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THE WHITE HOUSE  
Office of the Press Secretary

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For Internal Use

October 19, 1993

REMARKS BY THE FIRST LADY  
INSTITUTE OF MEDICINE ANNUAL MEETING  
WASHINGTON, D.C.

DR. KOOP: Good morning. Before I introduce Hillary Rodham Clinton to you, I want to express my personal admiration and my gratitude to her for her leadership of the President's health care reform effort.

She has brought to this assignment exemplary energy, unfailing diligence, breath of vision, attention to detail, care, and compassion. I'm sure that these words are not new to her at all. Ever since the Clinton Health Care Plan became public, and especially since her highly lauded testimony before congressional committees, accolades have come her way.

And although the compliments for her accomplishment in producing a comprehensive reform plan are well deserved, I must say that the tenor of much of the praise bothered me. There was too much oohing and aahing about how no first lady had never done such a thing before. I think these folks missed the point. They indeed missed the person.

It is my understanding that Hillary Rodham Clinton has presented this health care reform plan to the nation not as the First Lady, but as the American citizen whom the President decided he could best entrust with that task that he placed on top of his domestic agenda. Now, I'm not saying that being a friend of Bill hurt her chances at all.  
(Laughter)

After all, Presidents have always turned to trusted

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friends to fill important positions. But I imagine in this case that Mrs. Clinton received the assignment as much in spite of her being First Lady as because of it.

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

I also admire her, and the President, for their repeated statements that the plan they have offered is open to debate and amendment, that they welcome suggestions to improve upon it. And although the plan is complex, even complicated, I especially admire its breadth, and I thank you, Mrs. Clinton, for raising all of the issues, so that no matter what finally emerges from the national debate and the legislative process, you have forced us to deal with all of these issues: medical, financial, legal, public and private, as well as those of our personal responsibility for our own health.

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

MRS. CLINTON: Thank you. Thank you very much. Thank you very much, Dr. Koop. And thank you for your advice throughout this process, starting last spring, and your willingness to serve in this role as a facilitator of discussions moving forward, particularly with the medical and scientific communities.

And thank you, too, Dr. Shine, for your personal involvement and commitment to health care reform, and to all of you in the Institute of Medicine and associated with the National Academy that have been great supporters, but also excellent critics, as we have moved forward in this process. And I hope for both roles to continue in the months ahead.

When Dr. Koop and I first talked about what we hoped we could achieve, and what he is now referring to as our road show here, it was with the idea that I would do much less talking than listening and trying to answer questions

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that were on your minds, because I assume that, with an audience such as this, not only have many of you been personally involved in some way with the reform process, but most of you have avidly read what has been written, and have questions about the nature of the reform and particular issues that are of concern to you.

I would like, therefore, just to make a few minutes of opening remarks. I have looked at the program that you will have for the rest of the day, and I am very pleased to see the time you will spend looking at particular issues.

I am delighted that many of the people who have helped in this process, particularly Dr. Phil Lee, will be addressing you, and you will have further opportunities to ask questions during today, and, I hope, into the future.

I am very excited by what lies ahead of us. And I am excited because, as Dr. Koop has said, we have tried very hard to lay out the full range of issues that have to be addressed. These issues are ones that overlap, and certainly one cannot easily rank them in any importance because so many of them bear one on the other.

But what is exciting to me is the willingness of so many in the medical profession and the scientific community to begin to talk more often in public, with colleagues and with citizens, about the interrelationships of the pieces of health care reform.

It is a complex undertaking that we are about to begin in our country. I know no way to attempt what we are doing: to achieve universal coverage; to guarantee a comprehensive benefits package; to begin to simplify a system that has become much too cumbersome, bureaucratic, and overregulated; to attempt to begin to achieve savings and eliminate inefficiencies; but at the same time, to enhance quality through better outcomes research and reporting of those outcomes; to guarantee choice -- in fact, to enhance choice -- for both the citizen/consumer and the provider/practitioner; and to inject more responsibility into the system at every level.

And one of the questions that I'm often asked is how one expects to be able to do all of this in the face of complexity. And I always ask the one who questions me to

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please describe to me the way our current system works -- to take a few minutes, describe how people get into the system, whether or not they carry with them financial reimbursement, what are the conditions that either eliminate them from coverage or in some way limit their coverage, who provides health care, who holds it accountable, who pays for it, and on down the line.

I think it would be extraordinarily difficult to design a more complex system than the one we currently have. So what I hope we will do as we move forward is not only to question where we are going, but to have a very clear idea of where we are now and what the options are available to us and the costs of staying with our current system -- or non-system, as some are more appropriately calling it -- or making only marginal changes that will, inevitably, have just as many unintended consequences as any attempt at comprehensive reform.

There are a few issues that I wanted to highlight in these opening comments, because of your concerns and the concerns of many in the professions.

First, the problems that physicians and patients face in the current system are such that we know care is being rationed every single day. We know that choice is being limited every single day -- two issues that are often discussed in the context of reform that we know are having a bad effect in many settings already in the current systems.

Contrary to the way the system currently operates, we have made some fundamental changes. Although we have built on the employer/employee system, individuals will choose their health plans -- not employers, and not the government. This is a sea-change.

What is currently happening in our current system is that employers, in their effort to control costs, are pushing more and more of their employees into limited choice options. That goes along with the trend that many of you have observed, in which providers -- whether they be physicians or others in hospitals and the like -- are being also forced into situations where their practice is being limited.

What we are trying to do is to take back that power

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from insurers and from the federal government. Right now insurers have the ability to grant and deny coverage. They do it with a vengeance, because it has become the way in which they make money.

We believe that taking that power away from insurers is fundamental to any kind of health care reform. And so, from our perspective, putting the authority back in the hands of physicians and their patients will be absolutely essential to what we achieve.

Now, how will that work? Individuals will have choices among plans and providers. We will require that in every region there will have to be a fee-for-service network. It is absolutely not true that every physician will be forced into HMOs. That is not part of the plan. It is not going to occur, because we will guarantee a fee-for-service network.

We will also require that HMOs offer a point-of-service option. This is a very important feature, in part because we want to maximize choice as a principle, but also because we want academic health centers and other centers of medical excellence to be available for referral, even to patients within HMOs.

We also want physicians to have an option as to being able to join more than one plan. The fact that you might be in a closed-panel HMO would not prohibit you from also being in the fee-for-service network. The fee-for-service network will be open to all willing providers.

We think it is important to change the balance of power that currently makes too many of the decisions in the health care field. That's why having insurance reform is an absolute precondition of everything else we are attempting to achieve.

We intend not only to achieve universal coverage, but to eliminate preexisting conditions, to eliminate lifetime limits -- two of the issues that have been the most difficult for individuals, and for their physicians confronted with some of the hard choices that individuals with preexisting conditions or exhausted lifetime limits pose when care has not been completed.

