

Originally Processed With FOIA(s):
1999-0277-F; 1999-0285-F

FOIA Number:
S

FOIA MARKER

**This is not a textual record. This is used as an
administrative marker by the George Bush Presidential
Library Staff.**

Record Group/Collection: George H.W. Bush Presidential Records
Collection/Office of Origin: Chief of Staff, White House Office of
Series: Skinner, Sam, Files
Subseries:

OA/ID Number: 40923
Folder ID Number: 40923-013

Folder Title:
Louis Sullivan

Stack:	Row:	Section:	Shelf:	Position:
G	0	0	0	0

ARTICLE BY: Louis W. Sullivan, M.D.
Secretary of Health and Human Services
SUBJECT: The case against national health insurance
LENGTH: 690 words

First in a series

Proposals for national health insurance have been much in the news lately, and some polling data indicate that some Americans might favor such a system.

But at this point, the debate reminds me of the politician who, while campaigning among unsophisticated constituents in the backwater, accused his opponent of matriculating in college and having a sister who was a thespian in New York City. Sounds bad, I guess.

Americans are neither unsophisticated nor stupid. But some may express casual support for national health insurance simply because they think it sounds good. The problem is that few Americans know what national health insurance really means -- nor should they, having never lived under such a system.

It is important for Americans to understand what those who call for national health insurance really want.

National Health Insurance means replacing employer-provided or privately purchased health benefits with a government takeover of health care for all Americans, which would require massive new taxes.

(more)

They claim that a national health insurance system would reduce costs and provide egalitarian coverage. Let me dispel these myths.

Countries, like Canada, with national health insurance endeavor to constrain costs by government fiat. Governments negotiate with the medical community to determine the maximum amount of money available to be spent -- irrespective of contingency needs or actual demand.

Often, these systems are characterized by long waiting lists for medical services (including critical ones like heart surgery) and de facto rationing. They are also characterized by shortages in the latest medical technologies.

This is why President Bush and I have rejected nationalized medicine as a viable option for health care reform in the United States.

I contend that a nationalized system, with its delays and de facto rationing, would never suit Americans. Most of our citizens are receiving the finest health care in the world. Therefore, I find it remarkable to hear some people proposing that we scrap our system and make a radical reform to a Canadian-style system.

(more)

We need to build on our achievements by getting an even higher percentage of people covered by insurance, rather than replacing our system with something that Americans do not need and would not tolerate.

Furthermore, despite efforts to control costs with de facto rationing, some countries with national health care are experiencing faster rates of expenditure growth than the United States -- in direct contradiction to what proponents of national health insurance claim.

For example, a recent Heritage Foundation report revealed that: "Between 1967 and 1987, real per capita health care spending increased at an average annual rate of 4.58 percent in Canada, versus 4.38 percent in the United States."

Yet, it is not enough to criticize bad ideas. We need to identify good ones too. My goal is to put forth proposals that build on the strengths of our health care system, and on the things we are good at as a nation. The basis of my proposal is simple: choice, quality, access, and efficiency.

We know how to expand the social safety net when needed, but we know we must avoid creating unnecessary dependency.

(more)

We know how to innovate in technology; we must now innovate in our management and delivery systems, as well. Reforms should allow flexibility to continue in our health care system, not freeze one rigid system in place.

Our historic public-private partnership in health care has served us well; it should continue and should be strengthened.

We know how to use information to give people informed choices. We need to improve our systems for doing that so that people can make cultural changes, lead healthier lifestyles, and thus reduce the need for medical intervention.

We have a system of federalism which allows for experimentation and innovation at the state level.

In future articles on these pages I will discuss these strategies further and outline the ground work for some immediate and positive steps to strengthen American health care.

Our health care system evolved in a uniquely American way; likewise, solutions should be uniquely American. Most importantly, we don't want to undermine what is right about our system.

TOMORROW: The health care safety net

#

ARTICLE BY: Louis W. Sullivan, M.D.
Secretary of Health and Human Services
SUBJECT: The health care safety net
LENGTH: 600 words

Second in a series

Every American should have access to necessary health care. I think we all agree on that. Yet, as has been pointed out time and again, many Americans do not enjoy the access they need and deserve.

But what has not been emphasized enough is that the U.S. government is already spending billions of dollars on programs that are bringing health care solutions to those groups that are especially vulnerable: the poor, the disadvantaged, and those who live in medically under-served rural and inner-city areas.

These programs are in addition to the \$104.4 billion spent by the federal government in Fiscal Year 1991 on Medicare, the public health insurance program for older Americans, and the \$86 billion spent by the federal government and state governments in FY 1991 on Medicaid, the basic public health insurance program for welfare recipients.

For instance, in 1991, more than \$443 million was committed to help fund some 1,400 community health centers in inner-cities and rural areas across the country.

(more)

These centers provide primary health care services to approximately 6 million people, about 60 percent of whom have incomes below the federal poverty level, and another 25 percent with incomes between 100 and 200 percent of the federal poverty level.

In addition to meeting the needs of low-income people, community health centers are especially good at reaching at-risk populations: approximately 64 percent of those who use Community Health Care centers are disadvantaged members of minority groups.

The Department of Health and Human Services also has a matching grant program with states to support the establishment and operation of Offices of Rural Health. In addition, our Rural Health Outreach Grant Program supports projects that demonstrate new and innovative models of health care delivery in rural areas, especially those that emphasize efforts to improve the integration and coordination of rural health services.

Then there is the National Health Service Corps (NHSC) -- a highly effective way to get doctors into under-served areas of rural and inner-city America. The NHSC received an increase of \$40 million, to a total of \$91 million for fiscal year 1991, to pay doctors and other health care professionals to work in under-served areas.

(more)

Through the NHSC Scholarship and Loan Repayment Program, medical students receive scholarships and loans in return for their agreement to serve in communities desperate for health care professionals. For those doctors who have already graduated, the fund would assume partial or total responsibility for their outstanding student loans in return for a similar commitment.

By the year 2000, NHSC expects a field strength of 4,400 physicians, dentists, and other health care workers.

The National Health Service Corps has been especially effective in attracting minority health professions students, thus helping to fill some of the glaring holes in health care access in the nation's minority communities. Making sure there are enough minority doctors to meet the need is the goal of HHS's part of the overall White House initiative on historically black colleges and universities.

In FY 1990, HHS spent more than \$108 million in support of research and development, program evaluation, training, facilities and equipment, recruitment and tuition assistance on behalf of the students and bio-medical programs at historically black colleges.

(more)

Along with Medicare and Medicaid, these are the kinds of publicly-supported programs that can provide a health care safety net for the poor, minorities, and medically under-served rural and inner-city communities.

These initiatives complement our system of public and private health insurance. We need to support this public-private mix so that we can continue to offer quality health care to all Americans.

TOMORROW: Preserving the high quality of American health care

#

ARTICLE BY: Louis W. Sullivan, M.D.
Secretary of Health and Human Services
SUBJECT: Preserving the high quality of American health care
LENGTH: 700 words

Third in a series

Some commentators in the current debate over health care emphasize only the negative aspects of our health care system -- specifically high costs, and lack of access to the system for some. They miss the much more important point. In trying to improve access and reduce costs, we need to preserve the superior aspects of what we have while we address the problems. We do not need radical reforms that will undo what works well and cause problems we cannot predict.

