible) and about two-thirds of the pediatric physician scientists trained in children's hospitals. And, of course, one of the concerns among (inaudible) physicians is how we will continue to educate (inaudible) biomedical research (inaudible).

MRS. CLINTON: What we are doing is creating some (inaudible) we have price (inaudible), which was the most time-consuming and difficult part of this, because we wanted a comprehensive medical practice that really did give most people a good as they have or better than they have.

And in that, we have built in, in the premium bases, funding for academic health centers and for research, both for education and for quality as a part of the overall health -- and it's something that we have worked very hard on with a group of deans of academic health centers and we feel very comfortable that we've got enough money.

The distribution of that money we're working out -- you're having some advisory committees of academic health centers around the country created to help us from -- both in terms of education and in terms of the kind of quality research that we want to see done, how that money will be distributed.

One of our goals is to increase the number of primary care physicians (inaudible). The balance is so far out of what we need to be able to provide universal coverage right now.

That does not mean we are going to stop training specialists by any means, but it does mean that instead of only giving incentives, financial and otherwise, for the training of specialists, which is what we have done in graduate medical education for 20 years now in the medical area, we're going to start giving incentives for training primary care physicians. And, you know, it's one of the real jobs the academic health centers are going to have to help us with.

We're also changing the reimbursement schedules for primary care physicians. And we have identified internists,

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pediatricians, family practice -- ob/gyns because even though that sounds odd, that is the primary care physician for many, many women who go nowhere else -- and then, you know, just general practitioners, if there is such a thing (inaudible) left.

And instead of the reimbursement being skewed totally -- not only towards specialists as specialists, but toward a reimbursement based on diagnostic procedure and other kind of identified service, we're trying to provide reimbursement for clinical time for especially pediatricians for children and adolescents.

We are convinced that if we could reimburse for (inaudible) for parents and with children, we would have a better opportunity to make better diagnoses than sometimes we have time to do. So we're trying to change the number of ways we think will help support the training and education and practice of primary care physicians.

Q (Inaudible). I'm chairman of Radiology. One of the concerns we have at Children's Hospital is the fact (inaudible) we have a financial disadvantage (inaudible) many of our examinations and studies (inaudible).

(Inaudible) consumer. (Inaudible) and so this will be a major problem for us (inaudible). It's already occurring in California. (Inaudible) some of my colleagues (inaudible).

So I think we need a health plan (inaudible) care of (inaudible). (Inaudible) slows us down in ways that we may be able to provide service. But (inaudible) and (inaudible) sort of an extra benefit (inaudible).

MRS. CLINTON: I can't answer that specifically, but I'll get the answer for you. I know we have had long discussions with (inaudible). And we have gone over the differential costs in the care of children.

As you know, that while oftentimes when a child is not any bigger, the hospital (inaudible) -- they stay longer than they would the same diagnosis is an adult. And there are differentials. And I think we've worked out the formulas on that. But let me send that to you, because I don't want to -- I can't tell you off the top of my head exactly how

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they (inaudible). But it's an important caution because of the difference in adult and children in the way that they need to be treated.

I don't know that it is strictly a problem of managed care, because what we have found in looking at good managed care, as opposed to some of the (inaudible) --

Q (Inaudible) managed competition (inaudible).

MRS. CLINTON: Yes, but managed competition is a real misnomer. I mean, managed -- the President's plan is not managed competition.

There are competitive aspects of the President's plan that are very important to try to create a better marketplace and to try to give incentives for consumers to make more effective decisions and for hospitals and other provider groups to begin to make more cost-efficient decisions without necessarily affecting quality.

There will -- there are and there have been bills introduced in both the House and the Senate that are much purer managed competition, and I would frankly worry greatly about those.

I think this is one area that the medical profession in particular, but certainly specialized care facilities like this one, should be very vigorous, because what you will find in those proposals is that they fund the care that they provide by capping the tax benefits that anyone can receive at the lowest-cost plan, which means that employers will be pushing even more people into the cheapest possible managed competition plan.

And it will be, for me, a very unfortunate development if that gains much political currency, because there will be none of this sort of protective support that we've built into our plan, so that they've got different reimbursement schedules going to take account of different kinds of services that are available, et cetera.

So managed care is different. Managed care I think has some real strong features that, if done correctly, will enhance the care and will give you more tools as to how to use expensive equipment.

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You know, for example, you know, the kinds of technology that we now have available all too often doesn't become cost-effective because it isn't utilized sufficiently.

And we are now seeing some very interesting experiments done where hospitals and clinics are running their CAT scans and their MRIs 24 hours a day (inaudible) staff. And people get a discount if they're willing to come in at midnight for their CAT scan, instead of 9:00 to 5:00. They get a discount. Well, there are some creative ways of thinking about all of this that (inaudible) that kind of change that you (inaudible) think about. So I think there are some good (inaudible).

Q Mrs. Clinton, I'm Morris Carroll. And I have the misfortune of (inaudible) years in Canada before I came here eight years ago. I financed my residency by two years (inaudible) medicine.