I heard Dr. Shine speak about the work that you did

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yesterday with respect to genetics research. And it reminded me of an extraordinary comment made to me at the Mary Lasker Awards by Dr. Nancy Wexler, one of the recipients, whose pioneering work on Huntington's Disease is, I'm sure, well known to many of you.

She came up to me and said that, as a researcher in the area of Huntington's Disease and as a member of the Human Gene Project, she wanted me to be aware that, probably within 10 years, the state of our knowledge would demonstrate unequivocally that we all have a preexisting condition of some sort or another.

So we'd better hurry up and get reform or we're all going to be out in the cold. (Laughter)

Secondly, we intend to change the balance of power by moving forward with antitrust reforms. We believe that we need to level the playing field and provide more freedom to doctors and hospitals to work together to determine what is the best and most efficient way to deliver high quality services.

Doctors and other health providers will be able, under these antitrust reforms, to band together to form their own community-based health networks in which doctors will be able to negotiate to reduce interference with their practice.

They will also be able to negotiate collectively to insure that they have a role in setting any fee-for-service reimbursement rates, so long as they represent 20 percent or fewer of the physicians in an area and share in the financial risk.

Now, this is a request that had come to us from a number of groups representing physicians. We think it is a very important feature of what we are attempting to do, because part of what we hope will occur is a real flowering of networks of doctors and hospitals throughout the country -- allied often, or maybe even begun, through academic health centers as the center of excellence within a community.

But it was clear, in looking at the antitrust laws, there were too many obstacles to being able to achieve that realistically without the changes we are proposing.

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We also believe that, if we reduce the bureaucracy and the overregulation in the system, we will begin to free physicians from the kind of sapping of resources -- time, energy, financial -- that has occurred up until the present time. And I want to say something specifically about this, because it is not just rhetoric. It is a very important commitment to what we are trying to achieve.

We have tried -- and I think it has been a very good-faith effort in the past 20 years or so -- to perfect a micromanaged approach toward the paying for health care. We have done it in both the private and the public sector. We have laid out innumerable lists of what certain procedures should cost. We have gone to great lengths to check and double-check how procedures are described and coded and billed for.

But again, going back to my original question about describing our existing system -- if you take the time to actually list what the procedures are for a bill being paid by an insurance company or by Medicare or Medicaid, and you put everything in there -- you put in the billing and the coding departments, you put in the PROs and the fiscal intermediaries and all of the other acronyms that are out there -- you would be astonished to see where all of this money that you know is being spent is actually going and the kind of time that it is taking away from your practice.

The Children's Medical Center here in Washington conducted such a study recently, which they reported to the President. They actually went through and looked at every form unrelated to patient care or quality reporting -- mostly having to do with financing of the care -- and they determined that if every physician on the staff of that medical center, all 200 of them, were relieved of filling out the forms that were irrelevant, in their professional judgment, each physician would be able to see between one and two more patients a day.

That added up to 10,000 more children who could be seen by physicians in one hospital in one year, if we did away with the kinds of forms that they had identified. So this is a big issue. It's an issue not only for the financial implications, but also for patient care as well.

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I also want to emphasize our commitment to quality. We believe very strongly, and have set aside in this plan, funding for academic health centers and funding in outcomes research and effectiveness research.

We believe, as strongly as I can express to you, that expanded investments in health research and greater support of academic health centers are critical not only to insuring quality, but in controlling costs over the long run and promoting a philosophy of prevention and wellness.

With reform, new funding will be available for prevention research, outcomes research, and health services research. We also want to continue the work that Dr. Koop and Dr. Weinberg and others have been doing at Dartmouth, that will focus on the kind of shared decision-making between patients and doctors, exemplified by the prostate study that has had so much notice in the last year.

Now, when we lay out these and the many other features of the reform plan, people often say, "Well, how can we afford this?" And, of course, my initial response is not only how can we afford not to, but look at what we are currently spending.

There is no way to justify our current expenditure level, especially when we don't provide universal coverage, and, especially when, even for millions who have some kind of insurance coverage, their coverage does not cover preventive services and the kind of intermediary services that are often required and cost-effective.

So, certainly, we will in the next months have a great debate about how we will finance this. There is no real secret to our financing. We're going to require every employer and employee to make a contribution. That will amount to approximately \$50 billion. That's a lot of money -- new money going into the system.

With the new investments in health care, we will be driving up our GDP percentage, from the approximate 14 percent that it is now to about 17 percent by the end of the decade -- 2 percentage points below the projections if we do nothing, but still twice as much, at least, of any other industrialized country that is doing the job that needs to be done.

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So anyone who says we will be rationing the system or in any way constricting the system has not looked at the amount of money going into the system that will be new.

In the meantime, though, we recognize that there will be certain features of our existing system -- such as academic health centers, such as public health facilities in underserved urban and rural areas -- that will continue to need additional resources, which we have provided.

Now, finally, let me say that our commitment to basic research, our commitment to academic health centers, cannot be successful if we do not have an ongoing, consultative process with institutions, such as the institute with the group of academic health centers that Dr. Shine referred to, and that that kind of consultation be built into the reform process.

As a layperson, one of the surprising discoveries that I have made in the last month is that, here we are in a country that has by far the best basic research and best applied research in the medical sciences as any country -- or all of them put together in comparison, yet, too often, what you know in your academic health centers -- what this institute proves on the basis of the kind of rigorous peer review that it engages in -- does not penetrate into the larger medical and health care community.

There are still too many decisions being made which are being paid for -- not only made, but paid for -- that are neither related to quality nor cost-effectiveness. And if one looks at the pattern of expenditures and practice styles throughout this country, it is shocking.

Some of you may have seen Uwe Reinhardt's piece in -- I think it was the Times, over the last couple of days -- where he pointed out something that is obvious to a political economist like himself, but which has not become clear to the American public and even to many practitioners.

And that is that without sacrificing quality -- holding quality constant -- we have some areas of our country that charge three times or two times more than other areas for taking care of the very same kind of patients with the very same kind of problems.

We have not put to good use the kind of research

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that we know about what should make good decision making in medicine. And we have not had any accountability system to be able to compare that and to determine what should be reimbursed.

Our efforts up until now, although we have made progress in the Medicare system, have not influenced the entire health care system.

So these are the issues that we're going to have to face with your help. We will need your constant constructive criticism and advice. But I would close by just saying that Dr. Shine is absolutely right. This institute is committed to not only research, but health care. Most of you know, very clearly better than I, the shortcomings of what we are attempting to do now. Changing this system, no matter how flawed, will be extremely difficult.

And I would argue that the people who are most likely to have credible voices are people like those of you in this room, that when the dust settles, the highly financed advertising campaigns on behalf of special interests -- like the one that the Independent Insurance Agents are running now -- which goes to your expertise, which says, "You know, we're going to ration care. We're going to take away choice."