For example, some say that we need more taxes to pay for new government spending on those who lack health insurance. But as a society, we spent over 12 percent of our Gross National Product on health care in 1990. This amounts to \$2,600 for every citizen.

Our first question should not be whether we are spending too much or too little, but whether we are getting the most for what we pay.

In the same breath, people who call for more government spending also point with alarm to the spiraling costs of health care. Yes, costs are growing at an unsustainable rate.

(more)

But a prosperous people, having satisfied other necessities of life, can devote a higher proportion of their income to leading healthier and longer lives. We need to find ways to constrain costs through efficient medical practices and procedures, including health promotion and disease prevention activities, not through de facto rationing, such as is found in nationalized medical systems.

Critics of the American system of private-public partnership in medicine, quite rightly point out that some 33 million (13%) of our citizens are without health insurance. But, the flip side of that statistic is that over 85 percent of the population does have health insurance. That is a tremendous change from past generations when a large portion of the population was uninsured, and paid their medical bills as best they could.

Our solution -- employing both the free market, and legislation where appropriate -- is to facilitate an even higher percentage of Americans who are able to obtain necessary health insurance. Most particularly, we should improve incentives for small businesses, and the self-employed, to be able to afford insurance.

(more)

Proponents of radical reform in health care financing and delivery complain of the escalating costs of new and more elaborate medical procedures. They say that the enormous expense of biotechnological and other breakthroughs is pushing the costs of medical care beyond reach.

But, these new procedures are often known as near-miraculous, life saving medical advances. And we lead the world in this respect. We must preserve these advances through better knowledge about what works and what does not work in medicine, not through arbitrary curtailment of technology.

Some critics of our medical system criticize physicians for allegedly pushing up the costs of health care. But, one of our proudest accomplishments as a nation is that we train and produce an extraordinary pool of talented and dedicated medical professionals year in and year out. And many foreigners -- when they get sick -- come here for medical treatment.

To be sure, we do need mechanisms in both public and private health care programs which assure fair and reasonable reimbursements to health professionals and medical facilities. But those mechanisms must not be so arbitrary as to distort medical decisions, as all too often happens in nations with government controlled medicine.

(more)

We must sustain the special doctor-patient relationship that we have come to know in the United States.

For these and other reasons, Americans would not tolerate a nationalized health care system. But we do need a coherent national strategy.

Included in that strategy should be ways to make it easier for people to change jobs without losing health care coverage; making the cost of health insurance more affordable for small businesses and the self-employed; legislation to reduce excessive malpractice awards, which drive up consumer costs; likewise working to reduce administrative costs in our current public and private health insurance systems; and expanding health care access for our neediest and most vulnerable citizens.

Achieving these goals will enable Americans to have the security of receiving the finest health care in the world, without surrendering their freedom of choice to bureaucratic decision making by a remote federal government.

TOMORROW: Constraining costs in health care

#

ARTICLE BY: Louis W. Sullivan, M.D.
Secretary of Health and Human Services
SUBJECT: Constraining the costs of health care
LENGTH: 720 words

Fourth in a series

In seeking ways to improve the American Health care system -- to constrain costs and help all Americans gain better access to care -- there are those who propose that we not raise the bridge, but lower the water. They want to do it the hard and unnecessary way, if not the impossible way.

Some suggest that we embrace a centrally-run or regulated system, either in the form of national health insurance, or by government-mandated employee benefits. I am convinced that such approaches would be counter-productive:

- they would simply finance additional inflationary pressures on health care from the taxpayers' wallet;
- they would smother competition and innovation that is the key to continued quality; and
- they would lead to rationing and waiting lists for health care, exacerbating our problems with access to the system.

(more)

At the other end of the philosophical spectrum are those who call for much greater reliance on the free market and competitive mechanisms in health care. We do, indeed, need to establish mechanisms which promote economy in the health care marketplace. Yet, I firmly believe that full access to health care in America will continue to require a public sector that provides a safety-net for those whom the market overlooks.

I believe there are some immediate and practical options to constrain costs and provide better access, while avoiding the pitfalls of radical reform:

Making the cost of health insurance more affordable for small businesses. Most of the working uninsured are employed by companies with under 100 employees, and especially those with less than 25 employees. Legislation at both the national and state levels, along with private sector innovation, can greatly alleviate this situation.

Encouraging the use of more cost-effective health care procedures through effectiveness research. Greater knowledge about effective medical practices can greatly reduce health care costs. By determining what works, and what doesn't work, in the practice of medicine, we can decrease the use of unnecessary procedures.

(more)

Exploring tax policies that would both increase consumer awareness of the true cost of health care, and distribute current tax subsidies more equitably. We must examine whether the tax exempt status of health care benefits may insulate consumers of health care from the costs, thus driving up costs because of market distortions. We must also examine the tax treatment of privately purchased insurance.

Upgrading and expanding primary health care, especially our National Health Service Corps, and Community Health Centers for our neediest and most vulnerable citizens. Even under the best health care systems, there are still going to be those who need extra help from government. Along with Medicaid (the public health insurance system for welfare recipients) public health personnel and facilities can provide a health care safety net for the poor, and citizens living in medically under-served areas.

Working to reduce administrative costs in our current private-public health insurance system. While some exaggerate the savings to be realized, there are ways to reduce unnecessary paperwork, and streamline administrative procedures in health care to achieve savings.

(more)

Easing barriers to high quality, cost-effective managed and coordinated care. It is important that the market assures that individuals, as well as health care providers, are aware of the costs of health care. Coordinated care plans operate in a competitive environment, prompting the efficient management of health care resources.

On a parallel track, we should encourage and assist states to seek their own solutions, and provide a laboratory for testing innovation. This is the principle of federalism. As a private-public partnership should be the economic foundation of health care; so should decentralization be the organizational foundation.

Today, we see many innovations at the state level. Cost containment and expanding access are hallmarks of many of these experiments.

Yet, it must be recognized that a large part of our nation's ability to reign in the costs of health care rests with individual citizens. Too many of our citizens are living in ways that contribute to violence, injury, ill health, and premature death. A lack of personal responsibility for health maintenance is not only costing the nation enormous sums of money; it is also damaging lives, and costing us economic productivity, social harmony, and our sense of well-being.

Improving the health habits of Americans must be part of any strategy to achieve better national health and constrain costs.

(TOMORROW: Personal responsibility for health)

#

(more)

ARTICLE FOR: Louis W. Sullivan, M.D.
Secretary of Health and Human Services
SUBJECT: Taking Personal Responsibility for Health
LENGTH: 650 words

Last in a series

So far, the national debate on health care reform has been dominated by discussions of insurance, other financing strategies, malpractice problems, cost-restraint and treatment effectiveness...in short, every aspect of health care except personal responsibility. As we look for ways to improve our health care system, we must keep in mind that doctors, hospitals and insurance companies do not hold a monopoly on protecting our health. Our personal decisions -- about what we eat, whether we smoke, how much we exercise, whether we abuse alcohol or drugs, etc. -- will have a much greater impact on our personal health than any health care policy.