My question is: How can we avoid (inaudible). My daughter is a nurse at a hospital (inaudible). And it's very bad for morale to see the funding restricted at the children's hospital to the point where they (inaudible).

MRS. CLINTON: Well, (inaudible) rejected (inaudible) system for a number of reasons. Although there are a lot of strengths in that system as well. And it's not all one side or the other, because they have reached universal coverage, they do do a better public health outcome than we do. And we know all of that.

But it didn't seem to us to be much support for moving the system we have, which, where it works, works better than anywhere in the world. And we ought to try to preserve what works and then fix what doesn't work.

And so we have built up a public-private kind of approach that has been the hallmark of American medicine, and we are trying to avoid some of the down sides on both ends of the spectrum.

I mean, the kind of -- your top down, decision-making, and special financial decision-making that you find in Canada, which has consequences like you're talking about, compared to the sort of no holds barred competitive

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market-driven approach that some would like to put on the entire system so that if insurance plans don't want to use children's hospitals, they don't have to, and there's no point in even talking about it. We tried to strike this balance.

And that's one of the reasons why many people say, "Oh, you know, this is complicated. It would be so much easier if you just said, 'Oh, single-payer,' or if you just said, 'Oh, you know, managed competition,' because that's so much cleaner."

But we think both of those have serious problems that would undermine the long-term quality and viability. So we've tried to build in many, many safeguards in our system that we think will protect against that.

Now, will there be a transition period? Yes.

Will we see many regions of our country lose hospital beds because they're over-bedded? Yes.

Will we see practice styles have to change when we know that, for example, Medicare -- (inaudible) figures on that -- in Miami is taking care of at three times the cost of the Medicare recipient in Minneapolis without any difference in quality, something is going to have to change in Miami? Yes.

Will some institutions adjust better than others? Yes.

Will morale be high in some and low in others? (Inaudible.)

All of those transition issues will undoubtedly have to be faced. But I think we have at least tried to analyze all the different forces at work so that we have built-in protections against what we consider to be unfortunate, unintentional consequences. But you all will have to help us.

But that's one of the reasons that we've adopted this hybrid, you know, as Americans (inaudible) American (inaudible) instead of looking to anybody else and instead of buying what I think are the very dangerous line which is "All

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that this health care system needs is real market competition," without any regard for the kind of safeguards.

You know, health care is not traditional market risk, and there is no market now health care. And yes, we want more competition in the sense that we want people to be more efficient and be more creative and make some different choices of the health care they want and what they support.

But we'll never -- I mean, when we admit a child into an emergency room, the parent (inaudible) stand there arguing (inaudible) what medication they're going to use or what services they're going to -- you know, (inaudible) that's not how it should be. So that -- those are the two extremes, and we're trying to avoid both of those extremes.

Q (Inaudible) -- before you get this marvelous presentation --

MRS. CLINTON: (Laughter.)

Q -- I would like to simply point out that I've had a lot of battles (inaudible). But don't underestimate good will. So regardless of political (inaudible), you've got the right idea.

MRS. CLINTON: Well, the one thing that I hope -- and I'm so grateful for all of your questions -- and this is going to be a long education process for everybody. And there will be so many interests committed to derailing this. And we have to be so vigilant about what they're really saying, what their real perspective is.

And I think if we do that and if people stay in good communication, we've got very good relations with the American Academy of Pediatrics and the other representatives of groups that we're working with who stay in good communication with each other, we can work out a lot of these details (inaudible).

You know, this legislation goes (inaudible) -- I mean, as hard as we've worked, we're going to have to have glitches in it. I mean, one of the problems that we have is we're not living in the same time that occurred with Franklin Roosevelt's Social Security, when we could say, "Got a new deal for you. Put the money in, one of you work, it'll

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take care of you when you retire." And the whole Social Security bill was 32 pages long.

He didn't have to go around and say, "Well, you know, actuarially speaking, if you work 40 quarters as opposed to 38 quarters" -- (laughter) -- "if your spouse worked or didn't work."

But, I mean, we're living in such a skeptical, questioning time, that we have opted to try to answer every question we could think of in the legislation. So it will be long. It will appear complex, because it cross-references all of the, you know, bills that are changing. We're integrating Medicaid into the system, (inaudible) that you do not have to deal with a separate reimbursement system. You do not have to even know that a child is a Medicaid recipient. It will all be taken care through the universal system.

So we've done a lot of things, and that means it's going to be very lengthy. And there will be many opportunities for people to, you know, say, "Ah-ah, we've got you," and you know, "Page 742 doesn't cross-reference with page 933," and all that. (Laughter.)

And that's why I've always said, you know, these details we will get worked out. That's what the legislative process is for. But if we can stay focused on the overriding principles and guarantee at the end of it we have universal coverage and nobody falls through the cracks, that we've got sufficient protections for children, I think we'll be fine. And that's where I want to (inaudible).

Q Speaking of --

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