When really, if they were held to any standard of truth in advertising, it would be, "We won't be needed anymore, because we won't be underwriting risks and eliminating people from health care coverage." And that is something that we're concerned about. (Applause)

So what we need are voices of experience and expertise to join with us and to continue to improve what we have struggled to put together, until finally -- before this Congress adjourns next year -- we have passed fundamental health care reform that guarantees every American a comprehensive benefits package and fulfills the other principles that the President talked about in his speech.

Thank you very much. (Applause)

DR. KOOP: Several weeks ago, on the 20th of September, when all of these things began to become much more publicly known, I spoke at the White House on behalf of this plan. And the First Lady was about to go over to talk to a

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number of people from both Houses of Congress on what they called the university of health care reform."

And she suggested to me that I wait in the White House while she went across town, and I could work the crowd. (Laughter) And, whether you know it or not, yesterday I was working this crowd. (Laughter) And, some of the things that are of concern to you I have written down as questions that I would like to pose to the First Lady, and I would like to suggest the way that we would do it.

I would pose a question. Mrs. Clinton will answer it. If one of you out there has a question pertinent to what we're talking about at that moment, raise your hand and come forward to the microphone, and we'll take one such question. After I've done a few of these, then we will open the rest of the day to questions from you at the microphone.

I remind you that you were given some housekeeping rules yesterday by our President, (laughter) and be sure that you don't violate that. I think you've only violated half of them so far. (Laughter)

Mrs. Clinton, there was a very remarkable symposium here yesterday on genetics. And toward the end of the afternoon, a number of questions were raised. And I will just phrase those all as one. And that is, how will the plan deal with this exploding field of genetics? And just where will genetic screening come into it?

MRS. CLINTON: Genetic screening is part of the basic benefits package. And genetic screening and developments in genetics will be evaluated as we currently evaluate any new medical procedure or scientific breakthrough.

There will, obviously, continue to be clinical trials and research protocols. And the health plans will abide by those. But I think both with respect to inclusion of genetics testing, but also with an emphasis on increased investments in genetics research, I think this should be a step forward from where we are today.

DR. KOOP: Genetics question, near the microphones. Yes, sir.

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DR. RIMOIN: I'm David Rimoin from Los Angeles. With genetic diseases, many of them are extremely rare, and there are only one or two places within the country that currently have the expertise to deal with them. How will the allied health plans be able to be forced to send their patients for such expert help?

MRS. CLINTON: Well, I think just as many insurance policies now provide for referral to specialists outside of area or outside of plan, we're not leaving that to chance. We are putting in a point-of-service option referral.

And, just as now, there probably will be some disputes over specific referrals, but we will establish the general principle that merely because one is an enrollee in a health plan does not mean that one cannot be referred to the highest and best treatment center that is available for whatever the particular disease is. And that is something that we intend to insist on, even with closed-panel HMOs.

DR. RIMOIN: Thank you.

DR. KOOP: I think the point-of-service option that the First Lady referred to in her prepared remarks should settle a lot of the questions that you people asked me yesterday that are based on that exact same principle.

The next question that I would like to ask is, you have said, Mrs. Clinton, that a person can follow his or her doctor into an HMO, for example. But, by the age of 50, many of us have several specialists. We may have accumulated a cardiologist, a surgeon. We have physicians that we think are our own. So how can these professional relationships be continued?

MRS. CLINTON: Well, I think that, with respect to the multitude of specialists that some patients have, there will always be the fee-for-service network. That's another one of the failsafe guarantees that we are putting into the plan.

There will also, we believe, be an explosion of the networks of physicians, again, which will not be able to discriminate against physicians who wish to join them plus something else.

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Now, I cannot guarantee that you will be able to follow every single one of your specialists, if you have a multitude of them, if you do not go into the fee-for-service network. But that's one of the reasons we're having the fallback position on the fee-for-service network, so that that will be able to be continued.

And for Medicare patients over 65, who certainly have a tendency to have more specialists, that current system will remain a fee-for-service network for most recipients.

DR. KOOP: Will physicians be permitted to join an HMO or a PPO, for example, and maintain as well, a fee-for-service practice?

MRS. CLINTON: Yes. Yes.

DR. KOOP: That should answer a great many questions that I heard here yesterday. (Laughter)

MRS. CLINTON: Now, you know, clearly the HMO will be able -- if it's a closed-panel HMO -- to limit which doctors it will have on the panel. But that is not going to be a reciprocal limitation. The doctors will be free to join, if they choose. This is not required. It is if they choose to be, as well, in the fee-for-service network.

DR. KOOP: A question pertinent to this? Yes, sir.

A PARTICIPANT: Yesterday's Wall Street Journal said that a provider -- under the plan proposed, the provider may not charge or collect a fee in excess of the fee adopted by an alliance. Is that a true statement as regards the network?

MRS. CLINTON: Yes, but there will be fee reimbursement negotiations done within the health plans within an alliance, not the alliance so much as at the health plan level. But the alliance will be setting some kind of budget targets.

And under those targets the physicians in the various forms of health plans will be negotiating their own reimbursement rates, so that, for example, a fee-for-service, as I referred earlier, the physicians will be able to participate in negotiating what their reimbursement level is.

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The alliance won't be doing that. The alliance will be setting out the big picture. You know, here is what we intend to spend on health care in this region. And then the individual health plans will be setting their own rates, but within that budget target.

DR. KOOP: I think the concern brought forward was that the fee-for-service network couldn't survive with that condition.

MRS. CLINTON: You know, I don't believe that, based on what we have looked at. We've looked at a number of -- if you take, for example, those communities that I referred to earlier, where you have a 3:2 or a 3:1 or 2:1 ratio of what it costs in Medicare compared to what it costs in some other community, there are many communities where the fee-for-service network, or the fee-for-service rates, are very close to what you would find at an HMO or a PPO.

There will be some communities for whom this will be a major change. I don't want to mislead you. I mean, if you practice traditional fee-for-service medicine in some of our regions -- and I'll just name names.

If you practice in Miami, where you charge, on average, three times more than San Francisco, a city of comparable cost, your fee-for-service charges may not be able to be as high as they are now in competition with HMOs or PPOs that will see a terrific market in that community.

So it's going to depend very much on what the level of cost is now, what the practice style is now. And that's one of the reasons we're trying to get out and talk about this, so that physicians and others can begin to evaluate where they stand right at this time.

DR. KOOP: I asked a question a moment ago from the patient's point of view. I'd like to turn it around through the physician's concern. If, as we expect, the adoption of the Clinton Plan leads to an increase in the number of HMOs, PPOs, and so on, and if a large number of doctors in the community move into such organizations, what will happen to those physicians who are unable to find a slot in such an organization?

