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Georgia Baptist Medical Center

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QUESTIONS AND ANSWERS WITH THE FIRST LADY
AT GEORGIA BAPTIST MEDICAL CENTER

Q Now that those of you who thought that my introduction was a little exaggerated know that you're wrong, we can get on with the questions. This afternoon we are going to be focusing initially on urban issues for a few minutes, and I will pose several questions to the First Lady. These are not my questions. These are questions that I have picked up repeatedly as I travel around the country.

The first of these: if the possession of health security cards encourages people, as we hope, to seek more timely primary care, won't urban hospitals, already short on primary care physicians, end up, at least for a time, where they are now, treating all of these patients in already overcrowded emergency rooms?

MRS. CLINTON: Dr. Koop, what we believe will happen in underserved urban areas is that, with secure funding streams, so that patients are actually able to pay for the services that are being delivered, there will be a much stabler financial base on which hospitals in the urban areas can plan for the future and develop services.

We also know, though, that during this transition there will be some tough challenges for underserved areas to meet and there will be funding for essential community providers that will be available to hospitals in both urban and rural areas, to see them through this transition.

But the most important change will be they can begin to plan because their population base will finally have a secure funding stream that they can count on, and we intend to increase some of the reimbursement levels under both Medicare and Medicaid, to eliminate what have been disparities in payments for both urban and rural practitioners and hospitals in the past.

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Q I think another thing that people forget is that, when every single patient is covered by insurance, the income of all medical facilities go up. Therefore, a hospital in a city like this could very easily go out and open satellite clinics and find them not only breaking even but, indeed, profitable.

A second question, Mrs. Clinton, on the same subject. Overcrowded emergency rooms of inner-city hospitals have borne the brunt of primary care in the cities. They have been underfunded and understaffed.

Will they now face new competition with financially stable suburban hospitals perhaps opening city clinics or, maybe, with upscale private city hospitals, or because of decreased revenues from intended cuts in Medicare and Medicaid?

MRS. CLINTON: That really follows onto the first question, and let me just amplify what Dr. Koop said, because it may sound odd to some of you to say that inner-city hospitals will have opportunities because they will be financially more stable than they ever have before. But there are also opportunities for partnership.

For the first time, populations that have traditionally been avoided by some medical systems and insurance companies will no longer be avoided because they will have a funding stream that will come with them and, as I said, the disparities in payments between the public and the private systems will be eliminated.

(End tape 1, side 1.)

(Begin side 2, in progress.)

MRS. CLINTON (continuing): -- there and are there inappropriately. Will there be competition for urban patients between inner-city hospitals and, perhaps, suburban hospitals or private hospital? Well, I hope there is. I hope that hospitals that have never given a thought to practicing in inner-city Atlanta see an opportunity there and I hope that that makes the inner-city hospitals get as smart and efficient as they can be.

The inner-city hospitals, if they are well run and well positioned, should have an advantage because they have

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been the primary caregiver for that population so that, when it comes time on an annual basis for individuals to join up with health plans, it should be an advantage that they have been there taking care of those patients.

It can be an advantage that is overcome if other hospitals and other networks of physicians see an opportunity and decide to go after those patients. That's how we are hoping that more market-driven competition will actually enhance the care that is available in underserved areas today.

Q My last question has to do with manpower. Because of the obvious need for more primary-care physicians the medical professional is now attempting to turn out generalists as fast as possible and in higher numbers. So is the nursing profession trying, with added nurse practitioners.

Has any thought been given to looking down the road so that we don't have more professionals in primary care than we need in, say, 15 years?

MRS. CLINTON: Yes. We have tried to foresee the need for primary-care physicians and we are doing several things. We are going to be changing the mix of residencies. You know, we have gotten the residencies that we have paid for.

Medicare has funded specialists and subspecialists over the last 20 years and we have funded an oversupply of specialists and an undersupply of primary-care physicians. We are going to be increasing until we reach approximately 55 percent of the residency slots in the primary-care physician practice areas.

At the same time, that will take a number of years. We know that we cannot get there if we start with the current medical class and the current residency mix, when the bill is finally passed. So it's going to take a number of years before we reach what we think is an appropriate mix of primary-care physicians and specialists.

As you said, Dr. Koop, we're going to have to rely on not only physicians at the beginning of practice but, with increased reimbursements as we are planning under Medicare and the health plan for primary-care physicians, we're hoping

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that perhaps even some practicing physicians will take up more of a primary care emphasis, even though they may also have a specialization, and we're going to have to look to nurses, particularly advanced-practice nurses and particularly, in underserved areas, if we expect to meet the needs for primary care that we should be meeting if we're going to have a comprehensive health care system.

Q Now we're going to take questions from the audience, and that includes the audiences at the remote sites. We have three microphones in the aisles here, and I'll take those in rotation, and I will alternate questions from this site with a remote site.

I'm going to start with Albany and ask Joe Stubbs (phonetic), who is an internal medicine specialist and a community leader and the president-elect of the Dougherty (phonetic) County Medical Society, start off with the first question. Dr. Stubbs?

Q Good afternoon, Mrs. Clinton. I'd like to address my question with regard to office labs and the new, and the CLIA (phonetic) regulations that have been brought to the forefront recently.

In our office, as primary caregivers, we feel like that the office lab provides a great service to the patient as well as enhances the quality of service that we deliver in providing service here in Albany, Georgia.

The CLIA regulations have been a major stumbling block for us, and I was happy to hear at the last AMA meeting, when you more or less went to the lion's den there, and spoke about the President's health care reform plan, that you were a strong advocate of scaling back CLIA and scaling back a lot of other regulatory governmental agencies, particularly utilization review. I think that was, in large part, the reason why you got such a good reception there at the AMA meeting.

However, your efforts of scaling back CLIA in particular have seemed to be watered down lately and, in the final proposal presented to Congress, it seemed like a number of the specifics that you thought about, that you advocated doing, were deleted.

In particular, you had previously advocated trying

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to cut back on the number of inspection sites that were to be done, grandfathering in existing personnel, allowing an increased number of tests to be on the waived list. But now all that we see remaining here is that the registration fee will be waived for those wishing to have their labs be certified as a waived lab. Thank you.

MRS. CLINTON: Doctor, I appreciate that very much. We have worked very hard to try to bring about some changes in CLIA that we thought were offensive and oppressive to physicians, and we have a real uphill battle and the medical community is going to have to really help us on this.

We do have some changes in the Health Security Act but there has been an extraordinary resistance to changes because of abuses by doctors with referrals to facilities that they own and that they take a profit from. So somehow, we've got to figure out how do we eliminate the abuses in the system and permit you to do a strep test in your own office. I mean, that's the problem that we confront.

