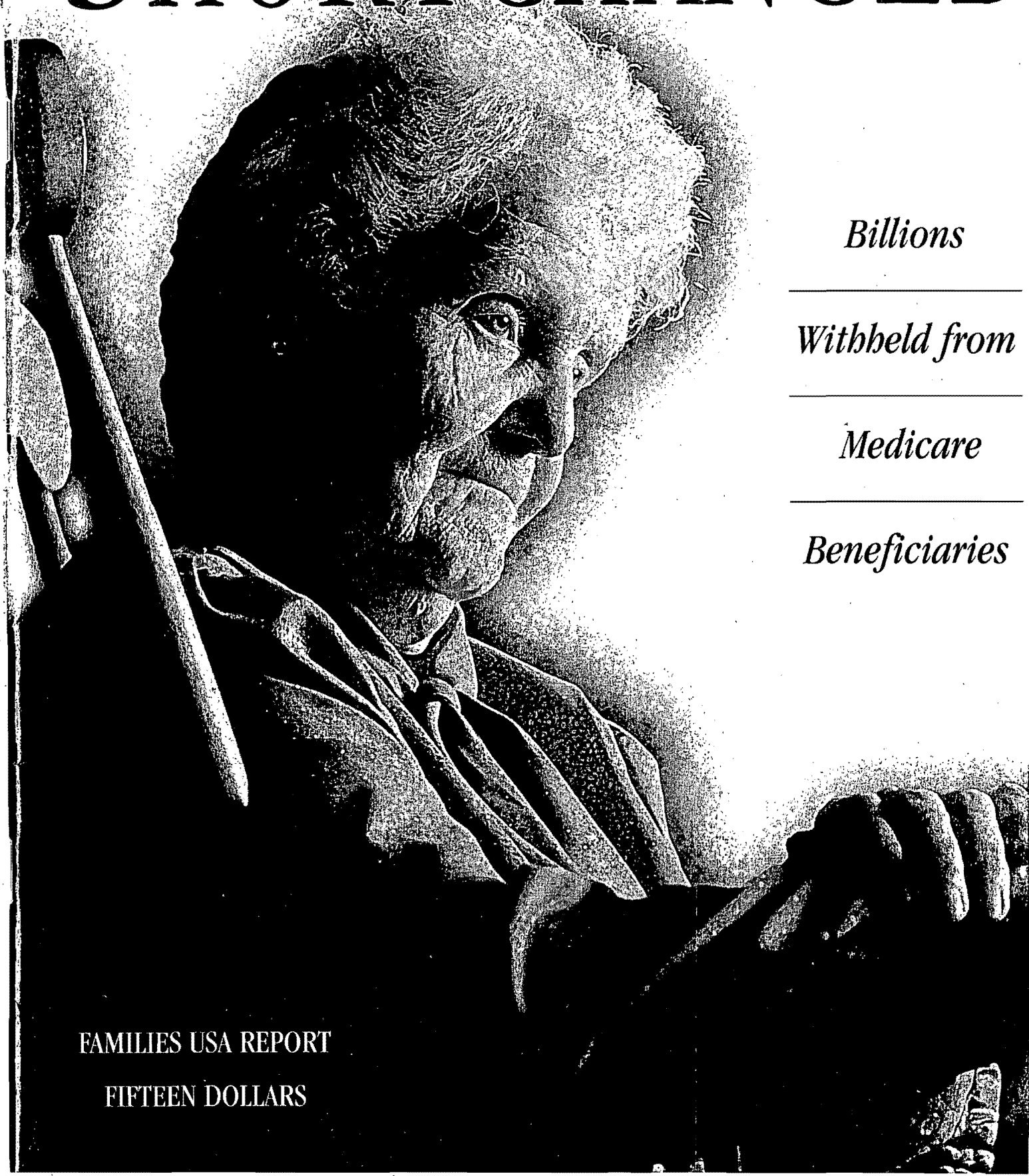
Medicare GMB Files

SHORTCHANGED



Billions

Withheld from

Medicare

Beneficiaries

FAMILIES USA REPORT

FIFTEEN DOLLARS

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~~HOLD FOR RELEASE~~
~~July 7, 1998, 10:00am~~

CONTACT: Lorie Slass
202-628-3030

SOCIAL SECURITY CHECKS BEING SHORTCHANGED $2 BILLION A YEAR

4 MILLION SENIORS AND PEOPLE WITH DISABILITIES AFFECTED

Four million low-income seniors and people with disabilities, who are entitled to have their Medicare premiums paid for by programs established by Congress, are not receiving such help and, instead, are having their Social Security checks slashed each month to pay for those premiums. That is the charge leveled today in a report issued by the health consumer watchdog organization, Families USA.

Shortchanged: Billions Withheld From Medicare Beneficiaries found that the Social Security Administration is withholding approximately $2 billion in annual premiums from Medicare beneficiaries who should have their premiums subsidized through Congressionally enacted programs. For low-income persons living alone, mainly widows and widowers, the amount being lost equals $525.60 per year. For couples, the loss is $1,051.20.

Close to half the people entitled to have their Medicare premiums paid for are not receiving such assistance, according to the Families USA analysis. The report indicates that many low-income seniors and people with disabilities are also entitled to have their Medicare deductibles and co-payments subsidized but are not receiving this help.

"As Medicare costs continue to grow, low-income seniors and disabled persons continue to see their Social Security checks shrink," said Ron Pollack, executive director of Families USA. "If the Social Security Administration is responsible for cutting the checks of these needy seniors each month, it should also be responsible for getting them the benefits Congress and the President established and that they desperately need. "

– MORE –

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The following states have the highest numbers of low-income seniors and disabled individuals eligible for payment of their Medicare premiums but are not receiving them: Texas (370,000 to 404,000); Florida (252,000 to 275,000); Ohio (233,000 to 264,000); Pennsylvania (202,000 to 231,000); Illinois (198,000 to 226,000); New York (148,000 to 192,000); Virginia (122,000 to 131,000); Michigan (103,000 to 118,000); Massachusetts (94,000 to 113,000); Washington (99,000 to 107,000); Alabama (92,000 to 100,000); and Georgia (88,000 to 103,000). [See Table attached to this press release.]

During the last decade Congress established a number of programs, known as the "Medicare buy-in," to help this needy population:

- The Qualified Medicare Beneficiary (QMB) program, enacted in 1988, is designed to pay the Medicare premiums, deductibles, and co-payments for seniors and disabled persons whose incomes are below the poverty line – $8,292 in annual income for people living alone and $11,100 for couples. The report finds that between 1.9 and 2.4 million of these people, the poorest seniors and people with disabilities in the country, are not getting the benefits they are entitled to receive.

- The Specified Low-income Medicare Beneficiaries (SLMB) program, established in 1990, pays for Medicare premiums for seniors and disabled persons with incomes between the poverty line and 20 percent above that line. The report finds that approximately 1.4 million people eligible for SLMB benefits are not getting them.

- For people with incomes up to 35 percent above the poverty line, a program was established in the Balanced Budget Act of 1997 to expand Medicare premium subsidization. The report finds that as of June 1998, of the approximately 499,000 people funded by Congress to get this aid, only 4,723 individuals – less than one percent – are receiving it.

"Since Medicare premiums will more than double over the next decade," Pollack said, "the withholding of these benefits will result in lower and lower Social Security checks. Unless the problems with enrollment in the Medicare buy-in programs are resolved, the federal government will take an even larger bite out of the meager Social Security checks of widows and widowers in years to come."

According to the Congressional Budget Office, Medicare premiums will increase from $525.60 per year to $1,268.40 in the year 2008.

– MORE –

Families USA cites lack of knowledge about the buy-in programs as the major reason for low participation. Although Medicare beneficiaries must visit a Social Security office to enroll in Medicare, and although the Social Security Administration deducts Medicare premiums from Social Security checks, low-income seniors and disabled persons are not allowed to apply for the buy-in programs at that office. Instead, people are required to apply at state welfare and Medicaid offices. In addition, there are many bureaucratic hurdles that must be overcome to apply for buy-in benefits, including extensive documentation and, in some states, requirements of in-person applications.

"There are some very simple steps that can be taken to ensure that more low-income seniors and people with disabilities don't lose out on these important benefits," added Pollack. "First and foremost, the Social Security Administration should directly enroll low-income Medicare beneficiaries in the buy-in programs at Social Security offices."

###

Medicare beneficiaries who believe they may be eligible for QMB or SLMB benefits, but are not certain, should call the Medicare Hotline at 1-800-638-6833 for the number of the Insurance Counseling and Assistance Program nearest you. Or, send a self-addressed stamped letter size envelope to Families USA/Shortchanged, 1334 G Street, NW, 3rd Floor, Washington, DC 20005 for a list of the Health Insurance Counseling and Assistance Programs in your state.

Copies of *Shortchanged* are available from Families USA for $15 each. Please see our website www.familiesusa.org for information on how to order the study, or call 202-628-3030.

Families USA is the national organization for health care consumers. It is non-profit and non-partisan and advocates for high-quality health and long-term care for all Americans.

Table 1

Low-Income Medicare Beneficiaries Eligible for, But Not Receiving, Buy-In

State	Number of QMB + SLMB Eligibles for Buy-in	Number of QMB + SLMB Eligibles Not Receiving Buy-in[1]	Percentage of QMB + SLMB Eligibles Not Receiving Buy-in[2]
Alabama	209,000	92,000 - 100,000	43.9 - 48.0%
Alaska	*	*	*
Arizona	118,000	70,000 - 75,000	59.6 - 63.3
Arkansas	139,000	66,000 - 74,000	47.2 - 53.0
California	826,000	74,000 - 100,000	8.9 - 12.1
Colorado	52,000	5,000 - 11,000	9.3 - 20.6
Connecticut	63,000	18,000 - 28,000	28.9 - 43.4
Delaware	21,000	13,000 - 14,000	61.5 - 66.8
District of Columbia	32,000	18,000 - 19,000	56.6 - 60.5
Florida	547,000	252,000 - 275,000	46.0 - 50.2
Georgia	249,000	88,000 - 103,000	35.4 - 41.5
Hawaii	32,000	14,000 - 16,000	44.1 - 48.6
Idaho	22,000	8,000 - 10,000	38.4 - 45.8
Illinois	325,000	198,000 - 226,000	61.0 - 69.5
Indiana	156,000	87,000 - 101,000	55.6 - 64.7
Iowa	43,000	** - 7,000	** - 15.2
Kansas	69,000	35,000 - 42,000	50.3 - 60.4
Kentucky	149,000	49,000 - 58,000	32.8 - 38.7
Louisiana	176,000	70,000 - 83,000	39.8 - 47.5
Maine	48,000	18,000 - 21,000	37.1 - 43.7
Maryland	127,000	72,000 - 82,000	56.8 - 64.2
Massachusetts	218,000	94,000 - 113,000	43.2 - 51.9
Michigan	226,000	103,000 - 118,000	45.4 - 51.9
Minnesota	86,000	36,000 - 46,000	41.7 - 53.7
Mississippi	111,000	10,000 - 17,000	9.0 - 14.9
Missouri	144,000	72,000 - 85,000	50.0 - 59.3
Montana	24,000	13,000 - 15,000	54.9 - 62.6
Nebraska	39,000	23,000 - 27,000	60.1 - 68.6
Nevada	43,000	27,000 - 29,000	63.0 - 65.8
New Hampshire	17,000	12,000 - 13,000	68.6 - 75.6
New Jersey	195,000	70,000 - 86,000	35.8 - 44.1
New Mexico	70,000	38,000 - 40,000	53.6 - 56.8
New York	476,000	148,000 - 192,000	31.0 - 40.4
North Carolina	270,000	71,000 - 86,000	26.5 - 31.9
North Dakota	20,000	15,000 - 16,000	75.0 - 80.1
Ohio	393,000	233,000 - 264,000	59.4 - 67.1
Oklahoma	125,000	68,000 - 77,000	54.3 - 61.1
Oregon	88,000	39,000 - 43,000	44.6 - 48.8
Pennsylvania	356,000	202,000 - 231,000	56.6 - 64.8
Rhode Island	43,000	28,000 - 31,000	64.6 - 72.4
South Carolina	152,000	51,000 - 54,000	33.5 - 35.7
South Dakota	22,000	11,000 - 13,000	49.2 - 59.2
Tennessee	176,000	19,000 - 33,000	10.7 - 18.9
Texas	684,000	370,000 - 404,000	54.0 - 59.1
Utah	22,000	9,000 - 10,000	38.7 - 47.0
Vermont	19,000	6,000 - 8,000	34.1 - 40.0
Virginia	224,000	122,000 - 131,000	54.4 - 58.7
Washington	181,000	99,000 - 107,000	54.8 - 59.2
West Virginia	99,000	59,000 - 63,000	59.5 - 63.4
Wisconsin	109,000	44,000 - 58,000	39.9 - 52.7
Wyoming	9,000	4,000 - 5,000	44.3 - 53.1
TOTAL	8,044,000	3,343,000 - 3,860,000	41.5 - 47.9

[1] This column presents a high and low range rounded to the nearest 1,000 of QMB and SLMB eligibles not receiving the buy-in who, as a result, are experiencing deductions in their Social Security checks.