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MRS. CLINTON: They will be in the fee-for-service network, or, I think, there is a -- unless we're dealing with -- let's put aside people who, for professional reasons, nobody wants. (Laughter) One of the things that we're going to be asking all of you is to perhaps take a little stronger stand against some of your colleagues that you have basically let go by for years, because you weren't involved with them.

As everyone in this room knows, the stories that I have heard over the last months about, you know, you don't think the fill-in-the-X physician is doing what should be done, but there's no real way, or no real incentive, to do anything about inappropriate or unnecessary care -- or fill in the blank.

So certainly there will be some who, for professional reasons, people don't want. I don't think that's all bad. There will, however, be protections against discrimination that is not related to professional competence, but is related to gender or race or minority status of some kind.

But that does not guarantee that every physician will have a place in every organized delivery network that is going to be available. - Again, that physician, though, will have to be considered as a member of the fee-for-service network. So there's going to be a sorting out.

But one of the things that I have been pleased by in recent conversations is that a number of these ideas about organizing delivery networks are certainly not new with the President's proposal.

For example, the Catholic Hospital Association had adopted its reform proposal during the two years before my husband was elected. It relies on networks. It relies on willing physicians working with hospitals, working with other providers to create organized networks of care.

Now, it may be that what is often said about lawyers is true about doctors -- that trying to organize them is like herding cats -- and I appreciate that. (Laughter) But I think there is such an opportunity here to get ahead of what is happening, and to not just wait to be purchased or to be moved into some kind of large delivery system, but to take the initiative.

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And again, just sort of speaking out of school, I think there is an incredible opportunity for academic health centers, because you are the most respected institution in most communities. You carry with you the validation and credibility that would be impossible to buy by most others who are going to be organizing networks. So I think there's a real opportunity there.

DR. KOOP: Would it not also be possible for a group of physicians who felt that they had not gotten into an HMO in time, to themselves form?

MRS. CLINTON: Absolutely. And because individuals are going to be making the decisions, individuals are going to be looking at criteria that are not all related to bottom line.

I mean, it's going to be choices based on cost, certainly, but quality, familiarity, and -- I just, again, would stress that individual physicians, individual clinics, individual hospitals, have such an opportunity now to join together to figure out how best to do this, and that I would urge that some thought be given to that.

DR. KOOP: Dr. Relman has a question on this issue.

DR. RELMAN: Mrs. Clinton, I'm delighted to hear that you are concerned about making it possible for physicians to form organizations of their own -- perhaps with a community hospital -- to form a health plan.

Are you going to encourage not-for-profit plans? Because, if you want to, it seems to me that you're going to have to deal with the problem of start-up capital.

MRS. CLINTON: Yes.

DR. RELMAN: As you know very well, the investor-owned insurance companies and many other businesses are now actively shopping for group practices and HMOs and individual practices that they're buying up all over the country. It's a great wave of acquisitions of physicians' practices.

And if the administration wants, as I know it does, to encourage independent physician organizations that will be not-for-profit, you're going to have to think about some way

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of giving them start-up capital that won't require such terrible risks that not-for-profit, community-based organizations are not able to assume. And I've suggested the possibility of grants -- maybe reimbursable grants. I hope you will consider that issue.

MRS. CLINTON: In fact, we have. And I appreciate that recommendation. We are putting into the plan a revolving loan fund and grants to do just exactly what you're talking about, because we know there are capital barriers to formation.

But don't sell yourselves and not-for-profits short. There is a tremendous capacity for entrepreneurial adjustments within the not-for-profit and the mission-driven provider world that -- you know, again, as an outside observer -- I think is not being fully appreciated.

One of my big fears is that too many physicians and hospitals -- particularly community and not-for-profit -- will not realize their own potential and will sell out, basically, to the investor-owned and the for-profit.

And so we're trying to provide incentives -- not only financial, but also legal, with the anti-trust changes and the like -- that would enable you to form your own networks. But we have to hope that some discussions and planning on that will begin immediately, and that those of you in academic health centers affiliated with community and not-for-profit hospitals in clinics will appreciate what you have. I mean, you are big prizes as well as extraordinary resources.

And there is a lot that you could get in terms of technical assistance, and limited capital infusion from for-profit and investor that would not amount to giving up control or turning over your entire operation. So these are some things that I hope the medical profession will be thinking about.

DR. KOOP: You alluded to the failure of this profession to police itself adequately, and I think there's no question about that. But the track record of people who have tried to do that altruistic task is not a good one.

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They frequently have lost out in courts, and have ended up not only without a job, without the policing effect taking place, but also without money. Is there any plan to provide some kind of protection -- some good samaritan principle -- for such people?

MRS. CLINTON: That's an interesting idea. The way we have approached it is along these lines. Part of the reason that the policing or the accountability -- whatever one calls it -- may not have been successful to date is because of our system of reimbursing almost on a piecemeal basis the work that you do, and treating all of you as individual entities.

And that has not created any incentives for you to hold each other accountable. And, in fact, there has been a tradition of basically keeping separate your business from others. And what I have hoped is that because -- if we form these networks, each of you will have a stake in both the quality and financial outcome, because every year citizens will choose.

The decision they make one year may not be the decision they make another year, which is another reason why I hope that doctor/provider groups and others form these networks, because I predict there will be evolving decision making and that it will, over time, trend toward the more not-for-profit community-based systems, if they are there to be taken advantage of.

If you, however, have this kind of joint responsibility, then all of a sudden decisions that were no matter to you become of consequence. And I'll just give you one example that I have used before, because I was so struck by it.

The hospital administrator of a large hospital in Ohio told me that many of the people on his staff were concerned about a particular surgeon admitting patients for care which they didn't think was appropriate. But nobody felt it was in their interest -- either professionally or financially or any other way -- to say much about it.

And when confronted, the surgeon just basically said, "I'm going to do what I want to do." And the net result was the hospital administrator and a number of his

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medical staff were feeling very frustrated because they had no tools with which to carry on the conversation with this particular surgeon.

In our system, there will be some kind of accountability and sharing of responsibility that will enable all of you to have more of a say in what your colleagues do or don't do. So those are the kinds of approaches -- the good samaritan idea is one that we will look at, Dr. Koop. I'm not aware that we have included that.

(End of side 1)

DR. SHERDER (phonetic): -- Joe Sherder, family physician in San Diego. As you talk about physician networks and some doctors being left out, our problem is not incompetence, but an oversupply of specialists. We find that we have as many as twice as many specialists in a given area as we need for our population. The overspecialization has been described as the invisible driver of health care costs."

How do you propose to reform medical education in that area in terms of reimbursement for medical education to correct the problem?

MRS. CLINTON: Well, we are as concerned about that as you are. And what we have proposed is that we begin to fund at a higher level medical education for primary and preventive care physicians -- including internists, pediatricians, family practice physicians, and others -- and that we de-link some of the reimbursement patterns that have funded medical education over the last 20 years from providing only funding for subspecialists.