I am not satisfied that we have reached the best resolution. We do have some changes, as you acknowledge and we would like to continue to work with the AMA or any physician group to try to reach even a better resolution, but you're going to have to help us deal with the critics who have been very strong in saying that CLIA was designed, as a lot of these other things have been designed, to eliminate abuses. So how do we strike the balance?

I am very open to trying to get where we need to go with that because I think it's absurd for both private physicians and for public health departments to be hamstrung the way they are under the current provisions, but I am very conscious of the reason why we have those, which are abuses by physicians in the system. So that's what we have to work out.

Q Go to microphone number one.

Q Hi, Mrs. Clinton. How are you?

MRS. CLINTON: Hi.

Q Women's health concerns have been historically shortchanged, both by our health care system and our scientific research community. Your proposal calls for data

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collection on outcomes and practice standards. What steps will you take to ensure that the questions asked are appropriate to women's health needs and will result in the collection of data that is gender-specific?

MRS. CLINTON: I'm glad you asked that because I have to confess, I didn't really appreciate how serious this problem was until I got into the health care work that I've been doing. I've been blessed with very sensitive and competent and caring doctors all my life and I didn't really understand how many women feel very shortchanged by the medical system and how the research that we have done over the years for all kinds of reasons have left women out of all sorts of clinical protocols.

You may know this, those of you in this audience, - but the first clinical work done on breast cancer was done on men; and that's the kind of thing that I think is finally behind us with some of the new legislation that was passed that the President signed, setting up some specific responsibilities within NIH and other federal agencies to monitor women's health and to ask those kinds of questions and to collect data that will give us a much better picture of what's happening to women. So we are committed to that.

Q Number 2.

Q Excuse me. Mrs. Clinton, I'm John N. Tallis (phonetic) and I'm a family practitioner in Dalton (phonetic), Georgia.

Many of my patients are small businessmen. We've had some discussion concerning the changes, and they're concerned about how much they're going to have to put in, because their overheads are so tight. Yesterday there was an article in the "Atlanta Journal-Constitution" that suggested that, for the cost benefit for employees, it could go up to 33 percent.

You mentioned caps in your discussion. Could you give me an idea, please, as to how much you think, for the small businessmen, how much will they be expecting to put in under the new system?

MRS. CLINTON: I can give you an idea on that. Obviously, it will depend upon the size of the business and the wage base and all of that. But in general, let me say

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this, that for small businesses of less than 75 employees and particularly for small businesses of the ones you described, with usually low-wage employees and very tight margins, we are talking about capping it at no more than 3.9 percent of payroll and, for most small businesses, their percentage would be less than that.

One of the ways that we've been talking with small businesses is there are several costs which they have that they've had to absorb over the last years. One are increases in the minimum wage and the other are Workers' Compensation. They all have to deal with those.

If you go back and look at the minimum wage being raised, I think it's been raised three times. I think it was raised under Carter, Reagan, and Bush. And if you think of a minimum wage increase of about 50 cents an hour, there is no evidence that a wage increase of that amount damages small businesses and results in loss of employment.

What we are asking is a much, much smaller commitment than that. For many of the small businesses that you are concerned about in Dalton, it would be about \$1 a day to insure their employees. It would be 30 cents, a 35 cents an hour increase, less than a 50 cent increase for many other small businesses.

We have taken small businesses and looked at their costs. Now, for small businesses that already try to insure, this is going to be a windfall because they are the most discriminated of all insureds. You know, the average small business bears about a 40 percent overhead cost, and those of you who are in private practice who provide insurance for your employees, that's what you are paying. And, if you're in a bigger pool, it may be down to 20 percent, but you're still taking a big hit. That will be eliminated.

Secondly, we are going to begin to fold in Workers' Comp. costs. This is something that will happen over time, but we are going to start by folding in the health care part of Workers' Comp. so that you have 24-hour coverage, and it's not going to matter so much whether you were hurt on the job or hurt at home.

Think of all of the stories that are told every day in this country by people trying to get under Workers' Comp. You know, they come in, I bet they've begged you -- "Doctor,

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please, I twisted this knee at work." And you know darn well they just twisted it, you know, mowing the lawn.

But if you say that they did it when they were mowing the lawn, they are uninsured and you can't even take care of them unless you want to absorb the cost. So you sometimes -- and I'll bet everyone of you in this audience, because you're not that different from Arkansas doctors -- you have found yourself saying, "Well, yes, I bet you did do that at work, didn't you, Joe?" Well, we're going to eliminate that extra duplicative cost for small business.

I just want small businesses that are really small, that are self-employed, to realize they are going to be able to provide coverage for their families and they're going to get 100 percent tax deductibility, and they will provide coverage for themselves and one or two or three employees for less than what it costs them to get family coverage today under this plan.

So I hope people won't jump to conclusions but will look at the costs they're paying now and what we believe the costs will be.

Q Number 3.

Q I'm Tom Price (phonetic). I'm an orthopedic surgeon in Roswell (phonetic) and I'm a member of the Medical Association of Georgia; and I've had the privilege to chair the Health System Reform Committee for the Medical Association of Atlanta.

I encourage my colleagues to read the "big book." This is the big book. It has many specifics in it that I think might belie some of the generalities that have been presented. It's to those specifics that I would like to address my question.

Many of the concerns regarding choice, security, and quality that physicians raised before the Health Security Act was finalized have been addressed only in the provisions that deal with the fee-for-service plans and not in the provisions concerning HMOs, PPOs, and other managed-care plans.

How are patients in these plans -- that is, the majority of Americans -- going to have true choice and

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quality without changes in the antitrust laws allowing physicians to negotiate as groups and inclusive of any willing provider language or HMOs and PPOs that would give patients the security of freedom of choice of their physician and not just freedom of choice for a plan?

MRS. CLINTON: Well, both of those are in the big version -- antitrust changes and willing provider changes. You'll have to get the one that went in over the weekend. That was the first draft.

(Laughter.)

MRS. CLINTON: I mean, you know, wait until we get it finished. And it is now finally finished, thank goodness. But, in both of those instances, we have provided for antitrust changes that will permit physicians to band together to negotiate. Those will be extremely hard fought. We are going to have a big uphill battle in the Congress to get those provisions.

And, with respect to HMOs and PPOs, in addition to having willing provider opportunities so that any provider is able to join any network, which we are providing for, we also have point of service options required in every plan. So even if you are not a member of the plan, if you're the best thoracic surgeon in the area, there's a point of service option referral that has to be available in HMOs and PPOs, and both of those are in the final legislation.