[2] This column presents a high and low range percentage of QMB and SLMB eligibles not receiving the buy-in. The percentages given in this column are calculated from data which have not been rounded. As a result, they may not match percentages calculated from previous columns due to rounding error.

* We do not report for Alaska due to insufficient sample sizes.

** Less than 1,000.

Table 2

Annual Funds Lost By Low-Income Medicare Beneficiaries

State	Dollars Lost[1]		
Alabama	$48,355,200	-	$52,560,000
Alaska	*		
Arizona	36,792,000	-	39,420,000
Arkansas	34,689,600	-	38,894,400
California	38,894,400	-	52,560,000
Colorado	2,628,000	-	5,781,600
Connecticut	9,460,800	-	14,716,800
Delaware	6,832,800	-	7,358,400
District of Columbia	9,460,800	-	9,986,400
Florida	132,451,200	-	144,540,000
Georgia	46,252,800	-	54,136,800
Hawaii	7,358,400	-	8,409,600
Idaho	4,204,800	-	5,256,000
Illinois	104,068,800	-	118,785,600
Indiana	45,727,200	-	53,085,600
Iowa	**	-	3,679,200
Kansas	18,396,000	-	22,075,200
Kentucky	25,754,400	-	30,484,800
Louisiana	36,792,000	-	43,624,800
Maine	9,460,800	-	11,037,600
Maryland	37,843,200	-	43,099,200
Massachusetts	49,406,400	-	59,392,800
Michigan	54,136,800	-	62,020,800
Minnesota	18,921,600	-	24,177,600
Mississippi	5,256,000	-	8,935,200
Missouri	37,843,200	-	44,676,000
Montana	6,832,800	-	7,884,000
Nebraska	12,088,800	-	14,191,200
Nevada	14,191,200	-	15,242,400
New Hampshire	6,307,200	-	6,832,800
New Jersey	36,792,000	-	45,201,600
New Mexico	19,972,800	-	21,024,000
New York	77,788,800	-	100,915,200
North Carolina	37,317,600	-	45,201,600
North Dakota	7,884,000	-	8,409,600
Ohio	122,464,800	-	138,758,400
Oklahoma	35,740,800	-	40,471,200
Oregon	20,498,400	-	22,600,800
Pennsylvania	106,171,200	-	121,413,600
Rhode Island	14,716,800	-	16,293,600
South Carolina	26,805,600	-	28,382,400
South Dakota	5,781,600	-	6,832,800
Tennessee	9,986,400	-	17,344,800
Texas	194,472,000	-	212,342,400
Utah	4,730,400	-	5,256,000
Vermont	3,153,600	-	4,204,800
Virginia	64,123,200	-	68,853,600
Washington	52,034,400	-	56,239,200
West Virginia	31,010,400	-	33,112,800
Wisconsin	23,126,400	-	30,484,800
Wyoming	2,102,400	-	2,628,000
TOTAL	$1,757,080,000	-	$2,028,816,000

[1] Range of dollars lost by low-income Medicare beneficiaries who are experiencing Social Security deductions because they are not receiving their buy-in benefits.

* We do not report Alaska due to insufficient sample sizes.

** See last footnote on Table 1.

FOR IMMEDIATE RELEASE
July 6, 1998

Contact: Lorie Slass
202-628-3030

President Clinton Responds to Alarming Findings in Families USA Report

New Efforts to Increase Awareness of Medicare Buy-In Programs Will Help Millions of Low-Income Seniors and People with Disabilities

Statement by Ron Pollack – executive director of Families USA, the national organization for health care consumers – on today's announcement by President Clinton to improve outreach efforts to enroll low-income Medicare beneficiaries in Medicare buy-in programs:

"We are delighted that the President has responded decisively to the problems low-income seniors and people with disabilities are experiencing paying for their Medicare premiums. The President's actions are likely to result in significant savings for low-income seniors and people with disabilities – savings achieved by ensuring that these people have their Medicare premiums paid for by Congressionally enacted programs.

"In a report to be released tomorrow, Families USA found that over 4 million low-income Medicare beneficiaries are eligible for these benefits but are not receiving them. Instead, each month, these low-income seniors and disabled persons are having their Social Security checks deducted to pay for their Medicare premiums – to the tune of $2 billion each year. For a low-income senior or person with a disability, the amount being lost equals $525.60 per year.

"We gave a copy of our report to the White House, the Social Security Administration, and the Health Care Financing Administration almost three weeks ago. I am delighted that they have worked cooperatively together to develop a responsive plan to deal with this problem.

"The steps outlined today by the President will go a long way to ensuring that low-income Medicare beneficiaries will have a much better chance to get their Medicare premiums subsidized so that their meager Social Security checks are no longer deducted."

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First Lady Commencement Speech File

FAX MESSAGE

TO: Mr. Chris Jennings, the White House
FAX No.: 202-456-5557
From: May C. Reinhardt, P6/b(6)
P6/b(6)
Date: May 17, 1998
Pages (cover included): 20

Dear Chris:

As you suggested, attached is a 10-page narrative Uwe wrote today before he left this afternoon--his vision of a possible commencement address to those Harvard Medical School graduates many of whom will be future leaders in American health care. Everything he says in it has been documented, as I am sure you are familiar with, and their sources are available "upon request". Also, Uwe will be glad to elaborate and/or clarify any of the points if needed.

Also attached are two short pieces Uwe wrote from which he drew for the narrative. You and Mrs. Clinton might find them interesting reading. The Commentary piece "Wanted: A Clearly Articulated Social Ethic for American Health Care" especially found wide echoes from all corners of the land.

Uwe will be back tomorrow evening and will be in Princeton most of next week except for Wednesday afternoon when he will be in NYC to receive a special award at Columbia School of Nursing's commencement. He leaves for Hong Kong early morning Friday, May 22. From May 23-26 we may be reached at the Hong Kong Grand Hyatt. Please do not hesitate to call if you or Mrs. Clinton need to.

Have fun with the project. Please give Uwe's and my warmest regards to Mrs. Clinton. I am certain this is one assignment she will really enjoy.

All the best,

MRJ

IDEAS FOR ADDRESS ON HEALTH

Uwe E. Reinhardt
Princeton University
May 17, 1998

After a more general survey of the current health-care delivery system, of the current insurance status of Americans and of recent initiatives in federal health policy, one might focus more narrowly on major issues that confront the graduates themselves, in a very personal way. If I were the speaker, I would make it a bit provocative, so that they would remember my speech. Thus, it might continue

. . . . .

As you embark upon your career in medicine, you will have to grapple with two major issues whose resolution will directly affect your daily work:

First, who will "manage" the treatment of your patients? Take it for granted that it won't any longer be you alone--the lone-ranger physician--as it has been for American physicians for so many decades. But will it be you and other members of your health-care team who will jointly manage the treatment of your patients, along with your patients themselves, or will it be done, as it now so often is, by strangers who monitor what you do and micro-manage you via an 800 number?

If you regain whatever control over clinical decisions your predecessors have lost in recent years, will you be able to exercise that control in a manner that rebuilds the trust American policy makers and the public once had in the medical profession? Think about it! What must you do to regain that trust?

Second, do you care what broader social ethic governs the distribution of health care in America, or should that question be left strictly to business executives and to politicians whose wishes in this regard you will faithfully execute? Remarkably, the bulk of your predecessors have remained aloof of this important decision, leaving it in the hands of politicians and executives. To make it very concrete, consider the following simple question [*****I had posed it recently in an op-ed piece in *The Journal of the American medical Association*--see the attached copy and, especially, the nasty letters thereto and my reply*****]

> *To the extent that a health system can make it possible, should the child of, say, a low-income gas-station attendant or restaurant worker have the same chance of staying healthy and the same chance of being cured from a given illness as the child of a corporate executive?*

Do you have a view on this question? Should your view carry political clout, as you have to live with the social ethic we impose on our health system? Your place in the history of

American medicine will be determined largely by how you will cope with these two challenges describe above. Because my remarks on them have been a bit provocative, let me examine both challenges in some more depth, looking at "managed care" first and "social ethics" thereafter.

A. WHO WILL "MANAGE" HEALTH CARE IN AMERICA?

In your conversations with older physicians, you will undoubtedly have discerned the deep disillusionment that has befallen many of them. Many of them would counsel their children against entering a profession that seems to have lost its professional freedom, its solid economic base and even its dignity. Older physicians may talk to you about the golden age of American medicine, when the individual physician was free to be the best for his or her patients and, in the process, made American medicine what they consider "the best in the world."

Surely you must have asked yourself: How was this golden age lost, and who stole it?

The answer, I'm afraid, is that the golden age was lost alright, but it was not stolen away. It simply was lost by a profession that took it too much for granted. American society was no longer able and willing to underwrite the rapidly rising cost of the clinical and economic freedom it had accorded its physicians. You had better get used to it: that golden age will never come back!

Only days after the election victory of then President-elect Clinton in the fall of 1992, American corporate executives jetted to Little Rock there to plead for help in addressing the seemingly intractable problem of rising health care costs. These costs, argued the executives, made it hard for them to compete in the global economy. Mayors, governors and the members of the United States Congress came to Arkansas, too, besieging the President-elect for help in addressing the deep inroads that health care was making into their budgets. In retrospect, it is truly remarkable that the leaders of academic medicine and of organized medicine paid these anguished voices so little heed. Was not the hand-writing of some form of "managed care" clearly on the wall?

What American medicine took for granted was the perpetuation of two rather naive **beliefs** among policy makers and the general public, to wit:

First, that the practice of modern medicine rested on solidly well tested scientific research--that it was solidly "evidence-based," as we now put it.

Second, that the providers of health care would not use more resources than were necessary to manage the health system.

On these two credos, for example, rested the methods by which physicians were compensated until the early 1990s. Private employers, who provide close to two thirds of Americans with private health insurance and account for about one third of all health spending in this country[1], basically told American physicians:

> *"When our employees come to you for advice or treatment, do for them what you, the individual doctor, thinks best and then send us a bill at your usual fees. We promise promptly to pay your bill, as long as it is at all reasonable."*

Formally this method of compensation was known as the "UCR" method, which stands for "usual, customary and reasonable." In practice, unless a physician's fee for a procedure exceeded the 90th percentile of fees for that procedure charged by physicians in the region, that physician was paid the fee. Furthermore, few if any private insurance companies then ever dared question the physician's clinical judgement.

Many of you may know that, at its inception, Medicare adapted itself to this UCR method as well. It did so until the mid 1970s, when the inflationary force of such a system became apparent and the Congress started to put a ceiling on that was considered "reasonable" fees. In the end, that effort resulted in a common fee schedule for Medicare to which, ironically, many private insurance companies now adapt themselves. But although both Medicare and Medicaid did in the end put ceilings on the fees they would pay, neither program did much if anything to interfere in the individual physician's clinical freedom. Managed care as we know it did not exist.

The ultimate result of this open-ended social contract Americans had with their health system was that their health system became too expensive and, moreover, that there seemed to be little observable correlation between what was spent on health care in various regions of the United States and the outcomes that were achieved with these expenditures. Both factors served to undermine the erstwhile blind trust Americans had in their health-care professionals, and both naturally led to the era of "managed care," which is best defined as

> *the external proctoring and, if necessary, micro-managing of the medical treatments otherwise managed by doctors and their patients.*

Let me first say a few words about costs and then about the relationship between costs and outcome.

Intolerable Cost Increases:

During the late 1980s, when GDP per capita (in current dollars) was rising in the neighborhood of 5.5 percent per year, the premiums private employers paid for health insurance rose by an average of between 15% to 20% per year. What individual firms paid fluctuated widely around these averages. Unable to pass on these costs to consumers in our increasingly competitive global economy, employers simply cut the premiums out of their workers' take-home pay. Health care was literally taking ever deeper bites out of the average American employee's paycheck.

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[1] Although covering close to **two thirds** of Americans, private employer-paid health insurance account for only **one third** spending because they cover mainly low-cost, young people while the public sector covers the old, the very poor, and the disabled.