We have gotten the system we paid for. Every time somebody tells me that we're going to impinge upon the right of young medical students to go into subspecialty X, my response is, "Why do you think, over these years, this young medical student chooses to do that?"

Medicare, for years, has been funding that subspecialist. You all have been able to hire terrific people, exciting new ideas, more money coming into that area -- which is very attractive to these young medical students.

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We have turned our back on primary and preventive health care. We've done it not only in medical education, but in the reimbursement system and Medicare. We have said to internists, or to pediatricians, "You're not going to get paid what you should get paid for clinical time with patients, which we know is important for your diagnostic needs. Unless you can figure out something to bill for, it's lost time."

I mean, we have just done this backwards. So it is absolutely clear, we have got to begin to bring more primary care physicians into our system, both through changing the incentives in medical education, changing the reimbursement patterns, and trying to provide incentives like loan repayment and the like.

And for those who will say that's unfair to specialists, please take a look at the overall system. It is not unfair to specialists to try to right a balance that is undermining our capacity to deliver quality health care so that specialists are not providing both primary care and specialty care, which too often is the case.

DR. KOOP: I have many more questions that you asked me yesterday. But, in fairness, we wanted to spend half the time taking questions from the floor. I would like to do that now, and would turn to Dr. Jonathan Rhodes (phonetic).

DR. RHODES: Mrs. Clinton, I find broad support for your program, but lingering doubts as to the financial viability of it. Those of us who are older remember, in the '60s, projections of the costs of Medicare and of Medicaid, which were shown later to be far too low.

In the event that the projections of this program should not be as favorable as they have been predicted to be, would the funds which will be raised under the deficit reduction legislation be available to bridge the gap?

MRS. CLINTON: Well, Doctor, let me just say a few words about the financing, because you raise a very important question, and it will be at the key -- it will be at the center, and one of the keys of what we do.

We know that there are going to be some evolving

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assessments of what any of this will cost, no matter what plan we were to choose, no matter how we were to design it. We know that. And we've watched other countries with different kinds of plans, whose costs have gone up faster than anticipated in some respects, as well.

But what we believe is that there is sufficient funding in the plan to do what we are talking about, but that, clearly, one can always go back to the Congress, in the event of shortages or needs that aren't being met, and increase whatever the amount of money needed would be.

We do not want to extend that invitation without some very careful planning, because part of the reason we are in the situation we are today is, as you rightly point out, starting in the 1960s we created a program in the Medicare and Medicaid public sector that far exceeded any cost projections. And at the same time, we had an explosion of costs in the private sector.

Our attempt to bring down the rate of growth in both of those, we believe, will succeed. But in the event they do not, yes, there is deficit reduction projections in this plan that certainly could be altered in the event of the need for more money.

DR. KOOP: Over here now, please.

A PARTICIPANT: Madam Chairman, I commend your wisdom and commitment. I'm concerned about the possibility under managed care, managed competition plans -- both notable oxymorons -- for exclusion of special populations -- special populations in terms of their historical, social, and health care burdens.

I'm speaking about the persons in the inner city whose physicians traditionally have not been associated with medical associations, or on medical staffs. I'm talking about the community clinics. What will happen there?

And I'm particularly concerned about what I hear -- that this plan will not embrace people in correctional institutions, which should be a matter of some concern, as they are imminent incubators of tuberculosis, which may be resurgent.

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MRS. CLINTON: Thank you, sir. Let me answer your last question and then go on to your more general point. The plan does not include incarcerated persons. Even though every citizen will have a health security card and be entitled to the comprehensive benefits package, during their term of incarceration they will be treated by whatever the correctional systems health care plan is.

The reasons for that have to do with everything from security, transportation, access -- there's a long list of reasons. We struggled with that very hard.

But, based on advice from both city and state governments that actually run these institutions, we determined it was not in either the institutions' nor the patients' interests during incarceration for them to continue as a member of whatever health plan.

They certainly would renew their membership once they were out. Now, that does not relieve the state, nor the health care system, from dealing with their health care problems, and particularly for any public health problems like tuberculosis and some of the things that we're dealing with right now.

I am particularly concerned about the points you make concerning underserved populations and minority providers. And we've done several things to try to protect against either the populations or the providers being discriminated against or being excluded.

For one thing, we are taking the Medicaid system and integrating it into the alliance and health plan system. We will no longer identify Medicaid recipients. When someone shows up at your clinic or your emergency room, they will not be identified as someone whose reimbursement is being provided through a government stream.

We will also have requirements for treating entire populations by the health plans if they choose to bid on the services that a population defined in an alliance will need.

We anticipate -- and there was an article recently that went in and talked to some minority providers in some of our inner cities -- that there will be linkages created that have never been created before between both private

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practitioners, community health centers, and other community clinics, because, for the first time, there will be reimbursement available. There will be an incentive for large institutions who aren't in that downtown area to want to take care of those patients.

And then finally, with respect to managed care, I really view managed care in much more basic terms. I view it as making sure everybody has a doctor. And it has gotten a bad name in some circles because of, frankly, some of the unsavory and inappropriate techniques tried in order to wring costs out of the system at the expense of the patient.

But last week I visited probably the poorest congressional district in America -- in the south Bronx. And I visited a satellite clinic that is part of a managed care system for Medicaid recipients.

The patients I talked to were thrilled because, when left on their own in a fee-for-service network where there were no providers in the south Bronx, where they couldn't get transportation to anybody else, they used the emergency room. They did not have a doctor.

Now they come to the clinic under managed care in the Medicaid system there. They get more -- from their perspective -- more visits, more access, a 24-hour telephone line where they can always get a doctor on the line.

So if we just take a step back and look at it from a ground up perspective, it has great potential to enhance services to underserved populations.

DR. KOOP: I would like to add one word in support of what the First Lady said about correctional institutions. Judging by my eight years' experience as Surgeon General, with the Federal Bureau of Prisons that's the way to go. And experiments have been done in the past which were disastrous when you moved outside that system.

DR. WARSHAW: Mrs. Clinton, I'm Joseph Warshaw, a pediatrician from New Haven. There are certain groups in the population -- children with special needs, the mentally retarded, the handicapped -- for whom the competition model in the health alliances may not provide the most appropriate services.

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What assurances will the plan have within it that will assure those populations the kinds of care that would provide the highest quality of service, not necessarily the least expensive?

MRS. CLINTON: Well, we are not only going to provide a comprehensive benefits package to which every child is entitled, but we are going to continue some of the special services that children need -- both those who are Medicaid eligible and those who are not but who have been receiving what are sometimes referred to as "wraparound services" because of mental retardation or physical disability of some kind.

So we have worked very hard on this with a number of advocates and experts in this area. And we think we can hold the health plans accountable. Again, I would ask you to look at the system now.

We have good plans and bad plans. We have good insurance policies and bad insurance policies. We have good doctors and bad doctors. I mean, we have the full range of everything out there now. We are not going to change human nature overnight.