There is both a public responsibility and a personal responsibility for health. Federal responsibility results in four of every 10 health care dollars spent in this nation being provided by the government. Personal responsibility refers to the steps which each of us must take to protect our health.

(more)

Half of the 2.2 million deaths which occur in the United States every year are potentially preventable. If I announced a health care initiative that would eliminate 45 percent of the deaths resulting from cardiovascular disease, 23 percent of deaths from cancer, and eliminating more than 50 percent of the disabling complications of diabetes, for a minimal price tag, who could refuse? These reductions can be achieved by improving our personal health habits.

A handful of lifestyle risk factors -- smoking, excessive drinking, high-risk sexual behavior, drug abuse, a diet high in fat and sugar, and a sedentary lifestyle -- are linked to a host of preventable diseases. Better control of only 10 such risk factors could prevent between 40 and 70 percent of all premature deaths, a third of all cases of acute disability, and two-thirds of all cases of chronic disability.

In addition to these lifestyle changes, we should take responsibility for maintaining our health by seeking appropriate preventive services. Discussions of health care reform can not afford to focus only on treating America's ill and injured. Such a narrow focus ignores the vast savings -- both in terms of human suffering and economic -- that could be achieved by preventing many of the conditions which cause citizens to utilize our health care resources. For example:

(more)

- o In addition to preventing poliomyelitis, for every dollar spent on polio immunization, \$10 are saved. This translates into an estimated savings of \$1 billion per year.
- o For every \$1 spent on prenatal care, \$3.38 is saved in medical care costs associated with low birthweight infants, and healthier babies are born.
- o Detection of high blood pressure through early screening can prevent an estimated 45 percent of heart disease deaths, if screening is followed by appropriate hypertension control.
- o Mammography is associated with a 50-60 percent reduction in mortality from breast cancer for women over age 50. Over 30 percent of breast cancer deaths and almost all deaths from cervical cancer could be prevented through early detection and treatment. Cervical cancer screening among low income women saves at least \$1600 to \$2100 per person.
- o Smoking is the single greatest cause of preventable death in America. It results in 435,000 deaths annually, and costs our nation more than \$52 billion each year for health care costs, lost wages due to absenteeism, etc.

(more)

Maternal smoking is also the leading cause of low birth weight in infants. For every \$1 spent on smoking cessation programs for pregnant women, \$6 are saved in neonatal intensive care costs and long term care of infants.

In order to empower individuals to practice personal responsibility, my Department will be launching an initiative early next year that will help patients and providers determine their preventive health care needs. I applaud the efforts of those insurance companies that have implemented prevention packages which tailor preventive health measures to the needs of each patient.

Taking greater personal responsibility for our health and incorporating preventive services are not the answer to all of the health care dilemmas we face. But they are an essential, and often neglected, part of health care reform.

#



HHS HIGHLIGHTS

THE BUSH - SULLIVAN RECORD

Under the leadership of President George Bush and Secretary Louis W. Sullivan, M.D., the Department of Health and Human Services (HHS) has moved aggressively to address our nation's most pressing health and social problems.

With some 250 domestic programs, HHS has the federal government's largest budget -- accounting for about 38 percent of all federal spending. The two largest federal programs, for example -- Social Security and Medicare -- are part of HHS.

The period since President Bush took office has been among the most dynamic in HHS's history. Among the highlights:

- o Major new initiatives addressing the problems of infant mortality, immunization, lead poisoning, tobacco use, child abuse and neglect, alcohol and drug abuse, minority males, and women's health.
- o A revitalized Food and Drug Administration, the most sweeping overhaul of its food labeling regulations in over fifty years, and major reforms in its drug approval process.
- o Development and release of "Healthy People 2000," a targeted, comprehensive health promotion and disease prevention strategy for America.
- o Creation of the Administration for Children and Families, which combines HHS's wide array of programs for children and families within a single operating division.
- o Greatly intensified efforts on HIV/AIDS prevention, on educating the public about HIV/AIDS, and on speeding the availability of drugs and services to the HIV/AIDS affected.

The following pages offer a capsule summary of many, but by no means all, of the outstanding accomplishments achieved by the Department of Health and Human Services under the Bush/Sullivan stewardship.

HHS HIGHLIGHTS
THE BUSH - SULLIVAN RECORD

CONTENTS

HEALTH PROMOTION/DISEASE PREVENTION.....	3
HEALTH CARE REFORM.....	4
CHILDREN AND FAMILIES.....	6
WOMEN'S HEALTH.....	8
OLDER AMERICANS.....	9
FOOD AND DRUG INITIATIVES.....	10
ALCOHOL AND ILLICIT DRUG ABUSE.....	11
BIOMEDICAL RESEARCH.....	12
MINORITY HEALTH.....	13

HEALTH PROMOTION/DISEASE PREVENTION

Health promotion and disease prevention efforts offer our best opportunity to reduce preventable disease, disability, and premature death in America. It has been estimated that upwards of 900,000 of the 2.2 million deaths that occur each year are avoidable. Under President Bush and Secretary Sullivan, health promotion and disease prevention have become major priorities -- at HHS and throughout the nation.

Healthy People 2000 -- A targeted, comprehensive health promotion and disease prevention strategy for the United States was completed in September 1990. "Healthy People 2000," a 672-page document offering specific goals, will serve as a guide for policies to improve the health of the American people for the remainder of this century.

Infant Mortality -- The Bush Administration's "Healthy Start" initiative represents a major new effort to reduce the intolerably high infant mortality rate in the United States. Demonstration grants targeted to 15 cities and rural areas with excessive infant deaths are intended to develop techniques for reducing infant mortality rates in the U.S. by up to one-half in five years.

"Healthy Start" builds on the already substantial resources -- some \$5 billion -- HHS is spending under President Bush on programs to decrease infant mortality and improve maternal and infant health. They include Maternal and Child Health block grants, support to 525 Community Health Centers and Migrant Health Centers, and the Centers for Disease Control's pregnancy risk assessment monitoring system.

Immunization -- In a far-reaching Immunization Initiative to address low immunization rates among certain populations of pre-school children, the Bush Administration is actively supporting innovative, comprehensive approaches at the state and local levels with the goal of ensuring that 90 percent of our children under age 2 are fully immunized by the year 2000.

HHS's budget for immunization activities has risen from \$98.2 million in 1988 to a proposed \$257.8 million for fiscal year 1992. Among the new approaches already being undertaken by the Centers for Disease Control are "express lanes" for vaccinations in public clinics, making vaccinations available in hospital emergency rooms, and making vaccinations available through the Women, Infants, and Children (WIC) and Aid to Families with Dependent Children (AFDC) programs.