Q I think there's something that could be made clear that puzzles many people. Usually when the White House delivers legislation to Congress, it's all over and Congress picks up the ball and runs with it. But this is a very different White House and it's a very different dynamic plan. As you're talking, it's being changed.

The First Lady is absolutely right. What you might think is set in concrete on Tuesday afternoon is changed by Wednesday noontime. So don't judge things until you're absolutely sure it's that way.

We now see Augusta on the monitor, and I would like to ask Dr. Ruth Neal (phonetic) to ask us a question. Dr. Neal has been a faculty member of the Medical College of Georgia, a radiologist for now 15 years. She's involved in community services there, including being the leader of the

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Augusta chapter of Jack and Jill which, as many of you know, is an organization that works with low-income youth and, currently, she is the second vice president of the Georgia State Medical Association. Dr. Neal.

Q Good afternoon. Health care efforts seem to be more focused on the supply side rather than addressing the demand side. As long as we have 13-year-olds having underweight babies, emergency departments crowded with gunshot and drunk driving victims, and people who smoke their way to serious chronic medical problems, can we really contain health care costs?

Is it fair to do little to address the increasing demand for more-expensive services -- for example, neonatal units, trauma centers, and critical care beds? What can we do to address these issues that, up until now, have been passed off as societal but that have very real and expensive impact on health care?

MRS. CLINTON: You're absolutely right, Dr. Neal, and that is one of the reasons why the President has spoken out about violence in a health care context, because we have to start drawing these connections.

When I was over at Grady (phonetic) in the rehab. unit, I met a young man who had been working -- in fact, his employer was there with him -- and he was carjacked and shot in the knee and whether he'll ever be able to work at that job again is up in the air, because of the injuries he suffered. So there's no doubt that we pay a much bigger price for our behavior than many comparable societies.

So there are several things we have to do at once, and we're trying to move on these at the same time. We are trying to make consumers more cost conscious about their health care. Americans, especially insured Americans and particularly those with first-dollar coverage, have not had a clue about how much it costs to get their health care, and we have paid a big price for that, because we have not had cost-conscious consumers who could participate in making decisions about their own health care future.

From now on, they're going to be making decisions every year about what health care plan to join and they will realize cost benefits. If they join an HMO, they will save money than if they join an indemnity plan, but it will be

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their choice and they will get the benefits of that choice. So that will be the first piece of this to change behavior.

The second is by emphasizing preventive care and, particularly, care like prenatal care, which we think can have long-term benefits for decreasing costs in terms of low-birth-weight babies and other problems associated with birth. We believe that preventive care, if properly administered and if people know that they have a responsibility to seek it out, will be able to help us control some of the problems that you spoke about.

Now, some of this, though, is beyond the purview of health care system reform. Some of this is the kind of people we are and how we expect people to behave and what sort of social messages we send and I'm hopeful that we will begin to have a breakthrough on that.

And it is related to health care in the sense that if you begin to tell people they will have health care and they will be taken care of but there are going to be certain consequences to that and, if you begin to send messages about how it is wrong to have babies before you're ready and to engage in drug abuse and other things that are self-destructive, those two things walking along together we hope will begin to change some of these disruptive behaviors.

Q Dr. Neal, I think I'm old enough to say this to this audience. And that is that this is a very complicated problem and, therefore, it will require a variety of answers. They will, of course, have to be national, which means regional and local, but it has to be also a public-private partnership.

But there is a sense in which every single citizen plays a role in how he personally will react to his obligations to take charge of his health. I can tell you that the things that are ascribed to me in smoking cessation during my tenure as Surgeon General could never have happened with the government alone. It took a government and private partnership, but it took the resolve of millions and millions of citizens.

And I think, although we always talk about the fact that we don't want the government doing things for us, when we ask these kinds of questions, we're really saying, "When are you going to do some more?" We've all got to do it

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together. First question.

(Applause.)

Q Mrs. Clinton, my name is Lindsey Durat (phonetic) and I'm a senior medical student at Mercer University. I've spent the last four years striving very hard to become the most educated physician I can be, working day and night so that I can be the best physician I can for my patients. I am now \$60,000 in debt.

After all of my efforts and sacrifices on my patients' behalf, your proposal plans to restrict my freedom to choose my career by mandating that arbitrary quotas are met of students becoming primary-care physicians, even though I feel I can become the most, the best physician for my patients as a surgeon. How will this improve health care quality?

MRS. CLINTON: Well, let me answer this in several ways. Nobody is going to restrict your desire to be a surgeon but the federal government has funded residencies for a number of years through Medicare. The government has provided the opportunity for physicians to make choices to be specialists and subspecialists. It has funded the infrastructure, it has funded the faculty, so that there has been a channeling of students into specialist kinds of residencies for over 20 years, largely created by the government which said, 20 years ago, we didn't have enough specialists.

Now, we don't have enough primary-care physicians. If the federal government is going to support residencies, there is a national interest in creating the appropriate mix of physicians. Now, that doesn't mean that you at this point in your career will be denied a surgical residency but you may, if you were coming into a surgical residency in five or six years, have to compete for a fewer spots. So if you were really good, you'd get one; but if you weren't, you might not, because we do have to have more primary-care physicians.

And it just is something that, if the federal government is going to foot the bill, it's something the federal government has a right to determine, what the mix is, and that's what we're going to doing.

Now, with respect to your loan problem, we hope to

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be able to make medical school and medical education more affordable by having many more loan programs at lower interest rates and many more loan forgiveness programs and also incentives for surgeons and primary-care physicians to go into areas where they are underserved and to pay off their loan by working in areas where people really need your services. And that will be available to specialists and generalists determining, based on what is the need in a particular community.

Q Dr. Rogers.

Q Mrs. Clinton, first of all, thank you very much for coming. We in this audience appreciate your taking time to listen to our problem that we have with delivering health care and I think it's important for all of us to understand that.

Dr. Koop mentioned the breadth and depth of your program and I think it is, in fact, very broad and very deep. And Mr. Clinton has said that universal access is the one non-negotiable part of this broad program that has been proposed. There are so many parts of it that are very expensive; there are so many parts of it that create large bureaucracies.

Would you please share with us, if you would, if it's possible, your priorities as you proceed during the next few months, year, to deal with the Congress as they fashion a bill that Dr. Koop pointed out to us will be a bill that is changed considerably?

MRS. CLINTON: Dr. Rogers, if I could, could I ask you what is -- what are the parts of it that are so expensive and bureaucratic?

Q Well, I think that, first of all, the national part of it is very expensive and bureaucratic, in my view. We have watched the development of a new board. We've watched the development of about four or five new councils or boards for graduate medical education, for drug review, and for quality. There are, to my mind, I think five national councils that have to be devised.