By 1992, total national health spending in the United States had climbed to about 13.5 percent of the GDP, far ahead of health spending in other industrialized nations with much older populations, all of whom spent less than 10 percent of their GDP on health care, with no visible, deleterious effect on the population's health status.

More alarming still, the Congressional Budget office at that time produced forecasts according to which the United States would be spending about 19% of the GDP on health care by the year 2000--almost every fifth dollar of the GDP. You may recall when, as part of the Presidents health-reform plan it was proposed to constrain that figure to about 17%, there was a huge outcry in the press that such a policy would require a degree of rationing unheard of in the United States!

[****** I attach two copies of Xmas cards I then made, spoofing this entire scene******]

It should have been obvious to anyone that the spending trends begotten by our trusting, open-ended social contract with American medicine could not be sustained any longer. Someone had to break these trends, be it private payers, the government, or both in tandem. As already noted, neither the leaders of academic medicine nor those of organized medicine seem to have been alert to that prospect. On the contrary, year after year there were laments that Medicare (whose outlays then grew at an annual rate of over 10%) was being brutally "cut" and that "cost containment had gone too far."

Is it any wonder, then, that both the private sector and government looked to people outside the medical profession--that is the managed-care industry--to gain better control over health spending.

Lack of Evidence Based Clinical Practice

But the intolerable spending trends were not the only force that eroded society's trust in its medical profession. Just as disturbing was the mounting evidence coming from the health-services research community that much of medical practice in this country (and, for that matter, elsewhere in the world!) lacked a solid scientific base. Because that is so brazen a proposition for a lay-person to offer--especially at this hallowed center of medical research--let me seek cover here behind the words of Dr. Kenneth Shine, the President of the prestigious Institute of Medicine of the National Academy of Sciences:

"If we ask the question whether physicians have based their practice on scientific principles, it is clear that the profession has been sorely lacking."

*[***** I shot a slide of this statement, but don't have the exact source at hand. it can be gotten, however. In any event, I have the slide off a printed text.]*

Two strands of research from the health-services research community support this troublesome proposition.

First, as the pioneering research of epidemiologist and physician John Wennberg and his associates at Dartmouth University shows, even after adjustment for geographic difference in the age, gender and health status of the population, there remain huge, inexplicable variations in the per-capita use of health services and total health spending. To illustrate, the President has to budget over twice as much per elderly residing in Florida or New York than for similar elderly in

Minnesota, Oregon or the State of Washington. Why should that be so? Similarly, as Dr. Wennberg had shown in earlier work, why is the per-capita use of health care in Boston so much higher than it is in New Haven, even after adjustments for the demographic mix of the populations? In the late 1980s, Dr. Wennberg estimated that if all Americans were treated as Bostonians then were, the U.S. would be spending then close to 17% of the GDP on health care. On the other hand, if all Americans were treated like New Havenites, then only 9% of the GPD would have been spent on health care in the United States. That is a huge difference by any standard.

If you doubt my words, look at Dr. Wennberg's recently published *Dartmouth Atlas of Health Care*, which is accessible also on a website. You will be stunned by the hitherto inexplicable geographic practice variations in health spending and health-care use that are exhibited in that volume.

A second quite distrubing strand of research bearing during the 1980s had focused on the clinical appropriateness of health care that was actually delivered to patients. Using clinical protocols carefully composed by panels of clinical experts, researchers at the Rand Corporation and elsewhere raked through large samples of actual patient-files and discovered that a disturbingly high percentage--often in excess of 20%--of the procedures such as pacemaker implants, coronary bypass surgery, expensive imaging tests and so on that were actually applied to American patients would have been judged unnecessary by these expert panels.

Both strands of research subsequently have led to a new field of research generally known as "outcomes research" or "evidence-based medicine." That research seeks to shore up the practice of medicine with a more solid scientific basis. Dr. Barbara McNeil and Dr. David Blumenthal of this university are but two of many researchers engaged nationwide in this research. Many of you will devote a good part of your life to this research as well. And you have the President's full support for that important research which, incidentally, is now a worldwide campaign.

Society's Response: Managed Care:

But my point here is not so much to plug outcomes research as it is to explain why, sometime in the late 1980s, American society lost its erstwhile blind trust in its medical profession, in spite of the leadership American physicians had assumed in world medical affairs.

The unvarnished truth is that the profession did seem to need outside help in managing the nation's health resources productively, even if the profession itself seemed unaware of the need for that help. Unable to find support for better clinical and economic control of health care among physicians themselves, private and public payers naturally looked to others for that assistance.That "someone else" was the managed-care industry, which one may view as **private health-care regulators** ready to take the place of government regulators. As you may recall, "managed care" was to be the central control device also on the President's healht-reform plan. [***** In some of my writing, I have even called them "bounty hunters"--see the attached title page of a paper.******]

At the turn of the current decade, the managed-care industry faced a uniquely propitious constellation of three economic circumstances that helped it jump into the breach.

First, throughout the 1980s American industry was buslly restructuring its workforce, which had put in jeopardy many jobs that seemed hitherto secure.

Second, staring with the stock-market crash of 1987, the American economy slid into a recession that lasted until about 1992 and amplified the job insecurity among American workers.

Both factors allowed employers to destroy one of the sacred pillars of American health care: the completely free choice of doctors and hospitals Americans traditionally had at time of illness. Henceforth, employers said, that choice would be restricted to physicians and hospitals in a closed health care network run by an insurance company--be it a Health Maintenance Organization or a preferred provider network.

The sacrifice of free choice of providers by employees made it possible for the insurance industry to engage a third propitious factor, namely, its decade old experimentation with closed-ended health panels and rather novel managed-care techniques. The willingness of employees to accept limited choice allowed insurers to engage in selective contracting with doctors and hospitals. **Selective contracting** became the legal foundation for a massive shift of market power from doctors and hospitals to the insurance industry. It is the *sine qua non* of the idea of "managed competition" (which forces health plans to compete fairly for enrolleees) and "managed care" (which allows health plans better to control doctors and hospitals).

Selective contracting is the central pillar of "managed care," because it allows a health plan to extract steep price discounts from doctors and other providers of care, as a condition for inclusion in the health plan's network. The economic power inherent in selective contracting also allows the health plan to impose upon freedom-loving physicians the straightjacket of externally imposed clinical practice guidelines, often read to the physician by a non-physician, over an 800 telephone line.

That such a regime was anathema to physicians is understandable. That in the crisis mood of the late 1980s and early 1990s it was unavoidable should be understood by physicians as well. Managed care was not a conspiracy visited by some evil force upon an angelic profession and its clients, the patients. Rather, it was at the time the only feasible response of payers whose budgets could no longer absorb the rapid annual increases imposed on them by the health sector.

Seen in this light, one must give the managed care industry credit for breaking the frightening cost trends of the last decade, even though there is now some question about the future of the industry's ability to constrain costs. If the managed-care industry has trouble of its own now, it is for other reasons.

The Future of Managed Care

For one, since about 1992, we have enjoyed sustained economic growth, driving the unemployment rate to 4.3 percent, a low level it had not attained in 30 years. In such a tight labor market, employees once again sit in the drivers seat and it is difficult to force them into limited-choice health care. Point of service contracts, direct access of specialists and very wide physician networks have been the answer of the managed care industry. But in widening their networks, the managed-care companies lost much of the economic clout inherent in selective contracting. Consequently, physicians and hospitals are regaining much of the economic power they thought they had lost in the early 1990s.

The moral of the story is that economic boom times are good for physicians, and you should thank those who you believe helped us get these economic boom times. As you can imagine, I have my own theory on that, but I will spare you the details.

Furthermore, however, the managed care industry also made a few tactical mistakes that earned it the wrath of the public and amplified the difficulties it would have encountered by virtue of the economic boom. Kicking people out of the hospitals earlier and earlier may be clinically safe; but the point is: is it what patients as consumers want? If this is to be a so-called "consumer driven" health sector, then should the managed-care industry not have heeded these consumers? Should patients or their physicians not have more say in how long they stay in the hospital? Should consumers not have been given information about the health plans--the private health-care regulators--they are forced to choose? Should there not be grievance procedures through which a denial of care can be quickly and easily appealed?

It appears that the American people believe there should be those consumers rights, and they now have turned to politicians, prominently among them the President, to address their concerns.

Frankly, after the painful defeat of the President's health reform plan, it is nothing short of ironical that some of the most regulatory legislation to be imposed on the managed-care industry comes not from Liberal Democrats, but from staunchly conservative Republicans, such as Republican Governor Whitman of New Jersey, or Congressman Harwood and Senator D'Amato at the federal level. After the demise of the President's health-reform proposal in 1994, there arose the mantra that the American people wanted the "government off its back." A new religion had taken hold, namely, that market forces in the private sector would be able to regulate health care properly, and better than government ever could. Perhaps even Republicans have now learned an important truth about health care:

> *By their very nature, market forces in health care can work to society's advantage only of they are guided and strictly constrained by careful government regulation. In the end, properly functioning "managed competition" in health care will always become "regulated competition."*

During World War II, as Americans were hesitant to enter the fray, Winston Churchill is reported to have remarked:

> *In the long run, Americans will always do the right thing, after exploring all other alternatives.*

This is so in health care as it is in war. Perhaps Americans first had to see first hand what a relatively unfettered health care market would mean to them, where the proverbial rubber hits the road: in their own medical treatments. Perhaps the public, policy makers and the providers of health care have learned in the meantime and will appreciate better that the proper management of a health system will always have to be a close, cooperative enterprise of government and the private sector. Perhaps, when the health-reform train comes around the next time, we shall all be wiser.

The next time the train comes around may be sooner than you think. It could come from the private sector in the seemingly unlikely event of a major recession. Should private employers find a severe decline in its profits, they would undoubtedly look to their outlays on health care as a source of relief.

But more probably the train will leave the station of Medicare, whose outlays must be better controlled in the face of the retiring Baby Boomers. Whatever particulars the now working Bipartisan Commission on Medicare will recommend, among them is likely the idea to have more

of the program regulated by private health-care regulators. These regulators may continue to be the insurance industry. But it could also be you--network of doctors and hospitals ready to take capitation payments directly from medicare (and eventually from private employers) and ready to assume full financial risk for the illness of large enrolled population. Under its Health Partners umbrella, the Massachussets General Hospital already takes such full risk for some 250,000 insured lives. If you are ready for it, that form of managed care could be the wave of the future.

How well that might work would depend in large part not on your brains but on your souls. The problem is this: under the fee for service system patients know that physicians might profit from extra procedures, but there is the abiding belief that more health care is better than less. Patients have always accepted that economic conflict of interest with relative equanimity. Under capitation, however, providers earn more, the more of the capitation they keep--the less testing and other services they put into the treatment of an illness. That conflict of interest is more problematic in the eyes of patients. There might come a day when the media spread the story that physicians in the mammoth Hippocrates Clinic, PLC enjoyed banner profits, but there might also be anecdotes of patients who feel they were shortchanged on health care by that clinic. In other words,

> *one of the most serious challenges you will face as physicians in practices that assume full risk for patients will be to gain and to retain the trust of your patients.*

Are you ready for this challenge? Do you have concrete ideas on how to build this needed trust, and on how to nourish it as you go along? If so, good luck. You will face exciting and professionally rewarding times. If not, better let the insurance industry be the flak catcher and work under their tutelage, acting as the patient's trusted friend. Think about it!

B. THE GUIDING SOCIAL ETHIC FOR AMERICAN HEALTH CARE

So much for the question of who will "manage" health care in the 21st century--you, or the insurance industry. Let me now come to the second major challenge that I mentioned at the beginning--the choice of a social ethic that should drive American health care in the next century.

The puzzling truth is this: uniquely in the industrialized world, Americans have never been able to agree on the distributive ethic that should govern American health care. The Canadians actually have written down that ethic and have only recently reaffirmed it. The statement says that being sick is trouble enough, and that the cost of the calamity should be shared by all members of society. Europeans have a similar explicit code of ethics in what they call the contract of social solidarity. Only Americans have shied away from ever making an explicit statement on this issue. Indeed, we seem too shy ever to discuss it openly, as we should.

Let me repeat the question posed earlier in this connection, namely:

> *To the extent that a health system can make it possible, should the child of, say, a low-income gas-station attendant or restaurant worker have the same chance of staying healthy and the same chance of being cured from a given illness as the child of a corporate executive?*

If you think Americans are of one mind of this question, think again! [***** Without being presumptuous, perhaps this would be the spot to cite my JAMA piece and the stunning letters on that piece--especially the letter by law professor Epstein! You may also enjoy my reply to his letter.**********]

There are two polar views on this issue in our land, and many more nuanced views in between. The polar extremes are these:

A. *Health care is a social good to which all Americans should have access on roughly equal terms, regardless of their own ability to pay for that access. The United States should never ration the health care a family receives by the family's income and wealth.*

Z. *While health care may be a basic necessity--like food and clothing--it is inherently no different from these other basic consumer goods. While people should have access to a basic minimum of care, it is quite alright to ration a family's access to health care by its income and wealth.*

If you had read or listened carefully to the debate on the President's health reform plan in 1993-94, you would have noticed that much of that debate actually was not over actuarial or economic technicalities at all, but over the fundamental question which of these two social ethics should drive the American health system. In his State of the Union address of 1991, President Bush had left matters a bit ambiguous when he said "Good health care is every American's right." What did he mean by "good health care"?