Lead Poisoning -- The Bush Administration developed a "Strategic Plan to Eliminate Childhood Lead Poisoning," describing actions that can be taken at all levels to help eliminate this disease within 20 years. New CDC guidelines call for less than half of the blood level of lead than previously advised. And new efforts are being initiated to screen children and remove lead from homes, neighborhoods, water supplies, and the air. The Administration has requested an increase of over 400 percent in funding for lead poisoning.

HIV/AIDS -- The widely acclaimed "AIDS Prevention Guide," designed to help parents and other adults give our young people the information they need to protect themselves against the HIV virus, was first released in 1989. It is only one part of a comprehensive program of HIV and AIDS prevention efforts which also include the National AIDS Hotline, the National AIDS Clearinghouse, public service advertisements, and assistance to state AIDS programs.

HHS spending on research, prevention, and education efforts will total almost \$2 billion in fiscal year 1992 -- a 50 percent increase since President Bush took office.

The appointment by President Bush of the widely admired basketball great "Magic" Johnson to the National Commission on AIDS presents a broad new opportunity to educate Americans, young and old alike, on methods of preventing HIV infection and on developing sorely needed compassion and respect for those afflicted with HIV and AIDS.

Tobacco Use -- Secretary Sullivan has become the nation's leader in the battle against tobacco use -- the number one preventable cause of disease and death in America. ASSIST, the largest-ever national program to combat smoking, was launched in October 1991. Its goal is to help more than 4.5 million adults to stop smoking and 2 million more young people never to start. And a model bill for states to use for restricting minors' access to tobacco was developed and released in May 1990.

HEALTH CARE REFORM

President Bush and Secretary Sullivan believe America offers the best health care system in the world. But because of the serious problems of rapidly escalating health care costs and the denial of access to the system for too many Americans, they share the view that reform of our health care system is needed. They have developed the following principles upon which they believe reform must be based:

Health Care Must Be Accessible To All Americans -- We must remove unnecessary barriers to obtaining health insurance for the some 33 million Americans without it. Elimination of these barriers should be the basis of a public/private national plan to provide access to health care for all Americans.

We Must Find Ways To Cut Health Care Costs -- National health care spending rose to 12.2 percent of our GNP in 1990, compared with 9 percent in 1980 and 7 percent in 1970. Choice is a key component. Market forces must be used to our advantage to encourage individual financial responsibility and to achieve greater efficiency.

We Do Not Need Wholesale Change -- Our system of private/public partnership has many strong and vibrant features and has served America well for many years. Adjustments are needed, but we must not act foolishly and threaten the excellent quality of care the majority of Americans receive.

Nationalized Medicine Is Not A Viable Option -- Federally-run, federally-financed health systems in other countries are characterized by diminished health care services, delays in providing care, and outright denial of care for some. It is ironic that when the rest of the world is moving away from the inefficiencies and shortages of centrally-managed economies, some propose that we go in the opposite direction.

As a first step in the reform process, the Bush Administration has offered a seven-pronged approach to constrain health care costs and provide better access to health care for all Americans:

Insurance for Small Businesses -- Making the cost of health insurance more affordable and stabilizing the insurance market for small businesses.

Effectiveness -- Encouraging the use of more cost-effective health care procedure through effectiveness research.

Tax Policies -- Exploring tax policies that would both increase consumer awareness of the true cost of health care and distribute current tax subsidies more equitably.

Primary Health Care -- Upgrading and expanding primary health care, especially the National Health Service Corps (NHSC) and Community and Migrant Health Centers, which provide health care for over 5.4 million of our neediest and most vulnerable citizens. Under the Bush Administration, funding for NHSC has already risen to \$48.8 million in fiscal year 1991 from a low of \$2.3 million in fiscal year 1987.

Malpractice Costs -- Encouraging states to adopt tort reforms through enactment of the President's proposed legislation, the "Health Care Liability and Quality of Care Improvement Act."

Administrative Costs -- Working to reduce administrative costs in our current private/public health insurance system. To this end, Secretary Sullivan convened a forum of insurance executives and representatives of hospital and physician organizations in November 1991.

Managed Care -- Easing barriers to high quality, cost-effectively managed and coordinated care.

CHILDREN AND FAMILIES

The Bush Administration is guided by the firm conviction that America's children are our most precious resource and that strong, self-sufficient families represent the basic building blocks of our society. Accordingly, the Administration has committed itself to a greater emphasis on the needs of the nation's children and families. And it is fulfilling that commitment.

Administration for Children and Families -- In a major reorganization designed to fulfill the Administration's commitment to strengthening families, the Administration for Children and Families (ACF) was created in April 1991. It combined HHS's wide array of programs for children and families within a single operating division with a staff of over 2,000 and a budget of \$27 billion in fiscal year 1991.

Head Start -- President Bush's number one National Education Goal is to have every child in America start school ready to learn. During the Bush Administration, Head Start, the early childhood development program for low-income children, has witnessed the largest expansion in its history. Its budget has been increased by 58 percent, enrollment is up by 145,000 to just under 600,000, and it now serves 55 percent of all low-income children for at least one year prior to their entry into kindergarten.

JOBS Program -- The Job Opportunities and Basic Skills Training (JOBS) program, which assists welfare recipients to become self-sufficient, was implemented in all 50 states by October 1, 1990. JOBS requires states to provide education, training and work activities to welfare recipients. For example, teenage mothers who have not completed high school must go to school on a full-time basis and child care is provided for their children while they attend school.

Expanded Medicaid Eligibility -- Beginning in April 1990, Medicaid coverage was required for pregnant women, and children up to age 6, with incomes below 133 percent of the federal poverty level. Coverage of children up to age 19 with incomes below 100 percent of poverty is being phased in. And Medicaid demonstration projects are testing expanded coverage for pregnant substance abusing women and coverage for low income families not otherwise eligible.

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program has been greatly enhanced -- states are now required to provide children with treatments for conditions discovered during a screening visit, regardless of whether such conditions are ordinarily covered by the state program. And EPSDT providers are now required to perform lead blood level assessments appropriate to age and risk as part of the routine screening. If blood poisoning is detected, Medicaid must cover the cost of treatment.

Child Support Enforcement -- A record-high \$6 billion was collected from absent parents on behalf of their children through the Child Support Enforcement program in 1990. And paternity was established for over 393,000 children born out of wedlock, an increase of more than 54,000 over the previous year.

Child Care and Development Block Grants -- This new program, begun in September 1991, provides financial assistance to low-income families with a parent who is working or attending a training or educational program. The parent is given a variety of options in addressing child care needs. The purpose of the program is to increase the availability, affordability, and quality of child care.

At-Risk Child Care Program -- Established in October 1990, this program provides child care assistance to families who are at risk of going on welfare if they do not receive employment-related child care assistance.

Child Abuse and Neglect -- Under an initiative launched in 1990, HHS is pursuing aggressive activities to enhance public awareness of the problem, to identify knowledge gaps, to formulate a research agenda for the future, and to support innovative prevention and other service-oriented projects.

Service Integration -- In recognition of the complex and multiple problems of many families, HHS is working with a number of states and local communities to better integrate services. The goal is to focus on an integrated approach to providing assistance which increases the self-sufficiency of families.