And then, on a state level, we've got to have the state providing the direction for the development of the alliances, and then the health plans. Now, we don't have the

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health plans in Georgia today. We have a few health plans, but these have all got to be developed within the private sector, so that there is, in fact, a large part of this that's new, that's going to be developed in the future; and it's going to be expensive.

MRS. CLINTON: Doctor, let me try to answer you in this way, because I certainly understand your concern and I would share it if I thought that were the outcome of where we are going, and I want to be as clear as I can so that we can discuss this.

What we currently have, if you could look at it from an aerial view are, you know, what, 1500 insurance companies with literally thousands and thousands of competing policies that are often more honored in the breach than in accordance with their terms, at least as the insured thought they were going to be.

You've got a huge bureaucracy that administers those insurance policies, that holds you accountable and your colleagues accountable. And then you've got the parallel bureaucracy on the public side with Medicaid and Medicare and all of their billing codes and their requirements, and on and on.

We are attempting to eliminate as much of that as possible. I have not met many doctors who will advocate for the preservation of the insurance industry as we know it today and yet it is the biggest piece of the bureaucracy that we have to eliminate in order to use the money that is in the system for better health care.

What we are trying to is, by eliminating all of that micromanagement, picking up the phone and having to call an insurance bureaucrat somewhere to see whether you can give the tests you want to your patients, hiring a person to be on the phone to argue with insurance companies about who gets paid how much.

We want to eliminate all of that and, instead, move toward a system which has much less either government or private insurance company bureaucracy. It may be a little bit of a leap because, as you said, here in Georgia, just like in Arkansas -- the head of our Baptist system is here with us from Arkansas today -- we don't have a lot of experience with different kinds of health plans.

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We have a lot of uninsured people in states like Georgia and Arkansas. We have a lot of Medicare and Medicaid people. And then we usually have a couple of dominant insurance companies that pretty much control the marketplace.

And what we believe is that, by moving to eliminate a lot of the unnecessary bureaucracy, you're going to be left with fewer insurance companies to have to deal with that will be run more efficiently and really give you less trouble in practicing medicine. And you're going to have different forms of delivering health care through health plans.

The Blue Cross/Blue Shield will be there, but it may also set up an HMO and you might be both in the HMO and in the indemnity plan. You're going to still be in your same office. Your patients are just going to sign up for different kinds of approaches and different co-pays in terms of what it will cost them.

In parts of the country where this has advanced further and where they see more people in more organized delivery systems, what they are finding, where it's well run -- obviously, you've got good and bad everywhere in terms of delivering health care. But, where it's well run, you are more likely to provide more services, more cost-effectively, by the elimination of all that bureaucracy.

The last thing in the world the President wants to do is to create any new government bureaucracy. This whole system is designed to push it down to the local level so that, you know, the Medical Association of Georgia can help run a network, the Georgia Medical Society can help run a network, the Grady Hospital and the Georgia Baptist Hospital, they'll be running the networks.

We see this as taking that kind of authority away from insurance companies and giving it to you. But now, many doctors are worried about that and are saying to me, well, you know, that's not something we have any experience with.

So we even have incentives in the plan to help give loans to groups of doctors so that they can compete with insurance companies, because we want you to, or that they can form multi-specialty clinics like Mayo, where everybody is on a salary -- and a very good salary, as those of you who know -- but they don't have to worry, then.

The surgeons at Mayo don't have to say to

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themselves, "You know, if I sent this woman over to the radiologist for the needle biopsy, then I take money out of my pocket that has to go to my overhead to keep all of my people living and I send it over to the radiologist because that's the way our system works now." At Mayo, the surgeon can say, "Go over to the radiologist." He's going to get paid no matter what.

It's that kind of difference in mentality that we think will actually free you all up to be less concerned about who pays you and more concerned about taking the money you're going to get and using it for your patients, and that's what we hope to see at the end of this process.

Q Microphone 3.

Q Mrs. Clinton, I'm Richard Cohen and I'm an orthopedic surgeon and I practice in the suburban Atlanta area. I thank you for coming. I thank you for allowing us this opportunity.

I'm concerned about your proposal for premium caps and other budget spending controls. These mechanisms would arbitrarily limit health care spending and, if they were directly tied to CPI and the gross domestic product, they would fail to take into account several important social issues: our aging population, technological advances, violence in our society, and other social issues that affect our health care system.

Mrs. Clinton, is it not true that recent figures on health care spending growth rates in almost all other industrialized nations have significantly exceeded their rate of general inflation and GDP because of the same forces?

MRS. CLINTON: I don't think that's true. I think it's true for some but it is not true for others and, you know, Germany had a special session of their legislature last year when their costs went up from 8.1 to 8.3 of GDP. They called in the legislature and, you know, made some changes in how they were funding health care.

Some of the systems are having some of those problems. Others are not. But look at the base from which they start. We're at 14-1/2 percent. They're at 7, 8 and 9. I mean, they have a long way to go before they are putting the kind of pressures on their systems that we are by our

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failure to try to figure out how to control costs.

Let me say something about the premium caps, because this is another area that I think has been misunderstood. Every time Blue Cross/Blue Shield of Georgia wants to raise its rates, unless Georgia is unlike any state I'm familiar with, it goes to your insurance commissioner, doesn't it? I mean, it says, "We want to raise rates for next year." And the insurance commissioner says, "Prove to us you can raise your rates at what rate, and we'll either say yes or we'll say no."

You have premium caps in Georgia right now. Every state in America does. If an insurance department says to a health insurer, "We're not going to let you raise your rates 10 percent; we're only going to let you raise them 6 percent," they are capping the rate of growth of that insurer.

So there's been this idea that somehow we're imposing some new kind of control over the system when what is going on today is that insurance departments can't compare apples and apples because Insurance Company X comes in and they say, "Here's what we offer, here's who we take care of, and we need to raise our rates this high." Insurance Company Y comes in. They take care of a different population. They have a different mix of services. So there's no way to really know whether the services are being fairly costed out or not.

The only thing we are looking to cap is the rate of growth in the comprehensive benefits package. There is no global budget in this plan. If somebody wants to have two facelifts a year, they are free to do so. We are not controlling anything beyond what we think needs to be contained, which is the cost in the comprehensive benefits package.

Now, how are we doing that? We are doing it by setting a budget of some kind of target that we think will be far in excess of whatever would reasonably be exceeded in any region that we have examined, and we have looked at the entire country. It will be based on experience.

It will be based on what are the costs that insureds are bringing to the marketplace. And how will we know that? Because every year, the health plans are going to

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be bidding on the services that they are going to be offering, like the Georgia Baptist Health Plan, for example.