Even so, his statement seems a far shade to the left of the prevailing sentiment in Congress, which would not now approve a sense-of-the Congress resolution that "good health care is every American's right."

In my view, the "health-care-is-just-like-food" ethic (Z) carried the day in 1994, at least for the duration. Whether the average American actually appreciates the full implications of that outcome remains a mystery. In any event, we now face a growing number of uninsured. The count is 41 to 44 million now; it was 35-37 million in 1992. The rolls of the uninsured keep rising in spite of the booming economy. Gone is the myth that economic growth will solve the problem.

It is no secret that I lean heavily towards view (A)--have all of my life and probably always will. But my purpose is not to proselytize on this occasion. Instead, I simply invite you to ask yourself: In which world would you rather practice medicine, in a world driven by ethic (A), even if not perfectly, or in a world driven by ethic (Z)? Of which world would you be prouder as an American citizen? In which world would you feel more comfortable as a prospective patient: What do you think the typical American would want--especially if they stood behind Harvard Professor John Rawls' famous "veil of ignorance" and did not know whether one day they will be rich or poor, chronically healthy or chronically ill.

World (Z), which declares health care to be basically a private consumption good, probably would be more profitable for you as physicians. World (A) might be less profitable, because only government intervention can actually drive a health system toward a reasonably egalitarian distribution of health care. But which world would you find more professionally rewarding?

Although to their credit *The Journal of the American Medical Association* and *The New England Journal of Medicine* have consistently kept the matter of social ethics before their readers' mind, it can fairly be said that most practicing American physicians and even organized labor as it lobbies the legislators have remained remarkably aloof of this important dimension of a health system. I urge you to be more engaged in the issue. We the people look to you not only as industrious folks who mastered a body a science and a bag full of clinical tricks. We know you are bright and have been trained beyond the strict confines of clinical medicine. We also know

that you know the drama of bedside health care not only in its clinical facet, but also its social and economic facets.

The Hippocratic oath, helpful as it is, deals in the main only with the professional ethic that physicians ought to observe at the bedside of those patients who have come to the physician (As an aside, in its classical version, the Oath also binds physicians to keep medical education strictly within the male progeny!)

"Primum non nocere!" says the Hippocratic Oath. "First do no harm!" A good admonition it is. But I plead with you, the future leaders of our health system, to think beyond the bedside, to see medicine as part of a larger society. I urge you to ask also the question: How can I help to avoid the harm that comes to my fellow human beings who, for want of ability to pay, do not even come to the site at which the Hippocratic Oath takes over.

Never forget that studied silence on that issue does harm, too!

Turning Our Gaze From Bread And Circus Games

by Uwe E. Reinhardt

Daniel Yankelovich argues that this nation's recent attempt at health care reform failed largely because the American public failed to "deliberate" properly on the issue. By "deliberation" Yankelovich means "mulling over" the costs and benefits of alternative choices and making tough choices, all in a serious "give-and-take" with the nation's "leadership class." Yankelovich places blame for the public's failure to deliberate squarely on the shoulders of the leadership class, which, according to him, deliberated only within its own ranks.

Embedded in Yankelovich's grand thesis are three hypotheses that warrant closer scrutiny: (1) The leadership class itself properly "deliberated" on health care reform but failed to communicate the product of that "deliberation" to the public; (2) there exist channels of communication through which the leadership class could, if it wished, engage in a "give-and-take" with the public; and (3) the public is intellectually and temperamentally predisposed to "deliberate" sincerely on complex issues of public policy and to make the tough choices in a lengthy conversation with leaders.

The validity of these hypotheses can be questioned. Indeed, they strike me as utopian, as does Yankelovich's strategy for fixing the "disconnect" between leaders and the public.

Deliberation In The Leadership Class

When America's leadership class sets out to debate health policy, its members invariably preface their deliberations with the mantra: "We all want the same things in health care. We are merely arguing over the means to that end." This is utter nonsense. The great health care reform debate of 1993–1994 was not just a technical dispute over alternative means of reaching a widely shared goal. It was a fiercely fought ideological battle over the goal itself. The nation's leadership class was and remains deeply divided over the ethical precepts that should govern the distribution of health care.

At one end of the ideological spectrum are the pure egalitarians who would like to see health care treated as a social good to be made available to all members of society, on equal terms, regardless of a person's ability to pay for it. This school of thought would like to see health care financed collectively, through mandatory contributions that vary strictly by households' ability to pay and certainly not by the health status of a household's members.

At the other end of the ideological spectrum is what one may dub the "food people." They are puzzled why anyone would make a distinction between health care and other basic, private consumption goods, such as food and housing. As Rep. Richard K. Armey (R-TX), a newly elected leader in the House of Representatives, put it to *The Wall Street Journal* in his inimitably blunt style: "Health care is just a commodity, just like bread, and just like housing and everything else."[1] The "food people" regard the procurement and financing of health care as chiefly the responsibility of the individual, whose own behavior is thought to be a major determinant of his or her health status. To be sure, the members of this school of thought do admit that the etiology of illness can be external, and they are prepared to guarantee the poor and near-poor at least a basic ration of critically needed health care. At the same time, however, they see nothing wrong with a health system in which the quantity, timeliness, and quality of the health care received by American families varies systematically and positively with household income. If one believes, as this school of thought tends to believe, that the American economy is the closest approximation worldwide to a true meritocracy, then an income-based

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health care system is much more defensible on ethical grounds than a purely egalitarian one would be.

The "food people" won the great health care reform battle of 1993–1994 squarely, although perhaps not fairly. One may question the fairness of the battle, because it was never fought openly, in the blunt language favored by Congressman Armey. Instead, much of the action was camouflaged behind soothing code words such as "empowerment," "personal responsibility," the "freedom to choose whether or not to be insured," and so on—code words all adding up to the proposition that well-to-do Americans should be empowered to allocate their income to health care and other commodities as they see fit, and that poor and low-income households should be empowered to do likewise with their much more meager budgets.

Three-tier system. In practical terms, the victory of the "food people" represents the official sanction, by the U.S. Congress, of an income-based health care system with the following three tiers.

For uninsured Americans who are poor or near-poor—chiefly, families of persons who work full time at low wages and salaries—we shall reserve and perhaps expand our current patchwork of public hospitals and clinics. These publicly financed institutions will be sorely underfunded, as they always have been, thus forcing severe limits on their physical capacity. Such limits, in turn, will beget the long queues that have always been the classic instrument of rationing. Lack of funding also will limit the medical technology available to physicians working in these public institutions. The uninsured will increasingly be driven to these public facilities, as government programs and private managed care systems eat ever more deeply into the profit margins of private hospitals, thereby limiting these institutions' financial ability to act as insurers of last resort.

The employed broad middle class will increasingly be enrolled in capitated health plans, such as health maintenance organizations (HMOs). These plans will be budgeted prospectively, on a per capita basis, through competitively bid premiums. To control their outlays, the plans necessarily must limit patients' choice of doctor and hospital at time of illness. Furthermore, they inevitably will come to withhold some care that patients and their physicians might judge desirable, but that the HMO's management (and the clinical experts advising them) may find too expensive relative to the expected medical benefits.

Finally, for well-to-do Americans there will continue to be the open-ended, free-choice, fee-for-service health care system without rationing of any form, even in instances in which additional care is of dubious clinical or economic merit. Well-to-do Americans will demand no less, and they will always have it. Furthermore, they will continue to have it on a fully tax-deductible basis, a tax preference to the rich that no economist would ever defend, but that no politician would dare to remove.

While the official sanction of this three-tier system by Congress is now a *fait accompli*, it cannot be said to be based upon a broad consensus among the leadership class. In Yankelovich's sense of the term, that class did not deliberate properly on the matter either. But even if there had been a forthright deliberation and there had been a consensus on the merit of a three-tier health care system, it would have been an extremely delicate task to explore that idea in an open give-and-take with the general public, large segments of which would find themselves at the short end of this arrangement. Furthermore, what channels actually exist for such a conversation?

Media As Communication Channel

Yankelovich takes the by now almost obligatory swipe at the media with his assertion that journalists were more interested in the political ramifications of the Clinton plan than in its contents. Although there is something to that proposition, his is much too broad an indictment. At the very least, a distinction should be made between the television media and the print media.

Television may, in the future, become a medium through which policymakers could communicate with the general public in an

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informative "give-and-take." So far, however, that medium has not been structured to facilitate such an exchange. Both C-Span and the public television stations allow the public to observe experts in the act of "deliberation," but that is not a conversation with the public. The remainder of the television industry has not been able to facilitate even a coherent one-way, top-down communication with the general public, aside from a bewildering scatter of sound bites.

The producers of television programs devoted to public policy invariably feel compelled to pack these programs with a variety of opposing views. By the time this dictum of "fairness" and the imperative of commercials have been accommodated, any one person's role on the program is limited to a few minutes of air time. The thought of using a simple graph or even a simple table to amplify a point in such discussions is quickly discouraged by the producers as too intellectually taxing for the general public.

The print media offer a better potential in this respect. Indeed, the staff reporters of the major newspapers deserve high marks for their ceaseless efforts at digging out the relevant facts on the Clinton plan and other health care reform plans. They also deserve high marks for their skill in presenting these facts to the public. Unfortunately, this channel is best suited for the one-way, top-down communication Yankelovich decries. Furthermore, it is not clear that the general public even had the patience to digest the lengthier, excellent articles on health care reform in the major dailies.

To the extent that the print media did improperly politicize the recent health care reform debate, as Yankelovich suggests, one must blame the leaders of the industry, not the rank and file. A concrete case can serve to illustrate this assertion.

In a commentary dramatically entitled "The Clintons' Lethal Paternalism," published in the widely read weekly *Newsweek*, syndicated columnist George F. Will flatly asserted that under the Clinton plan "there would be 15-year jail terms for people driven to bribery for care they feel they need but the government does not deem 'necessary'."[2] To the best of my knowledge, this is a falsehood, for at the very beginning of the Health Security Act, it is stated that "Nothing in this Act shall be construed as prohibiting the following: (1) An individual from purchasing any health services. (2) An individual from purchasing supplemental insurance (offered consistent with this Act) to cover health care not included within the comprehensive benefit package.[3]

Because it would be truly astounding to see an American president advocate fifteen-year jail terms for anyone seeking to purchase a health service that the government deems unnecessary (and therefore excludes from the mandated benefit package), I requested that Will pinpoint the paragraph in the Health Security Act that calls for the alleged penalty. So far, in my view, he has not been able to do that, and I doubt that he ever will.[4] One must wonder whether any senior editor of *Newsweek* at the time ever challenged him likewise on this point, as he ought to have been challenged.

It is entirely proper for a syndicated columnist to refract particular policy recommendations through the prism of his or her own ideology and to judge them on that basis. It is another matter entirely, however, when syndicated columnists use the extraordinary privilege granted them by the media to proffer their own ideology in the guise of synthetic "facts" that are likely to be accepted by the general public as reliable. Editors who passively accept that particular form of "spin doctoring" shortchange not only their own conscientious staff reporters, but the general public as well. They allow a potentially useful channel of communication to be polluted with static and thereby make it all the more difficult for conscientious leaders to communicate with the public. The recent debacle of health-care reform offers media leaders an opportunity for some soul searching on this point.

Deliberation By The Public

But suppose that America's leadership class had deliberated properly on health care reform, and suppose the leaders of the print media had acted responsibly, carefully

checking the veracity of whatever was presented as fact in their publications. Would this happy circumstance then have led to a productive give-and-take between the leadership class and the general public, and would it have triggered the proper deliberation within the general public?

One wishes it were so. Alas, Yankelovich's own paper is anything but reassuring on this question. He deplores the American public's habit of "blam[ing] the system rather than itself," its failure to "come to grips with reality," its "persistence of wishful thinking and . . . failure to wrestle with hard choices," and its "continuing belief that [the public] can have it all—quality *and* convenience *and* high-tech medicine *and* lower costs." "Polling data on health care," he writes, "are replete with evidence that people neither understand nor accept the consequences of implementing their wish list of expanded health care benefits."