WOMEN'S HEALTH

A vast knowledge gap exists between men's and women's health -- how, for example, different disease conditions uniquely affect women, and the different prevention and treatment measures women require. The Bush Administration has established women's health needs as a national public health priority and is moving forward with bold, new initiatives.

Women's Health Initiative -- The Bush Administration has proposed the largest-ever study of women's health issues. The Women's Health Initiative will, at a cost of an estimated \$500 million over 10 years, track at least 140,000 women to evaluate preventive approaches to cancer, heart disease, and osteoporosis.

Action Plan for Women's Health -- Released in September 1991 by the Public Health Service, the Action Plan for Women's Health lists the results of a nationwide assessment of the priority health concerns confronting women and identifies specific goals to be pursued and activities to be undertaken by HHS.

Breast and Cervical Cancer -- The Bush Administration has proposed a 52 percent increase in funding for breast and cervical cancer prevention -- to \$410 million. These funds will be used to pay for mammograms and pap smears for needy women, expand public education efforts on the detection and control of these cancers.

HIV/AIDS and Women -- The Social Security Administration published regulations listing symptoms for determining disability that, for the first time, take into account the fact that HIV and AIDS may manifest themselves differently in women.

Disability Benefits for Widows -- The Social Security Administration published regulations allowing widows to receive, for the first time, consideration of the same factors to determine disability as those used for workers.

The Surgeon General Speaks Out -- Surgeon General Antonia C. Novello, M.D., appointed by President Bush, has emerged as one of the nation's most powerful voices on behalf of women's health. Her no-nonsense approach -- "If you're going to smoke like men, you're going to die like men" -- has sparked a new awareness among women of the need to focus more keenly on health promotion and disease prevention issues.

OLDER AMERICANS

Our nation's older citizens represent not only a link to our past -- but a bridge to the future in the depth of their experience and their adherence to the values representing the best of America. The Bush Administration is committed to safeguarding the interests of our older Americans and to enhancing the quality of their life.

Social Security -- President Bush said, in his 1990 State of the Union address, "The last thing we need to do is mess around with Social Security." Because he has held firmly to this commitment, the Old Age and Survivors Insurance fund, from which Social Security benefits are paid, remains financially sound and will remain so well into the next century.

Nursing Homes -- Major new federal requirements to improve the quality of care in nursing homes and protect residents' rights became effective in October 1990. Also in 1990, a rule was issued which protects nursing home residents from being charged for costs payable by Medicare and Medicaid. And regulations requiring, for the first time, nurse aides in nursing homes to meet training and competency standards were issued in September 1991.

Breast and Cervical Cancer/Medicare -- Because half of all new cases of breast cancer occur in women aged 65 and older, the Medicare program began helping to pay for mammograms, to screen for early detection of the disease, in January 1991. Some 5.3 million women are expected to receive these benefits in fiscal year 1992. And Medicare began helping to pay for cervical cancer detection in July 1990.

Prescription Drug Safety -- So far in the Bush Administration, the Food and Drug Administration has issued guidelines intended to encourage drug manufacturers to carry out thorough evaluations on the effects of drugs on people over age 65; and has issued a rule requiring that information about the effects of prescription drugs on the elderly be included in the drugs' physician labeling.

Misleading Solicitations/Advertising -- The Bush Administration has cracked down on the deplorable practices of using terms, symbols, or emblems to mislead the elderly into thinking that solicitations or advertising represents official correspondence or endorsement from the Social Security Administration or the Health Care Financing Administration (Medicare). Under new regulations, violators now face stiff monetary penalties for such practices.

National Eldercare Campaign -- Launched by HHS's Administration on Aging in December 1991, the National Eldercare Campaign is a nationwide, multi-year effort to mobilize the resources of a wide spectrum of individuals, agencies, and organizations on behalf of older persons at risk of losing their self-sufficiency.

Medicare/Medigap -- The Bush Administration is implementing sweeping reforms in the supplemental health insurance for Medicare beneficiaries known as Medigap. Beneficiaries may no longer be denied coverage because of pre-existing conditions if they buy a Medigap policy within six months of becoming eligible. One standard benefit package must be offered by every carrier that fills in gaps such as drug reimbursement. Additional changes will simplify the language of policies.

FOOD AND DRUG INITIATIVES

President Bush's goal for the Food and Drug Administration was to revitalize -- and restore public confidence in -- the ability of the agency to regulate the safety and effectiveness of food products, medicines, and medical devices. Many of the boldest and most ambitious actions in the agency's history have already been undertaken.

Food Labeling -- The most sweeping overhaul of food labeling regulations in over fifty years was announced in November 1991. The new regulations will end the confusion consumers now face, eliminate unfounded claims, and -- for the first time in our nation's history -- provide Americans with the clear, true, and understandable information they need to make healthy dietary choices.

Drug Approval -- Major reforms in the FDA's drug approval process were announced in November 1991. Under these reforms, patients with serious and life-threatening diseases will benefit from earlier access to important new drugs; unnecessary regulatory burdens will be eased; and American competitiveness will be strengthened.

Drug Effectiveness -- In a broad clean-up of ineffective ingredients in non-prescription drug products, the FDA banned 223 ingredients in 19 classes of products in November 1990. The ineffective substances banned range from pine tar in dandruff products to ox bile in laxatives.

HIV/AIDS Drugs -- In May 1990, the Bush Administration announced the "parallel track" plan for speeding the availability of investigational new drugs for people with HIV and AIDS-related diseases. And in October 1990, the FDA approved dideoxyinosine (DDI), the second drug (AZT is the other) that has been found to be effective against AIDS.

ALCOHOL AND ILLICIT DRUG ABUSE

The toll exacted on health, society, and the economy by alcohol and illicit drug abuse is staggering. In the most recent study, the cost of alcohol problems in America were estimated to exceed \$70 billion a year, with an additional \$44 billion a year attributed to drug problems. Charged with addressing the health aspects of alcohol and drug abuse, HHS in the Bush Administration has moved forward vigorously with bold new initiatives.

ADAMHA Reorganization -- The Bush Administration has proposed a major reorganization of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) which will allow for enhanced basic research and more effective targeting of alcohol, drug abuse, and mental health preventive and treatment services to the people who need them.

National Training Center -- The Bush Administration announced establishment of a National Volunteer Training Center for Substance Abuse Prevention in October 1991. Headquartered in Washington, D.C. with five training sites to be designated in each of the 10 HHS regions, the center will train thousands of volunteers from around the country in effective anti-drug abuse strategies.

Perinatal Addiction Center -- Establishment of a National Perinatal Addiction Prevention Resource Center was announced in August 1991. Based in Washington, D.C., the center will provide information, training, and technical assistance for public policy development related to maternal alcohol and drug use, both before and after giving birth.

Grants for Addicted Women and Children -- The availability of grants was announced in February 1991 for demonstration projects to seek effective methods of coordinating medical care with drug treatment and other services for Medicaid-eligible, drug-addicted pregnant women and children.

Waiting List Reduction Grants -- A \$75 million grant program to help drug treatment facilities to reduce or eliminate waiting lists was begun in 1989. Priority is given to applicants that have the largest waiting lists and the longest average wait for services.