So I don't think that this is as different or new an approach to trying to get some budgeting in this system that some people are characterizing it, but it will begin to compare apples to apples by looking at what the services are that have to be offered and asking insurers and asking health plans to be able to meet those targets.

And then, of course, there are provisions in the event of the kinds of contingencies you talked about, that we have a contingency reserve fund if a region is hit by an earthquake and a plague, we've got that built in, to try to provide some additional cushion.

And let me just finally say the underlying issue in the concern about premium caps is rationing, isn't it? I mean, people are worried that you're not going to be able to provide the services that you want. I assume that's the underlying worry.

I mean, some participants in the health care system, in addition to physicians, would be worried that their profits are not going to be as big as they need them to be, to show their return to their shareholders. But the real, underlying social and medical concern is rationing.

But we ration now all the time. Dr. Koop has told me that, based on the research he's done, that if an uninsured person and an insured person go into the hospital with the same ailment, the insured -- the uninsured person is three times more likely to die. We have all kinds of rationing in our system. And what we want to do is to provide a rational basis for comparing costs in different regions of the country and within regions so that we can begin to have you make more cost-effective decisions.

Q It has been transmitted to me that we are going to have a second question from Augusta. Is that -- we're now shifted to -- no, we're back to Augusta. Which is which? We're in Columbus. Okay. And here we're asking Tod Jarrell (phonetic), urologist, second-generation physician, a native of Columbus in practice for seven years. Dr. Jarrell.

Q Good afternoon, Mrs. Clinton. My question today is concerning tort reform. We know that many trial lawyers

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do not want any significant tort reform in the new system. I appreciate your concerns for changing the system with the certificate of merit for suits, the caps on the attorney fees limited to one-third of the award, but no limits on -- to impose caps on non-economic damage.

We were just wondering if you, as a trial lawyer, would be willing to work with the AMA, the American Hospital Association, and the Medical Association of Georgia, to significantly strengthen the plan's tort reform provisions and, is it fair to expect doctors, nurses, hospitals to reduce and eliminate health care services through managed care without providing adequate protection from malpractice liability?

MRS. CLINTON: Well, Doctor, I think that your question has several parts and we believe, actually, that managed care and better-organized care where you have more peer review and more accountability within your services will help to eliminate malpractice and negligence and will help to decrease the number of lawsuits that are legitimately brought.

And the other thing to remember is that this has been an area that has always been left to the states. You know, there is a huge division in the Congress between those who think we ought to have national malpractice reform and those who think you should not have any national legislation, it should all be left to the states.

We have tried to come up with what we think is a reasonable and responsible package of malpractice reforms, and the Congress is going to work its will on that. There are -- there are schools of thought ranging from much more severe approaches, including all kinds of caps of all kinds of damages, not just non-economic, all the way over to doing nothing; and we've tried to strike what we think is a very responsible middle course that we think we can get through the Congress.

The President is in favor of malpractice reform. He is not going to stand in the way of the Congress if they choose to go another way, except that he is going to hold firm on what he thinks the elements in his plan at the minimum ought to be. But the states are always free to do as much as they can get through their own legislatures and we are urging the states to do that. And different states have

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tried different approaches. I haven't found any doctor living in any state who is happy with anything.

So I think the bigger issue is, how do we get to the point where we have an atmosphere in which physicians who are practicing are doing so in ways that give confidence to themselves and their colleagues with these practice guidelines so that we can eliminate malpractice at its source and if, unfortunately, somebody gets through all the hurdles we put in their way, they are immune from the kind of obnoxious lawsuits that too many people have seen filed.

So we're going to stick with what we've got and we're going to work very hard to get this through the Congress, and we're going to need a lot of help to get this through the Congress. And if others can get something in addition that would work, we're not going to stand in the way of that, but we're going to urge that we at least get this through.

Q Doctor (inaudible)?

Q Mrs. Clinton, my name is Gerald Gussick (phonetic) and I appreciate that opportunity of meeting with you again as I did in Chicago this summer. I'm the residency director for the otolaryngology and head and neck surgery service here at Emory, which is a private institution. It's one of two university-based post-graduate residency training centers in the state.

As a subspecialist, as a super-subspecialist who deals with tertiary referral problems, I still feel that we have a tremendous impact on what makes medicine great in this country, and it is the technology that has been advanced in specialties like our own. And I think many residency programs and directors in subspecialties, as echoed by the previous speaker of this microphone are concerned as to the elimination of X percentage of the residency spots.

I don't think that anyone would argue that, you know, perhaps that there are too many subspecialists out in this country and that this may, indeed, cause problems with increasing health care. I would wonder what role you would have these specialty residency programs and everyone else participate in the reapportionment of those funds and those spots.

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There's -- you know, we graduate two residents a year and the Medical College of Georgia graduates two residents a year. That's four new otolaryngologists coming from the state of Georgia whereas the city of Philadelphia may graduate 16.

My plea would be that you would involve those specialty programs, the medical schools, the residency directors, in addition to those students, in the reapportionment of some of these residency spots and funding through Medicare, and that it be done in a rational manner, and have physician input, unlike many of the lack of input, I think, that many of us have felt with the previous input in the task, in the Health Care Task Force. Thank you.

MRS. CLINTON: Well, what you're describing is exactly what we intend to do. And with me today is Dr. Phil Lee (phonetic) who is the Assistant Secretary of Health in Health and Human Services, and we have worked very hard to create a system in which the medical schools and the training programs are the advisors for the decision making, and to try to eliminate some of the discrepancies that you've described and to try to key it to, you know, populations and to the kind of needs that exist for specialists and subspecialists.

Q I'd like to put the technicians on notice that, after the next question, I'd like to move to the next distant site. Number 2.

Q Mrs. Clinton, my name is Lawrence Sanders (phonetic). I'm the associate director for community health at the Cabot (phonetic) County Board of Health, a member of the Georgia State Medical Association and the National Medical Association, where I serve on the Health Policy Committee with a special emphasis on standard benefits packages.

I want to thank you for taking the time to address our House of Delegates at the National Medical Association by telephone and we look forward to seeing you in Orlando because we care for a number of people who bear the disproportionate burden of poor health status in this country.

And, along those lines, I want to shift the topic toward prevention, and I want to applaud the health plan for including prevention as part of standard benefits packages.

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Prevention is important as a cost-saving measure as well as a means to bring equity to health status among American citizens.

I have a two-part question:

Given that prevention, at best -- the returns from prevention, at best, occur over the long run, how long do you predict it will take before we see the results of our investment in prevention?