If one had to distill Yankelovich's description of American public opinion on health care reform into one adjective, it would be "adolescent." This eternal adolescence of the plebs is by no means confined only to health policy, nor is it a uniquely American trait. Of the Roman plebs, for example, that era's great poet Juvenal wrote, in the first century A.D.: "*Duas tantum res anxius optat, panem et circenses.* (Its anxious longing is confined to but two things—bread and circus games.)"

Yankelovich's paper suggests that not much has changed in the course of civilization. Although, unlike their peers in other nations, America's leadership class seems unduly eager to pay homage to the legendary perspicacity of the grass roots, Yankelovich's survey of public opinion leads one to wonder whether, even in the minds of politicians, their habitual praise of the grass roots really is more than an expedient courtesy.

Indeed, Yankelovich's paper leads one to wonder whether the American public is either intellectually or temperamentally inclined ever to engage in the protracted, sincere, public deliberation of complex public policies called for by the optimistic author. If successful health care reform must await the day when the public musters the patience to deliberate carefully on the hard choices before us, at the price of abandoning the endless "circus games" that engage its mind, then we may have to wait a long time.

As someone neither born nor schooled in this country, I certainly do not mean to be disrespectful of a basically admirable people. Nor am I persuaded, however, that the American public somehow stands out among its counterparts elsewhere in the world in its willingness and ability to deliberate seriously on serious issues of public policy. My observation of this nation during the past thirty years persuades me that, in almost all cases, successful major initiatives in public policy occurred when the leadership class had reached a broad consensus on the matter and then simply told the rest of the nation what was good for it. President Reagan's "supply-side economics" was enacted on that basis, and so was the quite revolutionary tax act of 1986. In either case, the general public had only the dimmest idea of what these policies entailed; it simply took the leadership's assurances on faith.

Given the general public's age-old preoccupation with *panem* and *circenses*, it will generally go along passively with its leadership, unless that leadership makes evidently egregious mistakes or is evidently divided. Thus we start wars, thus we bomb whomever our leadership has decided to bomb, thus we end wars, thus we pass tax laws and civil rights laws, thus we allow the leadership (along with leaders of sundry special interests) to regulate and sometimes to deregulate the conduct of the plebs, and thus, perhaps one day, we shall undertake a major reform of our health insurance system. Perhaps.

NOTES

1. *The Wall Street Journal*, 23 November 1993, A4.
2. G.F. Will, "The Clintons' Lethal Paternalism." *Newsweek* (7 February 1994): 64.
3. Title I, Section 1003, page 15 of the Health Security Act as presented to Congress 27 October 1993. Reprinted by the Commerce Clearing House, Inc., Chicago, Illinois, 1993.
4. Because I apprised Will in my first letter that I would like to share the correspondence with others, I feel at liberty to offer copies of that correspondence to anyone interested in obtaining it.

Commentary

Wanted: A Clearly Articulated Social Ethic for American Health Care

Throughout the past 3 decades, Americans have been locked in a tenacious ideological debate whose essence can be distilled into the following pointed question: As a matter of national policy, and to the extent that a nation's health system can make it possible, should the child of a poor American family have the same chance of avoiding preventable illness or of being cured from a given illness as does the child of a rich American family?

The "yeas" in all other industrialized nations had won that debate hands down decades ago, and these nations have worked hard to put in place health insurance and health care systems to match that predominant sentiment. In the United States, on the other hand, the "nays" so far have carried the day. As a matter of conscious national policy, the United States always has and still does openly countenance the practice of rationing health care for millions of American children by their parents' ability to procure health insurance for the family or, if the family is uninsured, by their parents' willingness and ability to pay for health care out of their own pocket or, if the family is unable to pay, by the parents' willingness and ability to procure charity care in their role as health care beggars.

At any moment, over 40 million Americans find themselves without health insurance coverage, among them some 10 million children younger than 18 years. All available evidence suggests that this number will grow.[1] America's policymaking elite has remained unfazed by these statistics, reciting the soothing mantra that "to be uninsured in these United States does not means to be without care." There is, to be sure, some truth to the mantra. Critically ill, uninsured Americans of all ages usually receive adequate if untimely care under an informal, albeit unreliable, catastrophic health insurance program operated by hospitals and many physicians, largely on a voluntary basis. Under that status is poor or only fair.[3] Studies have shown that uninsured Americans relying on the emergency departments of heavily crowded public hospitals experience very long waits before being seen by a physician, sometimes so long that they leave because they are too sick to wait any longer.[4-6] Studies have found that after careful statistical control for a host of socioeconomic and medical factors, uninsured Americans tend to die in hospitals from the same illness at up to triple the rate that is observed for equally situated insured Americans[7] and that, over the long run, uninsured Americans tend to die at an earlier age than do similarly situated insured Americans.[8] Indeed, before the managed care industry cut the fees paid physicians sufficiently to make fees paid by Medicaid look relatively attractive to physicians and hospitals, even patients insured by that program found it difficult to find access to timely care. In one study, in which research assistants approached private medical practices pretending to be Medicaid patients in need of care, 63% of them were denied access because the fees paid by Medicaid were then still paltry relative to the much higher fees from commercial insurers.[9]

If the champions of the uninsured believe that the assembly and dissemination of these statistics can move the nation's policymaking elite to embrace universal coverage, they may be in for a disappointment. The working majority of that elite not only are unperturbed by these statistics, but they believe that rationing by price and ability to pay actually serves a greater national purpose. In that belief they find ample support in the writing of distinguished American academics. Commenting critically on the State Childrens' Health Insurance Program enacted by Congress in August 1997 as part of its overall budget bill, for example, Richard Epstein, author of the recently published *Mortal Peril: Our Inalienable Right to Health Care?*,[10] warns darkly

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The "yeas" in all other industrialized nations had won that debate hands down decades ago, and these nations have worked hard to put in place health insurance and health care systems to match that predominant sentiment. In the United States, on the other hand, the "nays" so far have carried the day. As a matter of conscious national policy, the United States always has and still does openly countenance the practice of rationing health care for millions of American children by their parents' ability to procure health insurance for the family or, if the family is uninsured, by their parents' willingness and ability to pay for health care out of their own pocket or, if the family is unable to pay, by the parents' willingness and ability to procure charity care in their role as health care beggars.

At any moment, over 40 million Americans find themselves without health insurance coverage, among them some 10 million children younger than 18 years. All available evidence suggests that this number will grow.[1] America's policymaking elite has remained unfazed by these statistics, reciting the soothing mantra that "to be uninsured in these United States does not means to be without care." There is, to be sure, some truth to the mantra. Critically ill, uninsured Americans of all ages usually receive adequate if untimely care under an informal, albeit unreliable, catastrophic health insurance program operated by hospitals and many physicians, largely on a voluntary basis. Under that informal program, hospitals and physicians effectively become insurance underwriters who provide succor to hard-stricken uninsured and who extract the premium for that insurance through higher charges to paying patients. The alarming prospect is that the more effective the techniques of "managed care" will be in controlling the flow of revenue to physicians and hospitals, the more difficult it will be to play this insurance scheme otherwise known as the "cost shift." It can be expected that, within the next decade, the growing number of the nation's uninsured will find themselves in increasingly dire straits.

But these straits have never been smooth for the uninsured, notwithstanding the soothing mantra cited earlier. Empirical research must have convinced policymakers long ago that our nation rations health care, health status, and life-years by ability to pay. It is known that other socioeconomic factors (such as income, family status, location, and so on) being equal, uninsured Americans receive, on average, only about 60% of the health services received by equally situated insured Americans.[2] This appears to be true even for the subgroup of adults whose health status is poor or only fair.[3] Studies have shown that uninsured Americans relying on the emergency departments of heavily crowded public hospitals experience very long waits before being seen by a physician, sometimes so long that they leave because they are too sick to wait any longer.[4-6] Studies have found that after careful statistical control for a host of socioeconomic and medical factors, uninsured Americans tend to die in hospitals from the same illness at up to triple the rate that is observed for equally situated insured Americans[7] and that, over the long run, uninsured Americans tend to die at an earlier age than do similarly situated insured Americans.[8] Indeed, before the managed care industry cut the fees paid physicians sufficiently to make fees paid by Medicaid look relatively attractive to physicians and hospitals, even patients insured by that program found it difficult to find access to timely care. In one study, in which research assistants approached private medical practices pretending to be Medicaid patients in need of care, 63% of them were denied access because the fees paid by Medicaid were then still paltry relative to the much higher fees from commercial insurers.[9]

If the champions of the uninsured believe that the assembly and dissemination of these statistics can move the nation's policymaking elite to embrace universal coverage, they may be in for a disappointment. The working majority of that elite not only are unperturbed by these statistics, but they believe that rationing by price and ability to pay actually serves a greater national purpose. In that belief they find ample support in the writing of distinguished American academics. Commenting critically on the State Childrens' Health Insurance Program enacted by Congress in August 1997 as part of its overall budget bill, for example, Richard Epstein, author of the recently published *Mortal Peril: Our Inalienable Right to Health Care?*,[10] warns darkly that the new federal plan "introduces large deadweight administrative costs, invites overuse of medical care and reduces parental incentives to prevent accidents or illness." Summing up, he concludes: "We could do better with less regulation and less subsidy. *Scarcity matters, even in health care*" (italics added).[11]

Clearly, the scarcity Epstein would like to matter in health care would impinge much more heavily on the poor than it would on members of his own economic class, as Epstein surely is aware. In his view, by the way, Epstein finds distinguished company in former University of Chicago colleague Milton Friedman, the widely celebrated Nobel laureate in economics, who had proposed in 1991 that for the sake of economic efficiency, Medicare and Medicaid be abolished altogether and every American family have merely a catastrophic health insurance policy with a deductible of $20 000 per year or 30% of the previous 2 years' income, whichever is lower.[12] Certainly, Epstein and Friedman would be content to let price and family income ration the health care of American children. They rank prominently among the "nays."

In his book, Epstein frames the debate over the right to health care as a choice between the "maximization of social wealth" as a national objective and the "maximization of utility," by which he means human happiness. "Under wealth maximization," he writes, "individual preferences count only if

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they are backed by dollars. Preferences, however genuine, that are unmediated by wealth just do not count."[10(p132)] One implication of resource allocation with the objective of wealth maximization is that a physician visit to the healthy infant of a rich family is viewed as a more valuable activity than is a physician visit to the sick child of a poor family.[13] If one does not accept that relative valuation, then one does not favor wealth maximization as the binding social objective.

Although conceding that wealth maximization does imply a harsh algorithm for the allocation of scarce resources, Epstein nevertheless appears to embrace it, even for health care. Establishing positive legal rights to health care regardless of ability to pay, he argues, could well be counterproductive in the long run, because it detracts from the accumulation of wealth. "Allowing wealth to matter [in the allocation of health] is likely to do far better in the long run than any policy that insists on allocating health care without regard to ability to pay. To repeat, any effort to redistribute from rich to poor in the present generation necessarily entails the redistribution from the future to the present generation."[13] Applying his proposition to the question posed at the outset of this commentary, the argument seems to be that poor children in one generation can properly be left to suffer, so that all children of future generations may be made better off than they otherwise would have been.

One need not share Epstein's social ethic to agree with him that, over the long run, a nation that allocates resources generously to the unproductive frail, whether rich or poor, is likely to register a relatively slower growth of material wealth than does a nation that is more parsimonious vis-à-vis the frail.[10(p114)] Nor does one need to share his social ethic to admire him for his courage to expose his conviction so boldly for open debate. Deep down, many members of this nation's policymaking elite, including many pundits who inspire that elite, and certainly a working majority of the Congress, share Epstein's view, although only rarely do they have the temerity to reveal their social ethic to public scrutiny. Although this school of thought may not hold a numerical majority in American society, they appear to hold powerful sway over the political process as it operates in this country.[14] In any event, they have for decades been able to preserve a status quo that keeps millions of American families uninsured, among them about 10 million children.

At the risk of violating the American taboo against class warfare, it is legitimate to observe that virtually everyone who shares Epstein's and Friedman's distributive ethic tends to be rather comfortably ensconced in the upper tiers of the nation's income distribution. Their prescriptions do not emanate from behind a Rawlsian[15] veil of ignorance concerning their own families' station in life. Furthermore, most well-to-do Americans who strongly oppose government-subsidized health insurance for low-income families and who see the need for rationing health care by price and ability to pay enjoy the full protection of government-subsidized, employer-provided, private health insurance that affords their families comprehensive coverage with out-of-pocket payments that are trivial relative to their own incomes and therefore spare their own families the pain of rationing altogether. The government subsidy in these policies flows from the regressive tax preference traditionally accorded employment-based health insurance in this country, whose premiums are paid out of pretax income.[16] This subsidy was estimated to have amounted to about $70 billion in 1991, of which 26% accrued to high-income households with annual incomes over $75 000.[17] The subsidy probably is closer to $100 billion now—much more than it would cost for every uninsured American to afford the type of coverage enjoyed by insured Americans. In fairness it must be stated that at least some critics of government-financed health insurance—Epstein among them—argue against this tax preference as well.[10(p182)] But that untoward tax preference has widespread supporters among members of Congress of all political stripes, and also in the executive suites of corporate America.