Community Partnership Program -- Launched in April 1990, this initiative supports some 150 demonstration grants to fight alcohol and drug problems through community-based coalitions of public agencies and private organizations.

"Campus" Demonstration Program -- A \$68 million program launched in August 1991, this program provides funding for communities to introduce a "campus" approach in residential treatment programs, under which as many as five to eight providers using different methods occupy a common facility.

BIOMEDICAL RESEARCH

Biomedical research is crucial in our efforts to address many of America's most pressing health problems -- diseases such as cancer, AIDS, heart disease, and many others. The Bush Administration has placed a high priority on strengthening our biomedical research efforts and capabilities.

Human Genome Project -- The Bush Administration is pushing ahead vigorously in support of the massive effort to map the human genome -- literally to understand the information encoded on the human chromosome. Gene mapping will help us understand inherited disorders and could lead to new strategies for the prevention of more than 3,500 diseases of known genetic origin, and to a better understanding of other diseases such as cancer, depression, and hypertension.

Medical Treatment Effectiveness -- In 1989, HHS created an agency to conduct a program of research on medical treatment effectiveness. This research provides scientific information about the most effective medical strategies for practitioners, consumers, employers, educators, and insurers.

Public/Private Partnerships -- The Bush Administration is working to form a greater partnership between public and private research. Laboratories in several Public Health Service agencies are, for example, collaborating with industry scientists in joint research projects under Cooperative Research and Development Agreements.

MINORITY HEALTH

There remains in our nation a shockingly wide disparity in health status between our white and minority populations. In almost every category of mortality, for example, minority deaths are greater than those of whites. Since our minorities are disproportionately represented among our disadvantaged, many of the programs and initiatives mentioned above have their greatest impact among these groups. However, the Bush Administration has recognized the need to take steps aimed specifically at our minority populations.

Minority Male Initiative -- This new special initiative reaches out to young minority males who, as a group, are faced with serious health and social problems at rates far exceeding the population at large. It provides funding to local organizations for efforts to find local solutions to specific local problems, and for demonstration projects to support innovative programs of outreach and service coordination.

The initiative includes program activities of several agencies such as the Minority Male Grant Program, the High-Risk Youth Grant Program, the Critical Populations Grant Program, the Target Cities Grant Program, and the Criminal Justice Program.

Health Training and Research -- The Bush Administration has requested a more than 18 percent increase in funding for the training and deployment of health professionals serving minority communities. Initiatives include a significant expansion of the National Health Service Corps recruitment program, recapitalizing the health professional Student Loan Program, and the establishment of a new federal construction program to enable historically black colleges to improve their research infrastructure.

The National Institutes of Health is developing a 4-year plan to increase support for minority health and training, establishing Minority Program Advisory Board, and supporting pilot projects aimed at developing new approaches recruiting and retaining minority students in the health professions.

Foundation for Reform



- **Improving Access**
- **Maintaining Quality**
- **Containing Costs**



Department of Health & Human Services

by Louis W. Sullivan, M.D.
Secretary of Health & Human Services

Louis W. Sullivan, M.D.
Secretary of Health and Human
Services
on Health Care Reform

In his State of the Union Message, January, 1990, the President asked me to look at possibilities for improvement in our health care system. As part of that charge, I have talked about health care reform with many groups — practitioners and other health professionals, industry and association leaders, Governors and state health officials, state legislative leaders, consumer organizations, and many others. I have also engaged the American people in a discussion of key issues through a series of speeches, addressing a number of important points:

- The principles that must guide health reform,
- The reasons why health care costs so much,
- The need for personal responsibility as part of health care reform,
- The vital role for successful government health programs for the poor,
- The importance of private insurance as part of any solution, and
- The need for better medical practices, and more effective use of procedures.

Our health care system evolved in a uniquely American way; likewise, solutions to current problems will be uniquely American. Most importantly, we don't want to undo what is right about our system.

It is in a positive context of finding ways to improve the system rather than a negative context emphasizing the problems that I want to focus our deliberations on options for reform.

PRINCIPLES FOR MEANINGFUL REFORM

One fundamental objective must inform any consideration of health care reform: everyone should be able to obtain necessary health care. As we consider how to approach this goal, we must strive to remove financial barriers to necessary health care. I believe the present private/public health insurance system should be the primary means by which we move toward this goal.

*“One fundamental objective
must inform any consideration
of health care reform”*

However, *even under the best system, there are still going to be people who need extra help from government — those for whom even the best designed health insurance system won't be enough.*

But for most people, insurance is the best way to be able to obtain necessary care.

This implies two things: first, in order to have access to proper medical treatment, Americans should be able to obtain health insurance; and, second, this nation's health care must remain essentially a free market system within a strong private-public partnership.

I will not suggest another grand, sweeping, speculative scheme. Rather, building on the thorough research my Department has conducted over the past months, I propose a two-part approach: the first is comprised of some immediate, practical options that address our most urgent health care concerns. The second is a program of tests of carefully selected ideas and mechanisms for gaining the experience with which to evaluate more fundamental adjustments to our health care system. This testing of various approaches will include using the States as laboratories for developing ways to achieve greater access and self-sustained incentives for cost moderation. Taken together, these options steer carefully between and away from the extreme solutions proposed by some, charting instead a sound, practical, middle course, bounded by public consensus and the test of experience.

I remain convinced that the American system of health care is without doubt, the best in the world. By sensibly and speedily addressing the system's flaws, we can insure that the basically sound principles animating it are preserved intact into America's 21st century.

The vast majority of Americans now have health insurance — either publicly or privately sponsored. This is unquestionably a welcome development. And yet, this progress sharpens our concern about the 31 million Americans who are now without insurance. In a way, this is a paradox.

Nevertheless, those who call for a radical revamping of our health care system — suggesting nationalized health insurance — are mistaken. *We need to build on our achievements by getting an even higher percentage of people covered by insurance, rather than replacing our system with something that Americans do not need and would not tolerate.*

For example, at a time when most Americans are receiving the finest health care in the world, I find it remarkable to hear some people proposing that we scrap the system and adopt nationalized medicine. These same people often point to Canada as a model. But the Canadian system has some very serious problems, including long waiting lists and de facto rationing for critical medical procedures. This, I contend, would never suit Americans.

But let it be understood: our independence has a price. To keep it, we must adhere to another general principle of health care financing: as much as possible, individuals must assume responsibility for the cost of their health care. Governments must concentrate their resources on the poorest and neediest.

In an era of Federal fiscal constraints, government dollars will never supplant private insurance. Nor should they, regardless of budget considerations.

An optimal health care financing and delivery system should embrace another general principle: the necessity of individual responsibility for health, and care giving and financial support by family members for each other.

In this respect, we need to acknowledge what access to health care and insurance *cannot* accomplish.

Just as fire insurance, in and of itself, will not prevent your house from burning down if you fall asleep smoking in bed, health insurance will not, in and of itself, prevent lung cancer and emphysema if you insist on smoking. Health insurance will not reduce infant mortality for mothers who smoke, drink or abuse drugs during pregnancy. Health insurance will not prevent cirrhosis for those who abuse alcohol... the list could go on and on.