And two, how do we sustain the interest in making an investment in prevention -- both clinical preventive services provided to individuals and community-based services provided to populations by public health departments, while we wait to see this return on investment? Because we tend to be a short-fix, immediate gratification society with little interest in taking a long-term view and I think bringing an end to the disparities in health status requires a consistent investment in prevention.

MRS. CLINTON: I think that's right. It is going to take some time before we see the long-term, positive results that we anticipate. But I think we'll see some short-term results as well, as we move forward.

I think we can begin to see some changes in pregnancy-related and prenatal kinds of outcomes if we truly have preventive health care that begins to reach pregnant women. I think we'll begin to see an increase in immunization rates, because we are providing for that as part of the health-care package. We're going to begin, I think, to see people taking advantage of the diagnostic tests that are going to be covered under the benefits package.

So I think that the word will spread and people will be much more aware of preventive health care. And we do have provisions to support the public health functions while this is going on, because we know that public health is still going to be very important for many populations but particularly the underserved urban and rural population, and we hope that there will be more connections between public health, community clinics, and other providers of health care.

I was recently visiting with people in Toledo who they've taken the largest hospital in Toledo, which has now

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created a contract relationship with their community health center, and it's working out very well for them. It's something they've never done in, you know, 25 years.

So those kinds of changes in both enhancing the public health system and finding a new preventive-oriented role for it, I think we're going to see. But you're right, it's going to take some time. It's not going to happen overnight.

Q Could we have the next --

(End tape 1, side 2.)

(Begin tape 2, in progress.)

Q (continuing) There's been a strange dichotomy in the United States for years between private medicine and public health, between the doctors of medicine and the doctors of public health. I think one of the most encouraging things to me about the President's plan is that there are so many opportunities in the future for bringing private medicine and public health together, not just on a personal basis but where each understands the other's profession and helps that person to practice it to the best of his ability.

We now turn to Macon and Billie Jackson, a dermatologist involved in community activities will now give us the first question.

Q Mrs. Clinton, thank you for taking my question this afternoon. We've heard it said earlier this afternoon to Dr. Neal that if you choose an HMO plan, you will save money but yet, we've also heard you promise the patients that they will have true freedom of choice.

But it seems that in the fee-for-service plan, which most of my patients say they would prefer, that that plan is not going to be as available to them. My patients are concerned that they're going to be forced to join an HMO plan because they're going to have to pay part of that premium and that's all they're going to be able to afford.

Even your plan's language seems to imply this. The HMO plan, the PPO plan, is called a "low-cost-sharing plan." That plan provides full coverage for hospitalization. It

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required a minimal co-payment for doctors' visits and for prescription drugs. Yet the fee-for-service plan is called a "high-cost-sharing plan" and patients are not going to be able to choose that option.

How can you say to our patients that they're going to have true freedom of choice when their preferred choice is actually going to be priced out of their range?

MRS. CLINTON: Well, I think that's yet to be seen. It depends upon how fee-for-service organizes itself. There isn't any question that organized delivery is more cost-effective and costs less than the traditional fee-for-service network.

Now, the fee-for-service network which we are guaranteeing in every region is going to be run by local physicians. They're going to be able to set the costs for that. They're going to be able to negotiate what they think their fees should be as they try to sell their plan to people to join them.

But, you know, it is something that I am a little bit bewildered by because when you have a traditional fee-for-service network, even though many people prefer that, there is not much difference between the fee-for-service networks and many of what are now being called the preferred provider networks if you don't eliminate the opportunity for physicians to join. And, if physicians are free to join more than one network, then why do you want your patients to have to go to the fee-for-service network if they can get your services if you join one of the organized delivery systems?

And I guess part of my bewilderment -- and I know that there's a lot of concern in this audience and among Georgia doctors over the traditional fee-for-service network, but I really think that, if you organize yourselves into networks, then you are going to be able to provide your services to your patients in a more cost-effective way.

If you, for example, pool resources so that you're not all paying an accountant, you're not all paying a bookkeeper, you're not all having one person on the phone going on and on about issues but, instead, you have that pool, it doesn't in any way interfere with your clinical autonomy but it will actually save you money which can then be used to provide more services to more people in a more cost-effective

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way.

So I think there is an issue of experience and comfort here that I know is not easily overcome if this is the only alternative that you've ever had; but it will depend upon how you organize yourselves in Georgia and what kinds of services you offer at what costs in all of these forms, including the fee-for-service. You all will control what the costs in the local fee-for-service networks are because you'll be setting them.

Q Number 2.

Q Mrs. Clinton, first of all, thank you so much for coming to Georgia. You honor the health care providers here in our state by being here.

The Health Security Act calls for less paperwork but increased quality assurance. It also calls for uniform reporting from the health plans to the providers. I work in a physician's office so I know firsthand how much time we spend on the phone dealing with regulations and requirements.

Does your bill also mandate that these health plans will have enough phone lines, knowledgeable personnel, and hours of operation so that we will be able --

(Applause.)

Q -- to get through to them for prior approvals and precertification without spending most of our time on hold, as we do now.

MRS. CLINTON: I hope you don't have to ask for prior approval and precertification. I hope that you're part of a fee-for-service network or a PPO or an HMO or something that is yet to be invented in Georgia, so that you are part of a network that agrees to take care of X number of people for a certain amount of dollars, and the decisions you make are your decisions.

I am trying to eliminate exactly what you just described. I don't want you to have to pick up the phone and call somebody for preapproval. If a physician decides to make a decision about an admission or a test, that should be sufficient and the only check at the end of the day is were you able to do it within some kind of a budget?

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You know, hospitals have budgets. You all know that, every one of you who practice in a hospital. We want to have some kind of budget in the overall health care plan so that you are able to know what kind of money you've got available to you that will be there because you've got a steady stream of patients who will all be compensated and you're not going to have to make those hard choices, and all of the services in the comprehensive benefits package will be available so you don't have to argue with somebody about whether or not this is a covered service.

I know that this is a leap of faith for a number of people, particularly in the south, because we do not have experience like people in Minnesota and California and Washington and Oregon and Hawaii and a lot of other places that have been delivering care in a more organized way for a longer period of time.

But what we are trying to do is eliminate all that middle that you have been hassled by and which drives your costs up without giving you one more minute to spend taking care of a patient and, I would argue, decreases your income because you have to spend so much money on overhead and paperwork and hiring people to argue with folks on the telephone instead of hiring another young doctor or another nurse practitioner to help you in the office. So that's what we're trying to get rid of.

(Applause.)

Q Microphone 3.

Q Mrs. Clinton, my name is Joy Maxey (phonetic). I'm first vice president of the Medical Association of Georgia and the immediate past chair of the AMA Young Physicians Section.