It is going to be very important to hold these health plans accountable, and for consumer groups and advocacy groups with particular concerns to make sure that people are getting those services. So we are providing them. And we're going to make sure they're available. But we're going to have to make sure they actually get delivered. And that will be one of the roles of the alliance, which will be to monitor such groups.

A PARTICIPANT: Mrs. Clinton, I compliment you on your availability to the American Public to tell them, from yourself, about the health care reform proposal, and your willingness to access to the public so that they may ask questions and bring to you their concerns.

I'm a medical educator, and I'm concerned about preparing physicians and other health care providers to serve in the areas of this nation that not only is there an economic disincentive to enter practice, but also, there is a geographic disincentive.

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You've traveled this great nation, and you know that there are areas that are not very densely populated where services are hard to get. And you've also traveled the inner cities, such as the south Bronx. And you know the scarcity of physicians who want to enter that area.

And I guess my question is -- as a medical educator, as dean of one of the finest medical schools in this country -- I would like to know what your message to me is about how to lead our young people into these areas.

MRS. CLINTON: I thank you for your concern and commitment on these issues. We are trying to build in incentives to do just what you're talking about, ranging from loan forgiveness, and additional funds for supporting facilities in underserved areas -- both rural and urban -- so that we can honestly tell young physicians that there's going to be support out there.

We are working very hard to set up a series of investments in informatics -- something Dr. Koop is very interested in -- and in technological advances, so that it's not just the financial disincentives that often keep physicians from these areas; it is also the sense of isolation from professional colleagues.

And we know we have to do better in order to provide those kinds of linkages. And that's something that Dr. Koop may want to comment on, because he has done a lot of work on that.

We also believe that, with respect to most underserved areas, we are going to have to rely on allied professionals as well. It may not be possible to staff every emergency clinic in rural Montana.

And Montana, for example, has adopted a law that permits EMTs and physician assistants to staff emergency rooms, because their view is that's a whole lot better than nothing when somebody is brought to one of those emergency rooms, and that it has actually proven very beneficial.

So we're going to ask for some changes in practice parameters for some allied professionals, because we share your concern that not only do we have barriers to overcome, but the sheer numbers -- especially with the specialist/

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primary ratio being what it is -- will make it very difficult for the next years, until we get this thing up and going and get the right incentives in it to be able fully to answer the question the way I would like to. But I think we're on the right road to it.

PARTICIPANT: Well, as an educator, if I can be of any help, I'm offering my assistance.

MRS. CLINTON: Thank you very much. Would you tell me what that great medical school is so that I can find you. (Laughter)

PARTICIPANT: Yes. I'm proud to say it's the Uniformed Services University of the Health Sciences.

MRS. CLINTON: I know where it is. (Laughter and applause)

PARTICIPANT: The B.F. Edward-Aberr (phonetic) School of Medicine. And Mrs. Clinton, you might also like to know that I am the only woman dean of a medical school in this country -- the fourth ever.

MRS. CLINTON: You know, one thing about practice in the military services which has been very interesting to me is that both physicians and nurses have testified on numerous occasions that their range of practice parameter was so much broader in the military than it was once they got into civilian practice.

Not just nurses, but physicians as well have told me that all of a sudden they find themselves being restrained by hospital or staff rules. And certainly nurses feel terribly constrained after having gone from being very responsible in the military system to becoming much less able to make decisions. So I -- there's a lot we can learn there. I appreciate that.

PARTICIPANT: We also train physicians for the Public Health Service and graduate nurse practitioners, and our students have a tradition of going to some places where they are desperately needed that aren't very popular.

MRS. CLINTON: Thank you.

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DR. KOOP: I'm not going to speak about informatics, as the First Lady suggested I might. But I don't think anybody in this room travels more than I do. And in those travels I try to meet as many medical students as I can. And I'm constantly pleased and amazed at how many more altruistic youngsters are coming into medicine.

And what I find that they see in this plan is that, having had the desire to go to a previously underserved area, but feeling they couldn't do it because they couldn't be paid enough, they now see an economic return that makes that kind of a life possible. Dr. Abdellah --

DR. ABDELLAH: I represent the Graduate School of Nursing at the University of the Health Sciences -- the President's own university. (Laughter) Mrs. Clinton, I am a nurse. We are preparing nurse practitioners to function in primary care centers, and also in underserved populations.

We know -- and this has been well documented -- that nurses can provide quality care and in an economic way. We are pleased that the health care report does recognize the importance of the contribution of nurse practitioners.

My question is, Mrs. Clinton, can you assure us that the support for the education of nurse practitioners will be forthcoming, and that the practice barriers at the state level can be removed? Thank you.

MRS. CLINTON: Well, that is certainly the intention of the plan. I will say that we're going to have to fight for that. That is not going to be easy to maintain for both, what I would consider, unfair reasons, and for some legitimate questions.

And this is an area where the Institute might very well help us, because we need some unbiased opinion out there, because we're going to have quite an argument, I would predict, as to how far we should preempt state practice barriers and whether nurses will be able to perform the full range of functions for which many of them are now being trained. But we intend to pursue that vigorously.

DR. KOOP: I would like to put some statistics in here. I think the backbone of the plan that the First Lady

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is talking about is really primary care physicians. And we are woefully understaffed in those on a national basis.

And if we were to turn out from our medical schools 50 percent of each class as primary care physicians from here on, it would take us 22 years until half of the physicians in the country were practicing primary care. And that means that what Dr. Abdellah has said requires some kind of stopgap mechanism for people like nurse practitioners, physician assistants, and so on.

But I have one warning. If both of these groups are striving to take care of the entire problem, we have to be able to reassess this about 10 years down the pike so we don't end up with an oversupply of both and one of the worst turf battles we could ever have. (Laughter)

Yes, sir.

DR. HERDER (phonetic): I'm Dr. Larry Herder of New York and Florida, and a member of another health profession, the dental profession, and we applaud you for your interest in this total picture, and what a great job in communication. Your lovely smile indicates the fact that the axiom that you cannot have total health without good dental health. (Laughter)

DR. KOOP: You might tell them who coined that phrase. (Laughter)

DR. HERDER: You betcha. Our concern is, what was the rationale of not having in the basic benefits package dental care for adults. We've been struggling for 30 years to help a whole segment of the population -- let's say under Medicare, and Medicaid, really -- to achieve good dental health. Can you help me with that?

MRS. CLINTON: Yes. And it is something that we are planning to add to the package within the next eight years -- or seven years, by the year 2000. It was largely a question of cost.

We were able to fund children's dental care, which we thought was very important. As you know, dentists were not included in Medicare originally. And so the costing on extending dental care to everyone prevented us from including

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it for everyone from the very beginning.