Along with better access to insurance must be the acceptance of personal and family responsibility for physical well-being. Families must care for their members. They must seek immunizations and regular check-ups for their children.

Regardless of access and costs, families and individuals are and will remain our first line of defense in preventing illness. Indeed, any strategy for constraining costs must include a plan to reduce the need for medical intervention.

Another general principle is that *we must fashion methods of health care delivery and financing that constrain growth in health care expenditures*. The health care market must offer an array of products and services that will meet individual needs at a reasonable cost.

It is my intention to look at options that facilitate diversity, encourage individual financial responsibility, and constrain the growth in health care expenditures through greater efficiency. We should *not* stifle economic growth and employment opportunities; we *should* constrain costs through the wise promotion of innovation and quality.

As much as possible, we must permit the medical marketplace to work. A dynamic economy will find many solutions on its own. We do not want to rush in with unproven government remedies that may create more problems than they solve. For example, a dangerous unintended consequence of overly burdensome mandates on business could be to retard economic growth and constrict employment opportunities. Without job creation — or worse, with job destruction — we will end up

innovation, the inefficient allocation of resources, and a much heavier burden on the taxpayer. At a time when the rest of the world is moving *away* from the inefficiencies, distortions, and shortages characteristic of centrally managed economies, it would ill-behoove America to entertain such an approach.

Others propose that we move in the opposite direction, toward dramatically expanded free market and competitive mechanisms in health care. Of course, reforms based on market mechanisms are the model for us: we do, indeed, need to establish a health care system of self-correcting, self-sustaining incentives, that will help us, moderate the rate of cost expansion, reduce wasteful consumption, and move toward greater economy and efficiency.

I have significant reservations about an abrupt shift to an unfettered marketplace in health care. First, radical change in the system would be unnecessarily disruptive. Moreover, full access to health care in America will continue to require publicly supported opportunities for the neediest and most vulnerable among us, providing a safety net for those whom the market overlooks. Finally, our high quality of health care derives in part from the fact that health care is not just a business or industry — it is also a serving profession, governed by the highest aspirations of ministry to mankind.

Americans clearly sense that they would lose more than they would gain by abandoning our current, basically sound system, to embrace radical, untested alternatives in either direction. That is why — no matter how urgent our health care problems are — *no consensus has formed* behind sweeping, systemic change of any sort. This lack of consensus is a fundamental, defining boundary which we must respect as we approach health care reform.

We must begin with people where they are, moving gradually from uncertainty and skepticism — through honest and thorough discussion, trial, and testing of various approaches — toward a sound health care system for the 21st century.

Policy-makers have to create an environment to facilitate the research.

Medical treatment effectiveness research will help improve the quality of care and surely save many lives. It will increase the functional abilities of our patients, thus they will maintain their independence and their dignity. This can result from resources devoted to developing and disseminating improved knowledge about patient outcomes, allowing physicians and their patients to make better decisions about treatment choices.

CONCLUSION

We are moving toward a health care system in which all Americans enjoy full access to reasonably priced, high quality, compassionate health care. And our reform has been guided by the following principles: containing runaway costs, expanding access to health care, and maintaining the high quality of care.

I remain persuaded that the surest and most direct route to this future will be provided by our current system of public-private health care provision. Its strengths are numerous and apparent: our health care talent, technology, and facilities are the envy of the world, and the vast majority of Americans enjoy access to them through a vigorous private health insurance system. As well, the American people will not — and should not — accept radical departures from the system that offers them so much. And yet, as we seek to deal with the very real problems of this system, the American people are being beguiled by proposals for unacceptably radical departures.

Some, for instance, suggest that we embrace a centrally-run or regulated system, either in the form of national insurance or the so-called “play-or-pay” approach. Such proposals, however, would carry us away from our ultimate goal, by introducing the likelihood of government managed health care rationing and waiting lists, the decline of quality through suppression of

with more, rather than fewer, persons lacking health insurance. Since without a job, one can not have employment-based health care.

THE HIGH COST OF CARE

Americans, as a society, spent \$665 *billion* or 12 percent of gross national product on health care in 1990. This compares with 5.3 percent in 1960, a bit more than 7 percent in 1970, and a little over 9 percent in 1980.

Unlike some, I do *not* argue that 12 percent of GNP is empirically too high. And, unlike others, I do not argue that we must spend substantially more. It seems to me that the \$2,600 spent in 1990 on average for each and every man, woman and child in the country *ought* to be enough. Even if government has no special insight to determine how much to spend overall, it nonetheless has a key role to play in assuring that individual health care decisions are indeed informed and that choices are made intelligently. Further, I believe government has a responsibility to assure that the goals of society as a whole play a role in that calculus.

I wonder whether we, as a society fully understand and appreciate the subtext of the \$665 billion we spend for health care? For example, how widely is it understood that total health care expenditures have risen 30 percent faster than GNP since 1970, while health care prices have risen 60 percent faster than general price inflation? For those who are uninsured throughout the year, and especially for those with low incomes, access to needed health care is often uncertain and sometimes unavailable. The uninsured under-use preventive care, and delay seeking appropriate care — which results in higher costs when care is ultimately secured. They misuse emergency room and other acute care services — which results in higher system cost. And they *do without some care*.

Without appropriate action the problem is likely to get worse in two basic ways: first, under pressures of sharply rising health costs, both private and governmental payors will seek to restrain their costs by eliminating their contributions to cross-subsidies which ultimately providing care for the uninsured; and, second, insurers will attempt to avoid the network of insuring risky and unprofitable businesses and individuals. As a result, more people will become uninsured and the problem of their access to care will be exacerbated.

I see at least *three key engines* primarily driving the growth in health care costs.

First, many consumers have been desensitized to the costs of their health care decisions — the very richness of insurance insulates many from the immediate effects of health care costs, and is, perversely, the source of the long term cost growth which so seriously threatens us.

Second, doctors, hospitals, and other providers of health care are focused on curing and caring — as indeed they should be — but they have paid too little attention to costs. That inattentiveness in the near-term, threatens the longer-term viability of our health care system.

Third, there is a reluctance to assume greater personal responsibility for our health. Too many of us view the health care system as though it were a general purpose “fix-it” shop. We choose behaviors and lifestyles that, while possibly personally gratifying in the short run, are harmful to our health. And we expect the health care system to compensate for our bad health habits, repair the consequences of our indulgences, and assure that we will live long lives. This is both an extraordinarily expensive, and unreasonable demand upon medical care.

These engines of increased costs have already driven us to a fearful point. In other times, most could buy medical care without the need for health insurance. Today, health insurance has become a necessity, if we are to afford modern care with its improved scope and curative power.

Of course, with so much riding on this effort, the integrity of the research must be guaranteed. Otherwise, practices incorrectly assured as more effective may actually harm the patient. Also, defective research would destroy the credibility of this effort. Such guarantees require an open, consultative process in establishing research priorities, adherence to rigorous peer review and a clear separation between those conducting the studies and those utilizing the results.