This regressive tax preference would only be enlarged further under the medical savings accounts (MSAs) now favored by organized American medicine. Under that concept, families would purchase catastrophic health insurance policies with annual deductibles of $3000 to $5000 per family, and they would finance their deductible out of MSAs into which they could deposit $3000 to $5000 per year out of the family's pretax income. In terms of absolute, after-tax dollars, this construct effectively would make the out-of-pocket cost of a medical procedure much lower for high-income families (in high marginal tax brackets) than it would for low-income families. It is surely remarkable to see such steadfast support in the Congress for this subsidy for the well-to-do, in a nation that claims to lack the resources to afford every mother and child the peace of mind and the health benefits that come with universal health insurance, a privilege mothers and children in other countries have long taken for granted. Unwittingly, perhaps, by favoring this regressive scheme to finance health care, physicians take a distinct stand on the preferred distributive ethic for American health care. After all, can it be doubted that the MSA construct would lead to rationing childrens' health care by income class?

Typically, the opponents of universal health insurance cloak their sentiments in actuarial technicalities or in the mellifluous language of the standard economic theory of markets,[18] thereby avoiding a debate on ideology that truly might engage the public. It is time, after so many decades, that the rival factions in America's policymaking elite debate openly their distinct visions of a distributive ethic for health care in this country, so that the general public can decide by which of the rival elites it wishes to be ruled. A good start in that debate could be made by answering forthrightly the pointed question posed at the outset.

Uwe E. Reinhardt, PhD

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Letters

Articulating a Social Ethic for Health Care

To the Editor.—Dr Reinhardt's[1] recent attack on my book *Mortal Peril*[2] presents this challenge: "to the extent a nation's health system can make it possible, should the child of a poor American family have the same chance of avoiding preventable illness or of being cured from a given illness as does a child of a rich American family?" The correct answer is no.

The health of youngsters is intimately tied to their parental care and attention; nutrition, location, and even the family car determine in part who will become injured or ill. Reinhardt tolerates these inequalities because they lie outside the health care system. But a consistent egalitarian should redress all sources of inequality, including child care, education, and crime prevention. Yet, Reinhardt neither justifies his priorities nor explains how to fund a full-scale initiative without destroying the social wealth it needs for support. Self-interest is not a universal and omnipresent human impulse, but it is a powerful one. To open the doors to forced redistribution induces the rich to spend more defending their wealth, and the poor to spend more to take it away. Both sides cannot win, and a smaller pie leads to worse health for the very persons Reinhardt cares most about.

Even within health care, his proposal for equal medical treatment perversely requires more care to children of poor parents than to children of rich ones, precisely because the rich families can more easily avoid injury and illness and can better pick up any slack in health care delivery. Worse, programmatic success depends not just on offering carrots but on wielding sticks by overriding parental judgments on children's food, lifestyle, and education. Yet, Reinhardt never explains how any ambitious program can curb political excesses, control administrative costs, prevent overutilization of resources, or ensure that equality in treatment comes from raising care for the poor instead of lowering it for the rich. Political interventions to date have created a 2-tier system that funds enormous Medicare subsidies in part by payroll taxes on the poor. Why expect the next generation of social programs to do better?

There is an alternative strategy. Do not increase taxes by ramping up subsidies and regulation. Reverse field and increase access by lowering costs, dismantling entry barriers, cutting subsidies, and increasing disposable income. Then, repair our tattered tradition of charitable service now crowded out by state-run programs. We can improve the situation for people at the bottom without lurching to Reinhardt's egalitarian ideal, which promises the same disastrous consequences in health care at home as it has wreaked in the world at large. How sad that at this late date Reinhardt has to search for a clearly articulated social ethic having none of his own to offer. After 30 years of trying, he should recognize that his conceptual cabinet is empty.

Richard A. Epstein, LLB
University of Chicago
Chicago, Ill

1. Reinhardt U. Wanted: a clearly articulated social ethic for American health care. *JAMA.* 1997;278:1446-1447.
2. Epstein RA. *Mortal Peril: Our Inalienable Right to Health Care?* New York, NY: Addison Wesley; 1997.

To the Editor.—I admire the zeal of Dr Reinhardt.[1] Not a physician, he has missed the intimate view of medical science, medical practice, yes, even of poverty, which is part of every physician's training.

Reinhardt views medical care in the ideological abstract. Couple his zealotry with his lack of actual medical care experience and his Commentary, it seems, becomes socialist propaganda. His "pointed question" becomes a loaded question complete with the ancient propagandistic use of children. Asserting the superiority of access to care in other nations ignores the quality of that care once accessed. Who is the patient's advocate? Who actually delivers quality scientific medical care? At a pragmatic patient level, who gets cured, helped, and comforted, or who becomes a unit to process as quickly and inexpensively as possible? Even though fomenting class distinctions is now fashionable, a large middle class is much less inclined to zealously do so. Many Americans value equality of opportunity rather than financial homogeneity. Reinhardt failed to mention the large middle class when discussing the rich and the plight of the poor. There is a curious implication in such positions. There are the rich, the poor, and those with power to protect the poor. The manipulation of dependence is left unsaid. Hidden is the quest for power and control.

Medical care insurance is not insurance. Claims control is impossible. Health care insurance is the problem, not the solution. Catastrophic care insurance is insurance and makes sense when patients and their physicians have free choice among competitive alternatives. Medical savings accounts make eminently good sense for the majority of Americans. Neither fits with the socialist need for power and control, under which patients are vulnerable and physicians are nearly powerless. More and more third-party interests are interposed between patients and physicians. Who now is the patient's personal advocate?

A social ethic holds that patient and physician each must have free choice among competitive alternatives. The vital special role of physicians and the vulnerability of patients must be valued and protected from subjugation or abuse. Physicians must be held to the highest technical and ethical standards. Each physician must cherish and practice the sacred

Guidelines for Letters

Letters will be published at the discretion of the editors as space permits and are subject to editing and abridgment. Letters will be considered if they are typewritten double-spaced and do not exceed 500 words of text and 5 references. Please include a word count. Letters discussing a recent *JAMA* article should be received within 4 weeks of the article's publication. Letters must not duplicate other material published or submitted for publication. A signed statement for authorship criteria and responsibility, financial disclosure, copyright transfer, and acknowledgment is essential for publication. Letters not meeting these specifications are generally not considered. Letters will not be returned unless specifically requested. Also see *JAMA* Instructions for Authors (January 7, 1998). Letters may be submitted by surface mail: Letters Editor, *JAMA*, 515 N State St, Chicago, IL 60610; e-mail: JAMA-letters@ama-assn.org; or fax (please also send a hard copy via surface mail): (312) 464-5824.

Edited by Margaret A. Winker, MD, Senior Editor, and Phil B. Fontanarosa, MD, Senior Editor.

duty to care for all patients with dignity and compassion irrespective of ability to pay, and they must teach those who can follow this highly demanding calling.

Donald G. Lindsay, MD
Ventura, Calif

1. Reinhardt U. Wanted: a clearly articulated social ethic for American health care. *JAMA*. 1997;278:1446-1447.

To the Editor.—Dr Reinhardt[1] paints a bleak portrait of America as a Dickensian society that woefully and consciously neglects its young. Few would admit to being a member of that society and few can argue with him since he has adroitly positioned himself so securely on the moral high ground that the rest of us, particularly those who may carp with some of his arguments, wallow in the swamps of social callousness and indifference. While other Western nations have said "yea" to his model for a nation's health care system, Reinhardt likely sees the United States as a primitive, socially backward society on the road to moral bankruptcy.

Why the contrast in attitudes about health care systems and social programs among these nations? Is it a fierce sense of rugged individualism, independence, and self-reliance that have been and still are the hallmarks of the American ethos? Is it because Americans have said "nay" not to a system that denies care but "yea" to the historical right of a democratic society to make its choices unintimidated by the steely hand of pernicious governmental influence and free of the specter of social systems that are bleeding the economies of Western Europe?

Reinhardt's bogeymen are the nation's "policymaking elite." He portrays them as a covert enemy, a cabal, ready to formulate policy that would deny social justice to the downtrodden and the dispossessed. Who are the members of this all-powerful elite? Where do they meet? Do they have an Internet address? I'm sure he realizes that it is not physicians who control the political process and the focus of health care. In Reinhardt's home state of New Jersey, physicians have become so politically impotent that they are attempting the unthinkable for professionals—joining a labor union. Reinhardt does tell us that a majority of the members of Congress are part of the nation's policymaking elite. If so, his argument is with the American people as their leaders and representatives mirror the ideas and sentiments of their constituency. If this elite that controls the direction of the nation's health care is special interest and lobbying groups, then Reinhardt's distress is with the current American political process. Reinhardt may be uncomfortable with this, but as we approach the fin de siècle, it is this same American political process that has triumphed in this century.

It has been said that "nearly every great domestic policy debate has revolved around the poles of elitism and egalitarianism."[2] In keeping with that theme and with all the guile of a polished politician, Reinhardt could not resist the temptation to frame his thesis in terms of class struggle and a redistribution of wealth. Reinhardt has much to contribute to the national debate about health care system reform; unfortunately, he dilutes his fine rhetorical skills by resorting to the effete ploy of class warfare.

James F. Lally, MD
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Newark, Del

1. Reinhardt UE. Wanted: a clearly articulated social ethic for American health care. *JAMA*. 1997;278:1446-1447.
2. Henry WE. *In Defense of Elitism*. New York, NY: Doubleday; 1994.

In Reply.—Only Mr Epstein answers my pointed question forthrightly; Dr Lindsay and Dr Lally beg the question with sermons.

Epstein considers it perverse to give more health care to poor children than to rich children whose parents can help them avoid illness or injury. To call giving disenfranchised children the health care that their parents cannot or neglect to give them a "deviation from what is considered right and good" (the meaning of "perverse") reflects his distinct social ethic and *de gustibus non est disputandum*. I wonder how many other Americans share that ethic? As to his query as to why redistributing wealth through health care is preferable to a full-scale but destructive redistribution of wealth, one answer is this: targeting subsidies narrowly on health care to avoid acute human suffering or stave off early death requires much less redistribution.

While impugning the quality of care that physicians in other countries give children, Lindsay sidesteps my question with the dictum that "each physician must cherish and practice the sacred duty to care for all patients with dignity and compassion irrespective of ability to pay." His is a romantic egalitarianism for which cost presumably is to be borne by the individual physician rather than by society as a whole. How could this work in practice? In the end, his approach would ration health care by ability to pay simply through the locational choices of physicians.

Lally writes of "a fierce sense of rugged individualism, independence, and self-reliance that have been and still are the hallmarks of the American ethos." Where are these rugged individualists? Are they among the rugged farmers, who cannot make it through the day without huge government subsidies? Are they among any of the Americans who plead for federal funds and for the Federal Emergency Management Agency whenever disaster strikes, or, perchance, among the investment bankers whose investments in Hampton Beach properties are protected by the US Army Corps of Engineers and by federal flood insurance? Would I find them in the medical profession, whose members rely so heavily on public subsidies for their education and the science they apply, who now seek a federal tax preference for medical savings accounts, who plead with government to punish managed care organizations that are late in paying bills, to impose on managed care organizations any-willing-provider laws, and to regulate managed care organizations with countless other strictures, and who have never balked at using archaic licensure laws to protect their own economic turf? Are there really any rugged individualists at all in this society of imagined victims who run to the courts for succor at their slightest discomfiture?

As all of these self-styled, rugged individualists enlist their government's coercive power to protect their own fiscal health, they might more gracefully countenance the use of that power to ~~and~~ also protect the physical health of poor children and, indeed, of all poor people. After all, serious illness is a natural disaster too.

Uwe E. Reinhardt, PhD
Princeton University
Princeton, NJ

Antihypertensive Therapy: Recommendations and Realities

To the Editor.—Experienced physicians may be unenthusiastic about the Fifth Joint National Committee on the Detection, Evaluation, and Treatment of High Blood Pressure (JNC V) recommendations for treatment of hypertension for reasons not addressed by Drs Siegel and Lopez.[1] β-Blockers significantly impair quality of life for many patients. For instance, if a husband neglects to mention his drug-related impotence to a physician, his wife might do so. Lethargy, constipation, and bronchospasm are common enough adverse effects to engender reluctance among physicians to burden patients with β-

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MEMORANDUM

TO: Jeanne Lambrew

FROM: Trish Nemore

RE: Administration commitment to effective implementation of buy-in programs for low income Medicare beneficiaries.