But it will be part of the legislation, that adult dental care will be available, as well as additional mental health benefits, by the year 2000. And that's the way we were -- those are some decisions we had to make based on actuarial decision making. It's been interesting dealing with actuaries on health care. (Laughter)

They don't believe in prevention. They think if you let people go to the doctors early, they'll just keep going to the doctors, even if they solve problems that might be more expensive in the -- the only data we've got, which is not really good, is that Hawaii, with its universal coverage system, has a higher per capita doctor/visit ratio than the rest of us, and lower costs.

But that's not convincing because everybody knows Hawaii doesn't count for comparisons because it's an island. You know, so there's all kinds of -- (laughter) -- and the dental issue got caught up in there somewhere, so -- (laughter).

DR. HERDER: Well, wait just for one more second. We appreciate your interest in the fee-for-service system as a potential part. I come from a little county in New York called Broome County, where we have something called Medmax and Dentmax, which, utilizing the best capabilities of the fee-for-service system, is now delivering care for Medicaid patients.

We have saved, among 1,200 Medicaid patients, \$1 million in prevented fees from them going to the emergency room for what we can handle in our own office.

MRS. CLINTON: That's what will happen all over the country if we can get this done right. Thank you.

DR. KOOP: There's one aspect of this that I think we haven't talked about. And, in the exclusion for the next seven or eight years of dental problems in adults, we have to remember that there are dental complications of diseases such as diabetes that do have to be covered meanwhile.

MRS. CLINTON: Right. And I believe those are covered. Medically necessary -- what's the -- there's a

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phrase for that. I'll check on that, Dr. Koop. But I think that there is a coverage for those kinds of dental problems.

DR. HERDER: Yes. It is covered, but it can get lost in the shuffle because of dentistry.

MRS. CLINTON: Right.

DR. WATTS-LUBEK (phonetic): My name is Ruth Watts-Lubek. I'm from another island called Manhattan. (Laughter) I'm a nurse-midwife, and we met last week, Mrs. Clinton, at the fundraiser for Mayor Dinkins (phonetic).

But I've been involved for 18 years in giving birth back to families, primarily through free-standing birth centers, which we have proven works at all socioeconomic levels, including in the south Bronx, where we have done a demonstration which Dr. Lee will be seeing next month, and also with rural, low-income families, as well as among the affluent.

There is a birth center here in Bethesda which serves middle-class families. But, if utilized by only 50 percent of child-bearing families in this country, such centers could save \$4 billion annually, because the birth center care for normal childbirth comes in at about half of the costs of in-hospital normal childbirth.

Expansion of such community-based services will require both construction and training monies. How will the plan accommodate to needs like this?

MRS. CLINTON: Well, we think that there will be a demand for birth centers. Again, this is related to how your services will be fit in with broader networks, and the role that nurse-midwives are permitted and encouraged to play in this system.

I don't know, though. I don't know the answer to whether there, specifically, is any funding available. I don't think there is. I think that is something that is probably not available in the plan at this time. I will look into that.

DR. WATTS-LUBEK: Thank you.

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MRS. CLINTON: Oh, Dr. Lee just corrected me. It is in the plan. Thank you, Dr. Lee. Okay. Nurse-midwifery training and some funding for capacity expansion.

DR. KOOP: Over here.

A PARTICIPANT: Mrs. Clinton, although budgetary restraints will not allow, as you said, comprehensive dental care for adult patients at this time, I think I beseech you to reconsider at least giving emergency dental care for adult patients, because we feel that the greatest amount of suffering and dissemination of disease come from the underprivileged, who cannot receive emergency care at this time -- dental care.

MRS. CLINTON: I will check on that. I think we do have emergency care covered. I will check on that again.

PARTICIPANT: Thank you.

DR. BOWMAN (phonetic): I'm Dr. Marjorie Bowman from Winston-Salem, North Carolina. I'm a family physician. And I thank you first of all for tackling this difficult subject. And I have multiple questions, but I'll limit myself to one.

And that is that, as you recognize, the bureaucracy of our current system is great. The paperwork is great. But I also note that in the new plan there are new bureaucracies built into the plan. And I would like to hear what you think about whether or not we would really be simplifying or if we'll be moving from one bureaucracy to others.

MRS. CLINTON: Well, from my perspective, we're going to be eliminating a number of the bureaucracies that we currently have to contend with. The 1,500 insurance companies will not survive. There will be some, but most will not. That will save an enormous amount of time, effort, and money in paperwork and bureaucracy.

The way we have tried to structure this is to take away from both private and public sector bureaucracies the need and right to micromanage independent decision making by physicians, hospitals, and other providers. Now, the trade-off is that we set some kind of boundaries. Namely, that we set some kind of budget.

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And some have said, "Well, you know, that's a very uncertain prospect, to be working within a budget." But your hospitals work within budgets, and you bust them all the time because you can't realistically predict what you're going to be spending on uncompensated care and other things that will no longer be part of the day-to-day worries that you will have.

The health alliances are consumer- and employer-driven organizations that are largely going to be collecting the funds and then, at your individual direction by the consumer, transmitting those to the health alliance that you choose. And that can change from year to year.

So I think that there is certainly an argument that what we're doing will be limiting bureaucracy. And it's one of our goals to continue to be extremely vigilant about that -- to limit it as much as possible. And it's just something that we're going to have to be watching all the time. But there is no doubt in my mind, we will significantly streamline the system over what we currently have.

DR. BOWMAN: But there will be a new national health board, a new graduate medical education board, a new board related to academic health centers, et cetera. And I perceive that those will engender bureaucracies related to them as well.

MRS. CLINTON: Well, that may be. But, you know, if we have a benefits package that's guaranteed, there has to be some entity that will make the decision about what benefits will be upgraded and included in years to come. Now, we could leave that to the Congress. I don't think that's a good idea. (Laughter)

This will take the politics out of it. But think now. We are replacing with one board, literally, hundreds of decision-making boards, all of them staffed, called insurance company executives and claims agents. I mean, we are replacing this huge infrastructure.

And it is a little bewildering to think that when we look out at how decisions are made now, that we will not be limiting bureaucracy. And yes, we do want some kind of advisory board for academic health centers to get together to make some decisions about quality and to make some decisions

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about the direction of graduate medical education.

That seems to me to be a very cheap and unbureaucratic way to help organize decision making. So we'll watch it, and we'll see how it develops, and we want as many of you to take a hard look at it as possible. But we've tried to be as focused as we can about the missions that these entities are to perform.

DR. KOOP: If you ask short questions, you might get as many as two in. (Laughter)

A PARTICIPANT: Mrs. Clinton, your leadership is simply inspiring. Thank you very much. I wanted to focus for a moment on one other aspect of education. I'm the dean of the medical school at Columbia University. One of the things that's enabled us to educate medical students, and I would submit that one of the -- American medicine at its finest is the finest. The thing is to get it to everybody.