I am indeed privileged and honored that you would share time with us today and am very delighted to see such an intelligent and well-spoken as yourself heading our health care reform efforts. I certainly hope that if I'm ever in need of legal services that I might be able to afford yours. You are very excellent.

I come today to discuss the issue which you just alluded to, and that is the issue of delivering primary care services. I am a pediatrician here in Atlanta. I am

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currently looking for a partner. We have 14 openings for pediatricians in general practice in Atlanta, and they are very difficult to fill. There is truly a shortage.

My concerns are -- and again, I have not read Saturday night's rendition. I have read the previous 1,300 and some-odd page tome but I have not seen the latest. And I guess my first question to you is more one of information.

What safeguards are there in your current bill to not preempt states from licensing both physicians and from eliminating scope of practice legislation as it exists state-by-state? I think that nurses and nurse practitioners are outstanding adjuncts to physician practices, to help deliver care to inner city, underserved, and many patient populations, and not just those two.

But I feel that there would be some quality issues if we were to have independently practicing nurse practitioners or other mid-level health care providers without consultation with physicians out in the patient care arena.

MRS. CLINTON: Well, this is one of those issues that I predict will be as hotly contested as malpractice in the Congress because we are increasing the scope of practice opportunities for nurses, advanced practice nurses, because we don't have adequate numbers of primary-care practitioners in either the private or the public sector. And we have tried to do that in a very responsible way, and I know that Georgia has just had -- gone through a battle over that about the scope of practice for nurses.

But we're just going to have to respectfully disagree with you. We do not have enough practitioners in our country in underserved areas at this time. And it is --

(Applause.)

MRS. CLINTON: -- it's going to take a number of years before we meet your pediatrician shortage. It's going to take a number of years before we get the balance right between specialists and generalists. And, until then, we don't think it's right to tell people that the kinds of limited-practice services that we envision for advanced-practice nurses is not available to them and so we are increasing the scope of practice for nurses in this bill.

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Q We'd like to go to Savannah now and ask Dr. Myra Pope (phonetic), who has been 13 years in practice as a family practitioner, much of that with significant inner-city and indigent people. First question. Go ahead, Dr. Pope.

Q Georgia is not a wealthy state. Our inner cities and vast stretches of our rural areas are disproportionately poor. How do you propose to ensure that our patients in the less-wealthy areas are not adversely affected by being isolated from the services of the more affluent health alliances?

MRS. CLINTON: Well, that's a problem that we've tried to address because rural areas historically have had fewer services available and we anticipate, actually, an increase in services for several reasons.

First of all, we will finally have a much firmer financial footing in rural areas because everyone will have a base for reimbursement. We will also be eliminating some of the disparities that have worked to the disadvantage of rural physicians and rural hospitals where they have been paid on a much lower base than some of those in the urban areas; and we're going to try to increase the reimbursement levels in rural areas.

We are also looking to increase the numbers of practitioners in rural areas by providing incentives for loan forgiveness and for capital formation, loans to create clinics and expand facilities so that you can be competitive in rural areas and also better technological links between rural and urban areas so that rural physicians don't feel as isolated as they often do, that they're much more likely to be tied in with what's going on at Emory, for example, if there is this kind of technological linkage.

And this is something that I'd ask Dr. Koop to say a word about because he's been pioneering in the area of rural practice for a number of years, but his institute at Dartmouth has a particular interest in this.

Q I think the future is very bright for the question that you asked. There is no doubt about the fact that, in days gone by, especially rural or solo practitioners felt separated from the mainstream of medicine. They felt isolated. And there are many ways that that kind of practice can be made more exciting, more rewarding, and more

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fulfilling.

I sit on the President's Informatics Task Force and I co-chair an ad hoc committee of the National Academy of Sciences that is studying the interface between health care reform and primary care, and I can tell you that there already is the technology available to take the medical center out to the family practitioner in rural America, whether he is in his home or his clinic or his hospital.

The cost of that technology today is, in some places, high and, in some places, exorbitant but those prices are coming down and I would think, by the time this health care plan gets through Congress, that you would see tremendous changes in communication to make life where you are talking about it ever so much more wonderful.

Number 1.

Q Hello, Mrs. Clinton. As you may know, this is much a world problem as it is an American problem and the whole world is watching and looking up to America to provide leadership. How do you think this important initiative will affect other health programs around the world, especially those sponsored by World Health Organization, for developing countries? And I would like both yourself and Dr. Koop to respond to this. Thank you.

MRS. CLINTON: Well, I hope that the continuing leadership that the United States has given to health care will not only inspire but help facilitate countries around the world in looking at their own health care systems. But I have to be honest. In some very important respects, underdeveloped countries, when it comes to public health, are quite in advance of us. I mean, they have often lower infant mortality rates, unfortunately, higher immunization rates.

And what we are trying to do is to fix those parts of our system that are not as good as they should be and I think, then, we will be in a position of undisputed leadership, that not only will we have the best health care in general and certainly by far the best tertiary care but we will also get to the point where we have the best public health. So all of those pieces will have to fit before we can have a health care system that operates as well as it should in every part of our country.

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Q There are several ways in which the United States does provide leadership. It may seem at times, as you watch it, to be spotty but it is rather comprehensive.

First of all, we provide a better research base for medical progress and public health progress than any other country in the world. We also are the greatest contributors to the World Health Organization, which actually funds, for much of the underdeveloped world, their public health problems.

But, then, there are also, out of this country, two separate ways in which the Third World is specifically cared for. One is by government response to specific requests to the Department of HHS, through the Public Health Service and, usually, through the Commission Corps, to go out and answer special epidemiologic problems and to help -- not necessarily to take over but to help -- other countries form an infrastructure that will prevent the same thing from happening again.

And then there is the final thing, which is a very special part of the American cultural personality and that is our tremendous ability to mount an effort of relief for any country in distress, even if that is on the other side of the world; and that is over and above and on top of the constant private effort that is made through missionaries and both religious and quasi-religious and civic organizations to provide benefits to less-well-off people around the world.

So I think you don't have to worry about America's leadership but, as the First Lady said, we have to clean up some old thing, some things in our own back yard as far as public health is concerned so that we are a better example than we are at the present time.

Second.

Q My name is Jeff Nugent (phonetic). I'm a practicing surgeon and chairman of the board of Medical Association of Georgia. I would like to express my concern that the 55/45 percent generalist to specialist residency ratio which you announced today will result in the closing of many specialty training programs and affect the great success of specialty research in this country.

Since sophisticated, clinical research and much of

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the basic science research has been done by specialists or scientists working in their laboratories, have you given due concern to the effect that reducing specialty funding will have on quality and quantity of medical research in the United States -- the best medical research in the world?