DATE: February 20, 1998

Jeanne, as you know, last year the Kaiser Foundation released a report prepared by the Law Center examining the causes of low participation in federally-mandated buy-in programs for low-income Medicare beneficiaries. The report examined issues that exist for the QMB, SLMB and QDWI (Qualified Disabled and Working Individuals) groups; now, as a result of the Balanced Budget Act, we have two new buy-in groups called Qualified Individuals: QI-1s and QI-2s. Participation barriers identified in the report include unfamiliarity with the program, unfamiliarity with the State Medicaid system and offices, and excessive application and verification requirements.

Throughout the BBA debate last spring and summer, as Medicare was being dramatically restructured, press reports touted the Administration's support for financial protections for low-income Medicare beneficiaries. The Administration now has a golden opportunity to take direct action to demonstrate that support.

During the nine years of the mandatory buy-in programs (QMB began in 1989), Members of Congress and advocacy groups have urged that the Social Security Administration take applications for the benefits; Social Security has resisted doing this, claiming overwork and inability to make the state-specific eligibility determinations required for buy-in. In 1990, Congress amended the Medicare law to require HHS to establish a beneficiary assistance program that, among other activities, offers assistance "through operation using local Federal offices that provide information on the medicare program." (A copy of the law is attached to this memo.)

We now have both a new Commissioner of Social Security and a new Administrator of the Health Care Financing Administration; the time is ripe for conversation between

these two agencies concerning cooperation to better implement buy-in benefits.

We suggest the following possibilities for collaboration between HCFA and the Social Security Administration to improve participation in the programs:

1. At SSA offices, screen all new Medicare enrollees for possible buy-in eligibility. Take applications for buy-in programs from all those who enroll in Medicare who appear to be buy-in eligible. This could be done by agreement with the states, similar to a 1634 process or the process by which SSA administers mandatory and optional SSI state supplements. Or, Social Security could complete short-form buy-in applications that would be forwarded to the states.

2. Enroll every SSI/State Supplement (SSP) recipient in QMB as part of their SSI/SSP application; include notice of enrollment to the state in the routine State Data Exchange (SDX) transmission.

3. Use SDX data to inform states of buy-in eligibility of those receiving SSI, SSP or of those who are cut off of SSI but whose Title II income is at or below buy-in eligibility. The SDX indicators currently contain a "QMB" entry which is not used, but is identified as "for future use." This could be expanded to include all the buy-in programs, not just the QMB program, i.e. to reflect those for whom SSA's information is that the individual has income below 175% poverty.

4. Include in every annual COLA/Medicare premium notice letter (or at least for those with incomes below 175% of poverty) information about eligibility and application for buy-in. This should be specially highlighted – in boldface type or in a box.

5. As an alternative to No. 1, above, include information in every SSI and Title II/Medicare award letter where the award is for a monthly benefit under 175% of poverty that the individual may be eligible to have her/his state pay some portion of the Medicare cost-sharing.

6. Post Buy-in Posters in every SSA office.

7. Give a simple brochure describing the buy-in programs to every Medicare enrollee.

These are some ideas to begin the conversation. I look forward to talking with you further about efforts to improve access to health care for low-income Medicare beneficiaries.

OFFICE OF THE VICE PRESIDENT

WASHINGTON

AGENDA FOR PLANNING SEMINAR
FAMILY RE-UNION 7: FAMILIES AND HEALTH
Vice President's Ceremonial Office
October 28,1997
1:30-4:00 PM

I.	**Welcome and Introductions**	1:30-1:40
II.	**The Family Re-Union Policy Initiative**	1:40-1:45
III.	**Comments from Sponsors and Chair**	1:45-1:55
IV.	**Welcome from Vice President Gore**	1:55-2:00
V.	**Presentations**	2:00-2:30

- **ANN ROSEWATER:** Families and Health
- **BEVERLY JOHNSON:** What is family centered care?
- **JUDITH KATZ LEAVY:** Implications for mental health care
- **BARBARA HUFF:** The parents' perspective
- **KAREN SCHROCK:** Implications for a state-wide public health system
- **BOB BLUM:** Family involvement in adolescent health

VI.	**Discussion led by Vice President Gore**	2:30-2:55
VII.	**Implications for Conference Plan and General Discussion**	3:00-4:00

FAMILY RE-UNION 7: FAMILIES AND HEALTH

Family Re-Union 7 will address the issue of families and health. Following the pattern of previous conferences this will be an opportunity to view an issue of critical concern through the lens of its affect on whole families. Vice President Gore and Mrs Gore will moderate the conference that will be held at Vanderbilt University and is scheduled for June 22 and 23, 1998.

Initial planning discussions have included leaders from the fields of family centered care, mental health, public health, family members and physicians involved in the care of chronically ill children, and experts in managed care, among others. They have introduced the body of research that demonstrates reduced mortality and health costs, improved patient outcomes and strengthened family structures when an entire family is involved in prevention, decision-making and care. They have raised the issues of training of health care professionals, the impact of managed care and public health policy, the support needed for whole families of chronically ill dependents, and the importance of treating family members as full partners in health care.

The early discussions have also dealt with the constituencies that must be involved in any systemic change; heath care professionals, families who are consumers, purchasers of managed care, health care executives, community-based organizations, etc. Special attention has been drawn to the issues of family partnership in mental health care, neo-natal care, oncology, and in isolated rural and poor urban areas, pediatric AIDS and other more specialized issues. Innovative strategies have been explored, such as bringing pediatric medical students to the homes of families with chronically ill children to understand the realities of their care.

In short, the participants in these discussions are determined that polices and programs should involve families as partners in maintaining, improving and restoring their health and that of their dependents. Health care should not be something that is "done to" families. The mental health and family strength of those coping with chronic illness of the very young or elderly family members is achieved by thoughtful teamwork. The rest of the planning process and the conference itself will bring these issues to leaders in practice and policy and result in programmatic and policy change to a more family centered approach.

The conference will again be co-sponsored by the Children, Youth & Family Consortium of the University of Minnesota and the Child and Family Policy Center of Vanderbilt University. As in the past there will be hundreds of down-link sites around the country, as well as a few selected interactive sites, and numerous workshops. The UCLA Center for Communications and the Boston University School of Film and Broadcasting will produce short films addressing this topic, and follow-up activities, especially those addressing professional training will be designed.

BRIEF LIST OF SOME FAMILY RE-UNION OUTCOMES

***FAMILY RE-UNION*:** April 24, 1992

This conference was built around a belief in the strengths and assets of whole families, and urged the importance of listening carefully to their self-defined needs in determining policy, rather than building bureaucracies around the pathologies of individuals. Vice President Gore was the junior Senator from Tennessee.

- Local groups from around the state took up the idea of **"Care Fairs"** suggested by one speaker. These were gatherings held before the opening of school at a local elementary school which brought together all services for families in one location, giving families better access and communities an opportunity to build networks.
- The 800 participants agreed that major changes in policy and programs were essential if families were not going to be torn apart by attempts to "fix" individuals. Senator Gore promised to reconvene the conference the following year to **pursue this policy shift.**

FAMILY RE-UNION II: REINVENTING FAMILY POLICY July 30, 1993

Adopting the perspective of the first "Family Re-Union", the Vice President and representatives of federal, state and local government held a day-long series of roundtables seeking to understand what we mean by "Listening to families", how programs and policies would work if they used this approach, how we would measure and reward success if family strength were the goal, and how policy would have to change as a result.

- An intergovernmental partnership of major federal agencies and state and local government known as **"Partnerships for Stronger Families"** was formed and continues to exist. The Partnership has worked to achieve bottom-up reform and benchmarking of results in such initiatives as the **Indiana Step-Ahead Councils**, the **Oregon Option** and the **Connecticut Memorandum of Understanding**. In each case state and local government has sought flexibility of federal funding and guidelines that would respond to local initiatives and be accountable to local measures in order to respond to the needs of families and communities.
- At the Vice President's request senior representatives of the Departments of Health and Human Services, Education, Housing and Urban Development, Justice, Labor and Agriculture met to determine a set of **principles of family policy** derived from the work of the conference.
- These principles were used in designing the application process for the newly created **Community Empowerment initiative** led by Vice President Gore. Local communities were encouraged to define their own goals and needs and strategies such as a "single point of contact" were employed to facilitate the federal response.

FAMILY RE-UNION III: THE ROLE OF MEN IN CHILDREN'S LIVES, July 11, 1994

The previous conference had noted that men were frequently excluded from policy affecting the lives of children and families. This commission had led to self-fulfilling prophecy that needed to be reversed if the family were to survive and be strengthened.

- A **Practitioner's Network** of those working to help men in urban communities become more responsible fathers was formed and has continued to grow.
- At the Vice President's suggestion a private sector **Father to Father** initiative was started and has strengthened programs across the country with the notion that men can reach out to one another with the intention of becoming better fathers.
- A **Funder's Collaborative** was formed among foundations that are committed to this issue.
- After the Vice President's staff met with leaders in the field to define issue relating to federal policy, a **Presidential Memorandum** was issued directing all federal agencies to review and reform programs, policies, research, and personnel practices so that they proactively strengthen fatherhood wherever appropriate. The interagency working group which formed in response to this request meets regularly and has affected real change. Among many are the following: Changes in **federal housing regulations** so that fathers are not excluded from public housing, **redesigned research** which, unlike previous studies, actively seeks data on fathers, **redesigned requests for proposals** which encourage father participation, and **personnel policies** which encourage fathers' active participation in their children's lives.
- A year later, the Vice President chaired a **large conference of federal workers** in order to review progress and suggest additional strategies.
- Recently, the **National Center on Fathers and Families** issued a **report** on this conference.
- **FatherNet**, an interactive electronic resource for individual fathers, researchers, organizations and communities is thriving and providing a lively exchange of information on this topic. It is housed at the University of Minnesota.

FAMILY RE-UNION IV: FAMILY AND MEDIA July 10, 1995

Spurred by a concern the previous year on messages children were receiving from media about the role of men and fathers which was too often depicted as violent and destructive, the sponsors and the Vice President turned their attention to the positive and negative roles that media plays in the lives of children and their families. Bringing together industry leaders, educators, psychologists and experts in technology, Family Re-Union IV broadened the options for families concerned about the impact of media.

- President Clinton announced the legislation which made the **"V-Chip"** a reality and will require that all televisions are equipped with a device that enables parents to control their children's access to violent programming.
- Following a **White House Summit on Children's Television in 1996** broadcasters voluntarily agreed to a **rating system** to help parents screen content for children.

- An **improved rating system** was agreed to in October of 1997
- At a **White House Summit on Children's Programming** the industry agreed to provide a minimum of **three hours of quality children's programming a week.** This plan was adopted by the FCC and went into effect in September 1997.
- **The National Institute on Media and the Family** inspired by the conference was founded by Dr David Walsh in Minnesota. The center has become an internationally recognized resource on this issue.

FAMILY RE-UNION V: FAMILY AND WORK June 24, 1996

A growing tension between the demands of work and family had been outlined in several of the conferences and FR:V tackled this issue head on. Bringing together corporate leaders, labor leaders, workers, academics studying the balancing act that families experience and its impact on the workplace, the conference explored strategies such as telecommuting, flexible work schedules, job sharing and the role of quality child care and workplace attitudes.

- President Clinton called for an **expansion of the Family and Medical Leave Act** that would enable families to participate in their children's schools and take them and elders in the family to medical appointments.
- The President also announced a **"comp time" proposal** that would give workers discretion to take time in lieu of compensation.
- **A Presidential Memorandum** required all federal agencies and programs to re-examine and rewrite their personnel policies so they created a **"Family Friendly Federal Workplace"**. The Vice President has just presented a **report to the President** on the successes and remaining tasks related to that initiative.
- The Vice President and members of his staff have addressed numerous conferences, groups of employees and **human resource managers seeking advice** on this topic.

FAMILY RE-UNION VI: FAMILIES AND LEARNING June 25, 1997

Work and family discussions had focused a great deal of attention on the issue of family involvement in children's learning. This conference reviewed the research showing how crucial this is from the first days of life in a child's intellectual and emotional development. Highlighting remarkable examples of family/school partnership, the conference explored ways in which this approach transforms children's learning, parent's lives and job prospects, teachers and administrators understanding of students and connection to the community, and ultimately, school governance and structure.