But one of the things that enables us to do it is the fact that we've been able to educate medical students. And as the needs change, we can change those needs. But there has to be support of the education through the medical schools themselves.

I know you have streams of money. I guess one of the concerns is that some of that money be designated for the education of the medical students, which heretofore has been done by cross-subsidization of clinical practice and also a lot of voluntary teaching. I wonder if you could comment on that?

MRS. CLINTON: I believe that in the designated streams, we do designate funding for medical education, as well as for other roles we want academic health centers to play.

PARTICIPANT: I think one of the fine points to make is that the educational part of an academic health center -- the medical schools, the nursing schools -- have to have those educational monies to make sure education gets done in the ambulatory care setting or anywhere else we think it should be done.

MRS. CLINTON: I absolutely agree with that. And

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based on the many conversations we've had with you and others who have been kind enough to share your time with us, we have drafted legislation that we think will do that. And, obviously, we want you to carefully read it and make sure it's in accord with what we think we're doing together on this.

PARTICIPANT: Since Dr. Koop said I could have a second question, I'll make it very quick. (Laughter)

DR. KOOP: Herb, I didn't say that.

PARTICIPANT: Thank you for helping destigmatize mental illness.

DR. WOLHAMEL (phonetic): I'm Stephanie Wolhamel from Cambridge, Massachusetts, and I'm not going to ask about the details, which are really dazzling in their elegance, but about your poor decision to embrace managed competition, which at best -- at best -- is untried in terms of cost containment, and also your decision to turn your back on the single-payer system that many of us in the room have advocated and has a proven track record not only in covering the population, but in controlling costs and simplifying bureaucracy.

MRS. CLINTON: Well, I appreciate that. And I also appreciate greatly the extraordinary work you and your colleagues have done over the past decade to raise a lot of these issues that weren't raised before. And if it had not been for your painstaking comparisons of Mass General and Toronto General, a lot of these distinctions would not be well known.

In the legislation, we are providing that any state that wishes to be a single-payer state may choose to do so. Now, this is a decision that I'm sure will be controversial in some quarters. But it seems to us an appropriate role for the states, who will be given a lot of decision making authority in this area, to be able to choose.

And as the speaker has pointed out, there are a number of physicians, the New England Journal, other very distinguished observers of the medical scene, as well as practitioners, who believe totally in the single-payer system. There are many who believe it is totally wrong for

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this country.

And we, in attempting to figure out how to create a system that would build on what we have -- to preserve what works and to fix what's broken with it -- have opted to create a system which, in general, would provide accountable health plans that would be competing on the basis of cost and quality.

But we want to be sure that the legislation provides for single-payer. And I anticipate, in going back to Dr. Shine's remarks, that there will be some states that will choose to have a single-payer system. And so, during the next 10 years as this system evolves, we will be able to make some legitimate comparisons.

We will have an opportunity to dispel myths, both pro and con, of both approaches -- or all approaches, because there will probably be more than two that you can describe. And I think that is the realistic and appropriate step for us to take at this time.

And I will look forward to seeing which states choose to go in that direction, and to watch closely the kind of support they engender and the kind of results they have.

This will be an area that we will have to fight very hard to keep in the legislation. Those of you who are single-payer advocates will really have to work hard to keep this option in this legislation, because right now there is not anywhere near a majority in either house to do anything beyond that with single-payer. But we have to try to preserve that option. And that's what we're going to do.

DR. KOOP: We'll take the last question from here.

DR. FRANK: I'm Ellen Frank (phonetic) from the University of Pittsburgh School of Medicine, and I do treatment outcomes research.

I would like to return to the last theme of your prepared remarks, and that is to ask what provision there is in the plan for shortening the time lag between the publication of a treatment outcome finding and its adoption in general practice. My understanding is that on average now, that's about 10 years.

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MRS. CLINTON: Well, we don't have any sort of magic remedy for that. (Laughter) But you are absolutely right, that it is a significant problem.

We think, though, that through devices such as quality report cards, through the kind of peer accountability we think that the networks will engender, through the kind of small-scale, comparative research that Dr. Weinberg and Dr. Koop have been doing -- we really think we will have better mechanisms for getting information out, and there will be a return to the physician or the provider for doing it.

Now, I'll just give you one example that was brought to my attention in Minneapolis. One of the fine clinics in Minnesota developed a procedure -- radiological procedure for the detection of breast lumps, the mammo test.

They're having a difficult time beginning to introduce it and utilize it, even within their area, because there is, frankly, no incentive for surgeons to make referrals to radiologists so that a noninvasive procedure can be used, even in the numbers necessary to provide the kind of information that you're talking about.

In better organized networks of care, we won't have that kind of either/or situation in quite as stark a way as there is now. So information coming from basic research and applied research and clinical trials will have a more receptive audience, because it will not be so clearly viewed as a threat, very frankly, to the reimbursement patterns that currently exist to continue what has been done.

And I think we're talking about big changes in attitude to support big changes in practice styles. But we've got some mechanisms that we hope will push that. Any ideas you would have, we would certainly welcome to try to enhance that transition period.

DR. FRANK: Well, thank you for that opportunity, and thank you for all of your hard work. It's much appreciated. (Applause)

DR. KOOP: At the risk of being anticlimactic -- (laughter) -- there is one question that I would like the First Lady to have the opportunity to answer, and it was posed to me by a number of you last night, and I'd like to

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put it to her just as bluntly as you put it to me.

The plan is so complicated. There is so much to expect. There is so much possible opposition from Congress and from lobbies. If you don't have a simple fall-back position, isn't there a chance that we could lose it all?

MRS. CLINTON: Well, there's always that chance. But my view is that we have to believe we're going to succeed at this effort. The details will change. There will be a lot of good advice -- from you in this room and others -- that will be legitimately aimed at improving what we are trying to do, that we will be very open to.

But I don't think you bring about change in the kind of atmosphere in which we live without enormous persistence and commitment to the final outcome. And from my perspective, there are certain absolutely nonnegotiable conditions -- like universal coverage and comprehensive benefits and enhanced quality and the things we've talked about.

And if we stick to those, and particularly if you become partners in this reform effort -- and when I say that, I don't mean that you will agree with everything that's in it, but you will stand behind and support what we're doing, and speak out for it -- I am very confident of the outcome.

And I wish we lived in an earlier time. I wish that this were the Social Security instead of the Health Security battle and that the legislation could be 32 pages long and the President could just go around saying, "Here's the deal. It's a new deal. You just put your money in and we'll take care of you when you're old." (Laughter)

But we don't live in those times. We live in an information overload time where everything is second-guessed and skepticism abounds, and where, as a result, we do have to present as many details as possible. But the details should not obscure our fundamental goal, which is to secure health security to every American, and to do it in a way that enhances their access and quality of care.

And if we stick with that, I think we're going to get it done. And, I don't think about fall-back positions.

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