MRS. CLINTON: Yes, we have, and we have gone over it exhaustively, and we've talked to every expert in the field and we intend to increase research. But there -- you know, and I'm going to ask Dr. Koop to comment on this because we had a question similar to this at one of the meetings of the medical colleges.

It's a very ironic question. The federal government has paid to create these specialists. This has not happened by accident or by an Act of God or by the private sector. It has happened by the federal government paying to create specialists. And we have too many of them for the population that this country has in comparison to the number of generalists.

So if the federal government is going to pay for it, that doesn't mean that it is going to eliminate the further training of specialists. It means that it's going to decrease the numbers and the rate of growth while we try to increase the numbers of the generalists.

At the same time, we are going to be putting more money into medical research than has been going into medical research for a number of years. We have underfunded medical research in the last 15 years. We are putting more money into that.

There may well be a reaction on the part of those in specialties who have been trained in the programs which we built up in the last 20 years. But we have every reason to believe we are not in any way either decreasing research or clinical work or availability by trying to increase the number of generalists. There is, I don't think, any expert in the area of medicine and the allocation of resources who will disagree with that.

That doesn't mean the state of Georgia can't fund more -- if the state of Georgia wants more specialists, the state of Georgia can fund them. If the private hospitals or philanthropies want them, they can fund them. But the federal government has a special responsibility to try to

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create a better balance. We created the imbalance; now we've got to try to create a better balance. And that's what we intend to do.

Q I'd answer your question and concern three ways:

First of all, there is a lot of research done in specialties that is not done in the specialty programs of clinical residencies in hospitals.

Secondly, hospital staffing of specialists in training has never been based upon societal needs in this country.

And, finally, most of the kind of research you're talking about takes place in academic medical centers. And it's difficult to pull these figures out of the plan but I think that this is approximately right, that over the next five years, instead of the \$46 billion that would have been available to academic medical centers, it will now be a little bit over \$50 billion.

So I think that there will be a sufficient amount of money from other sources hitherto not tapped that will take care of the shortfall that you anticipate.

Yes, go ahead.

Q Do you think that we have the number of specialists that we have today because of the wishes of the American people in wanting more specialty care or because by government planning?

MRS. CLINTON: By government planning. There's no doubt about it. I mean, we didn't -- you know, when we started funding specialists through Medicare, we can show you on charts the increase in the number of people who went into specialty care. It's supply and demand. It's cause and effect.

And, because at the same time, as Dr. Koop has pointed out, the sort of status of specialists -- because that's where the money was coming -- began to increase, people were kind of turned off from the idea of becoming generalists. That was not that sort of aura and glamour and status associated with it because the infrastructure, the faculty salaries, the dollars were going into specialist

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training.

There is -- I mean, that is -- you know, you can look at any history of what Medicare funding through indirect and direct medical education has done to create specialists. You don't have -- the American people did not stand on street corners saying, "Give me more thoracic surgeons." I mean, that is not how it happened, I'm sorry.

(Applause.)

MRS. CLINTON: And, you know, we -- we need thoracic surgeons. We need specialists. But if we're going to have a health care system that provides primary care and refers people to specialists who need to see specialists, then they have to have primary care generalists who perform that function.

And I guess the other point that Dr. Koop has made several times is that, you know, a good generalist has to have a much broader field of knowledge than a good specialist who can begin to narrow, because that's what we expect that doctor to do for us. The kind of effort that goes into becoming a generalist today is often very burdensome and the financial rewards are not often very forthcoming.

So if you're a pediatrician and you have an adolescent in your office and what you really need to do is to sit and talk with that young man or woman to try to figure out what the real problems are, you don't get paid for that so you're going to either have to figure out some test to prescribe so that you can get reimbursed for the 30 minutes you spend or you're going to have to send him on the way.

There's no systemic way to reward clinical practice by generalists, and we've got to change that. We can't have a comprehensive health care system without that kind of base of primary care physicians.

(Applause.)

Q This is the most unpopular thing I'm going to say this afternoon. In order to keep to the First Lady's schedule, this next question is the last question.

Q Mrs. Clinton, my name is Bill Mitchell (phonetic) and I'm currently a fourth-year general surgery

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resident here at Georgia Baptist. My work week here is greater than 100 hours a week but my student loan debt unfortunately forces me to work a large number of hours moonlighting in order to pay the interest on my loans.

I recently listened to the young lady in the other aisle speak of having a student debt of \$60,000 and I was quite envious as I looked at her. My own student debt is currently greater than \$120,000. Between pre-med, medical school, residency, and fellowship, my training is going to last a total of 15 years and the total payments on my loans will be in excess of \$486,000 according to my current calculations. In 1986, the federal government pulled the rug out from underneath my feet by eliminating the tax deduction on student loans, which I was counting on as a first-year medical student at that time.

I've heard you discuss a few generalities in terms of loan forgiveness, loan repayment programs, et cetera. I was wondering if you could tell me and some of the other residents here what your timetable is and the size and scope of these programs and whether or not they will affect us during our training?

MRS. CLINTON: It depends upon when we get the legislation passed, Doctor. I mean, that's the real key. Our plan is to begin to move immediately to relieve the burden of existing students as well as future students and it will depend upon how soon we can move. I mean, all of the features of this plan have to be enacted in the Congress, obviously, and then we have to move to implement them.

If we're able to achieve Congressional action by next summer, which is what our hope is, then we could begin to implement this bill in 1995. And I think we are aiming to have a direct impact on existing medical students and residents, not just those in the future. So that's my hope for you because, obviously it's a terrible burden for you to be laboring under.

Q I want to thank you all for your attention and we're sorry that we can't stay longer. Thank you.

(Applause.)

Q A couple of things to say and then a real, real surprise. I've been advised that I failed to mention the

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Health Science Television Network is televising this over 2,000 hospitals in the United States. I apologize for this.

Dr. Koop, Mrs. Clinton, from the Georgia Baptist Medical Center, from the physicians of the Georgia State Medical Association, from the physicians of the Medical Association of Georgia, from the elected officials in Georgia both on a local and state level, and from all the citizens from our great state of Georgia, we want to thank you for coming here today to be with us.

We promise you that when this debate gets into the legislature, in Congress, that the things that we do not agree on we will be able to disagree without being disagreeable. But again, we thank you for coming.

The surprise that I want to let you know is that Mrs. Clinton has stated that she will be down on the floor to shake hands after we are through with this. The ones that will be leaving through the back, be sure you leave through the back doors and do not come through the front of the auditorium. Thank you very much.

(Applause.)

(End of tape.)

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