- In November 1997 a **collaboration of four graduate schools of education**, formed in planning the conference, together with the **Partnership for Family Involvement** of the Department of Education co-sponsors a **national teleconference providing training for teachers** in successful techniques to involve parents. A **guide** will be published and widely distributed to the many satellite downlink sites.
- Some statewide and local **downlink sites** have organized a response to the teleconference which will move the agenda in many parts of the country.

Planning Seminar for Family Re-Union 7
"Families & Health"

Ceremonial Office
1:55-2:55 PM, Tuesday, October 28, 1997

Meeting called by: Nancy Hoit
Staff contact: Nancy Hoit, Trooper Sanders
Briefing prepared by: Nancy Hoit

EVENT

You are hosting a seminar on a family centered approach to health care.

LOGISTICS

The participants will have been meeting for a short time before you arrive. The presenters will each speak briefly on their topics so that there will be time for discussion. The conference sponsors will not be expected to speak except during the general discussion.

NOTE: Marti Erickson is on a speaking tour in Australia and in her absence **Dr Robert Blum**, who is chair of the Consortium is representing the University of Minnesota. An internationally recognized expert on adolescence, he has gained wide recognition for his recently released study demonstrating the importance of parental involvement in positive outcomes for adolescents.

YOUR ROLE AND CONTRIBUTION

You will greet the group on arrival and thank them for their willingness to contribute to this policy development process, and to your understanding of a complex issue. Although this session is related to the conference topic it is not specifically a planning session for the conference.

ATTACHMENTS

- List of Attendees
- Agenda for the meeting
- Biographies of the participants
- A background piece on this conference and another on Family Re-Union
- A summary of the outcomes of previous conferences

Medicare Commission	Will be in the middle of commission, issues raised
Quality Commission	Anti-gag rules, commission report due in the spring, legislation moving
HCFA	Executive Orders, what Medicare/Medicaid can do to be more family friendly.
Healthy Families	exercise and preventive care -- skin cancer, heart disease, diabetes,
Long-term care	Strategies for long-term care, nursing home quality, alternatives, family friendly
Children's Health Implementation	Child care centers what families can do to get children more involved, Helping children with long-term illnesses
Physicians	Family friendly
Children's health	Reaching out to ensure children, family involved in children's health care, child care centers.

<u>VP Priorities</u>

→ Genetics

→ Cancer

Mental Health

AIDS

Environment

Infant Mortality. Healthy babies, building on Mrs. Gore's SIDS campaign. Well-baby well child care.

Tobacco

FAMILY RE-UNION 7: FAMILIES AND HEALTH, PLANNING SEMINAR
LIST OF ATTENDEES
Vice President's Ceremonial Office
October 28, 1997

CHAIR AND CO-SPONSORS

Jill Iscol, Family Re-Union Chair — 203-972-5235

Bill Purcell, Director, **Child and Family Policy Center** — 615-343-9905
Vanderbilt University

Robert Blum, Professor and Director, Division of Pediatrics — 612-626-2820
& Adolescent Health, University of Minnesota
Chair of the **Children, Youth & Family Consortium**

Barbara Huff, Executive Director, — 703-684-7710
Federation of Families for Children's Mental Health

Beverly Johnson, President and CEO, Institute for Family Centered Care — 301-652-0281
and former pediatric patient in chronic care

Judith Katz-Leavy, Senior Policy Analyst, Office of Policy, — 301-443-2440
Planning and Administration, federal Center for Mental Health Services

Ann Rosewater, Counselor to the Secretary, — 202-260-9923
US Department of Health and Human Services

Karen Schrock, Chief, Center for Substance Abuse Services, — 517-335-8808
Michigan Department of Community Health

STAFF
Lucia Gilliland, Mrs Gore's Staff
Nancy Hoit, Family Policy Advisor to Vice President Gore
Susan Liss, Chief of Staff to Mrs Gore
Lisa Mallory, Chief of Staff, National Performance Review
Crystal Roach, Staff to the National Performance Review
Trooper Sanders, Policy Staff for Mrs Gore
Katie Smith, White House Intern
Beverly Yates, Senior Policy Advisor, National Performance Review

BIOGRAPHIES IN ORDER OF PRESENTATIONS

Robert Blum, MD, PhD Professor and Director, Division of Pediatrics & Adolescent Health, at the University of Minnesota received international acclaim for the study recently released on the importance of the parental role in the social, academic and emotional health of the adolescent. Editor of two books over a hundred articles and reports, he is past President of the Society for Adolescent Medicine, serves in leadership roles in the Guttmacher Institute and the National Campaign to Prevent Teen Pregnancy, and consults with UNICEF and other international organizations. As **Chair of the Children, Youth & Family Consortium he is representing the co-sponsoring organization in Dr Erickson's absence.**

Barbara Huff, Executive Director, Federation of Families for Children's Mental Health, a national family-run organization for children with emotional, behavioral or mental disorders and their families. Having developed a state-wide children's mental health advocacy organization in Kansas in 1988, she was the first president of the Federation and is herself the parent of a daughter with serious emotional problems. She provides training, workshops and lectures to organizations across the country, and has received numerous awards and represents the Federation on many national boards and task forces.

Beverly Johnson, President and CEO, Institute for Family Centered Care in Bathesda, MD, and herself a former pediatric patient in chronic care. Beginning as a family support worker in a children's hospital, she later served as trustee of Children's National Medical Center in Washington and as Executive Director of the Association for the Care of Children's Health. She has co-authored books on family centered practice for maternity care, newborn intensive care, and guidelines for hospitals. She is currently developing family centered materials for adult oncology. She has produced two award winning films.

Judith Katz-Leavy, Senior Policy Analyst, Office of Policy, Planning and Administration, federal Center for Mental Health Services. She is the co-founder of the Child and Adolescent Service System Program (CASSP), and has spent her career working to improve service delivery systems for children and adolescents with mental health needs and their families.In 1993 she served as Co-Chair of the Child Mental Health Sub-Group in the Administration's National Health Care Task Force.

Ann Rosewater, Counselor to the Secretary, US Department of Health and Human Services Ann serves as the Secretary's principal advisor on cross-cutting initiatives including domestic violence, follow-up to the White House Conference on Early Childhood Development and Learning, and strengthening the Department's capacity to address health, social and economic development at the local level. She serves as co-chair of the Department's Steering Committee on Violence against Women and coordinates the Department's National Strategy to Prevent Teen Pregnancy.

Previously she served as Deputy Assistant Secretary for Human Services Policy and Deputy Assistant Secretary for Policy and External Affairs. She has been a senior associate at the Chapin Hall Center for Children at the University of Chicago and a senior consultant to the Pew, Casey, Ford and Rockefeller foundations, staff director for the US House of REpresentatives Select Committee on Children & Youth which she helped to create, and in major roles with Children's Defense Fund and the National Urban Coalition.

Karen Schrock, Chief, Center for Substance Abuse Services, Michigan Department of Community Health. Previously Ms Schrock served as Chief of the Division of Services to Crippled Children, Chief of Minority Health, and of the Eastern Regional Division of the MDPH Bureau of Community Services. She serves on several national substance abuse related boards and the board of the Institute for Family Centered Care. She is active in state and local organizations including the PTA.

AGENDA FOR PLANNING SEMINAR
FAMILY RE-UNION 7: FAMILIES AND HEALTH
Vice President's Ceremonial Office
October 28,1997 1:30-4:00 PM

I. Welcome and Introductions	1:30-1:40
II. The Family Re-Union Policy Initiative	1:40-1:45
III. Comments from Sponsors and Chair	1:45-1:55
IV. Welcome from Vice President Gore	1:55-2:00
V. Presentations	2:00-2:30

- **ANN ROSEWATER:** Families and Health
- **BEVERLY JOHNSON:** What is family centered care?
- **JUDITH KATZ LEAVY:** Implications for mental health care
- **BARBARA HUFF:** The parents' perspective
- **KAREN SCHROCK:** Implications for a state-wide public health system
- **BOB BLUM:** Family involvement in adolescent health

VI. Discussion led by Vice President Gore	2:30-2:55
VII. Implications for Conference Plan and General Discussion	3:00-4:00

FAMILY RE-UNION: A FAMILY POLICY INITIATIVE

BACKGROUND AND HISTORY

Vice President Gore is leading an ongoing family policy initiative that is informed by the annual family policy conferences which he moderates. These "Family Re-Union" conferences provide the Vice President and others who make policy at the federal, state and local level an opportunity to learn from the experience of families themselves, and those who work with them. The Vice President believes that for far too long we have created programs designed to address the pathology of individuals, or the needs of the bureaucracy that serves them. He seeks to find ways that we can understand the needs of whole families and communities and build on their strengths. Each conference brings together 1000 individuals on site and thousands more at remote satellite sites and provides an opportunity to explore a topic suggested by the work of the previous conference.

The conferences are sponsored by the Children , Youth & Family Consortium of the University of Minnesota and the Child and Family Policy Center at Vanderbilt University. Funded by charitable foundations and individual donors, they have provided a lively exchange of ideas among experts in various fields, grassroots program directors, academic researchers, and average citizens. The conference site is Vanderbilt University in Nashville, Tennessee.

Family Re-Union initiative seeks to "reinvent" family policy so that it reflects the realities facing families and government today. For example, in response to one of the conferences, "Family Re-Union III: The Role of Men in Children's Lives", private sector organizations have acted on the Vice President's concept of a national "Father to Father" program, created "FatherNet" and a Practitioners Network of those who work with urban fathers, and a collaborative of foundations concerned with the issue of father involvement. A Presidential Memorandum entitled "Supporting the Role of Fathers in Families" is being implemented by a wide array of federal agencies and programs.

Each conference is the result of a year-long planning process that brings together experts and academics in the field along with program leaders and individual family members affected. They engage in a dialogue with each other, the sponsors and the Vice President, raising crucial programmatic and policy issues that become the core of the conference. Perhaps the most significant outcome of each conference has been the ongoing partnerships created between organizations and individuals in each field that have built momentum behind new ways of addressing long standing issues such as the absence of fathers in children's lives, the impact of the media culture on children, the delicate balance between work & family, family involvement in education and family centered health care.

FAMILY RE-UNION 7: FAMILIES AND HEALTH, PLANNING SEMINAR
LIST OF ATTENDEES

Vice President's Ceremonial Office

October 28, 1997

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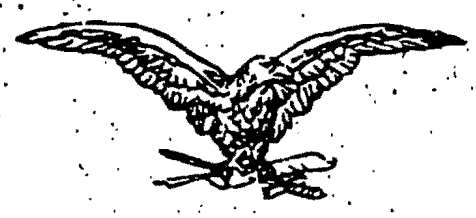
File Alissa Fox

LOS ANGELES TIMES EDITORIALS



Crash Course for Doctors in Treating the Elderly

The aging of America necessitates medical changes

Like children, older people have special medical needs. Adequately meeting them is a growing challenge as the elderly population increases. Longer lives and an aging baby-boom generation will boost the share of the U.S. population over 65 from less than 14% now to 20% by the year 2025, meaning that about 70 million Americans will be 65 or over. Yet too few physicians are specialists trained to deal with the illnesses and bodily changes that often go with aging. The American Geriatrics Society and the Blue Cross and Blue Shield Assn., the nation's largest health insurer, hope to do something about that.

The aim is to better acquaint family doctors with the health problems they are more likely to encounter in the elderly than in the general patient population.

The geriatrics society is offering to provide a crash course in treating the elderly to about 10,000 Blue Cross Blue Shield doctors. The aim is not to produce more certified geriatricians—there are only about 8,000—but to better acquaint family doctors with the health problems they are more likely to encounter in the elderly than in the general patient population. Those include adverse drug reactions—older people are more likely to be taking a number of medications, raising the risk of harmful interactions—malnutrition, sleep disorders, osteoporosis, depression and dementia.

This initiative follows closely on the incentives Congress and President Clinton have approved to encourage Medicare recipients to enroll in managed care health plans. About 12% of seniors are now in such plans, a number expected to double in five years. Under managed care, Medicare patients are more likely to be treated by a general practitioner than a specialist. It's increasingly important that managed care providers understand the particular problems of the elderly.

Besides trying to familiarize doctors with these special clinical problems, the new plan aims to alert physicians to other needs associated with growing older—for example, whether a patient's physical or mental state indicates a need to get help with daily living activities. And, recognizing that older people tend to seek advice from their doctors more often than young people, the training will even suggest that doctors set aside time each day to return calls to elderly patients.

Medical science has learned much and is learning more each year about aging and its special health problems. The imperative is to spread that knowledge more widely among physicians. The Blue Cross Blue Shield experiment provides a possible model for other managed care providers.