That is why this cannot become only a Federal program. *We need partnership and cooperation between the Federal government, state and local health officials, researchers and medical educators in the private sector, physicians and other health personnel. It is important that the medical community, the Congress, and the American people have full confidence in the methodology and the integrity of the research findings.*

Such a partnership will also give this research a greater impact. Medical research can never be viewed in a vacuum. Consumers, educators, physicians and policy-makers all must be involved because medicine is a process.

"It is important that the medical community, the Congress, and the American people have full confidence in the methodology and the integrity of the research findings."

Everyone must participate. Consumers must be given adequate information to make intelligent choices. Educators have to train their students to fully understand the options available. Physicians and other health care professionals have to present the options to the consumer. Corporate America must assist in this research to help provide better health care for their employees and to control escalating health care costs.

For example, the movement of some surgical procedures from the in-patient to the outpatient setting, such as cataract removal and arthroscopic knee surgery, has significantly reduced the cost of these procedures without compromising quality. As well, the development of laparoscopic cholecystectomy has significantly reduced the length of stay for a cholecystectomy and has remarkably decreased the period of physical recovery.

We need to create a true health “marketplace” based on adequate information for suppliers and for purchasers of health care. These services must be shifted from demand-based to need-based. We must *rationalize* health care before we even *begin* to think about *rationing* health care.

This type of information is necessary to facilitate decision-making by patients and physicians. We know that, if this information is available, it will be used. Previous studies by Dr. Wennberg and others suggests that *physicians will use this information and will voluntarily change their behavior* when informed about variations in their geographical area and the findings of relevant patient outcome research. In fact, it is when this information is absent that many of our health care problems emerge. As Dr. Lewis Thomas has argued, “It is when physicians are bogged down by their incomplete technologies, by the innumerable things they are obliged to do in medicine when they lack a clear understanding of disease mechanisms, that the deficiencies of the health care system are most conspicuous.”

Therefore, it becomes imperative that results from effectiveness research become integrated into medical education. I know from my own experience as an educator that one important audience for the findings of patient outcome research is the medical faculty responsible for training new physicians and providing continuing education to practicing physicians. They are in a position to influence the way physicians think about medicine and practice their healing art. My department is working with medical schools to make this information a priority in their educational environments.

Further, as payors recoil from rising costs they are coming to view as unbearable, both insurance coverage for the broad population and the web of cross-subsidies for the uninsured threaten to break down.

Two fundamental consequences follow from this: first, low-income, uninsured persons, now dependent on charity, will more and more find themselves faced with greatly increased difficulty in securing all the care they need; and second, there is the risk that, with costs perceived as out of control, all of us, the insured and uninsured alike, will get less needed care as *de facto* rationing grows.

Because those with financial capacity receive usually the best health care in the world, one could simplistically conclude that the residual problem of access to quality health care could be solved if society would only spend more. Indeed, such a superficial multiplication of dollars per head is fundamentally the basis of some of the simplistic proposals which have been put forward of late to “solve” the problem of American health care.

But the more pertinent issue is whether even those with virtually unlimited financial access are getting the care they need. We are all too familiar with such estimates as 20 percent or more of hospital days may be unnecessary, or that 50 percent of antibiotic prescriptions are probably unneeded or misused, or that too many of the coronary artery bypass grafts performed lack clear medical justification, and so forth.

Why is this? Physicians derive information from many sources, but clinical practice usually represents a mix of new knowledge with prior experiences about patients, the physician’s own abilities, the limits of his or her practice and past training, and the experience of colleagues. This pattern reflects the physician’s professional and personal commitment to provide his or her patients with care which, having withstood the test of time and community usage, we perceive to be of acceptable quality and faithful to the commandment to “do no harm.”

The evidence is substantial. However, this practice style often leads to the provision of care which, while generally harmless to the patient in its ultimate outcome is often is ineffective. This problem was most tersely stated by a former Harvard Medical School dean in addressing the graduating medical class. He said: "Half of what we have taught you is wrong. Unfortunately, we do not know which half."

To return to cost concerns, it is a fact that each sector of our economy feels the growth of health care expenditures. Consider the pressures on employers, individuals, government, and providers.

Employers find the cost pressures of health care too great.

The differential growth in American health care costs is one factor increasingly claimed to disadvantage the competitive position of United States products internationally. Our ability to export is reduced and foreign products become increasingly attractive economic choices.

Employers are pressured by the increased costs and frustrated at their inability to control them. As the costs of health care rise, more employers seek to reduce their financial exposure for, or to opt out of providing health benefits. The importance of employer health insurance decisions is evidenced by the AFL-CIO estimate that three quarters of the days lost to strikes in 1989 resulted from health insurance disputes.

Cost pressures of health care on *individuals* are intense.

Health care consumes an increasing part of effective wages for those businesses and industries providing health insurance to their employees. Even with the substitution of health insurance for direct wage compensation, workers find their health insurance covering a declining share of costs.

More workers find themselves and their families without employer-sponsored coverage and must seek it on their own, obtain public coverage, or go without. Many individuals

There is another agency in the Department that is also working on medical treatment effectiveness research. As the largest health insurer in the nation, the Health Care Financing Administration (HCFA) has unique access to clinical and billing data from the Medicare program. The Department is eager to make it available for effectiveness research. HCFA has begun the process of merging Medicare data, thus providing researchers with a more complete data base for effectiveness research. Data linkages are being established between HCFA and other entities, including the Cancer Registry of the National Cancer Institute, the National Death Index, and the End Stage Renal Diseases Registry.

We are also expanding our patient outcomes research program to encompass medical treatment issues involving the entire population. We are not limited to the Medicare population. We are also examining hysterectomy, Caesarian delivery, otitis media, implants, and other procedures which, though used on patients of all ages, might have different risks and benefits in younger populations.

As medical treatment effectiveness research is conducted, the results will be disseminated widely to patients, physicians, payers, and others. *Armed with this information, the practicing physician will be in a stronger position to make better informed decisions about patient care.* Also, representatives of several medical societies have emphasized that guidelines can serve as educational tools for both physicians and patients, to help reduce uncertainty and to clarify controversial or unproven areas of medicine.

In addition, *this research may be helpful in the effort to contain rising health care costs by adding to our knowledge about the benefits associated with the cost of health care.* As consumers and physicians assess their options and eliminate unnecessary procedures, resources could be conserved and quality enhanced. And, by utilizing the most appropriate procedures, good health may be regained more quickly, thereby reducing actual use of health care resources.

discharge are taken into account, and, in borderline cases, physicians and patients need to weigh the benefits and risks far more carefully.

Other studies sponsored by the Department have also shed light on one important controversy in alternative treatments for breast cancer: lumpectomy, removal of only the tumor, versus mastectomy, removal of the entire breast. Researchers found that, for small tumors that have not spread, lumpectomy plus radiation is often as effective as mastectomy.

More projects are now underway. Two years ago, Congress recognized the work of the Department in this area and in the Omnibus Budget Reconciliation Act of 1989 created the Agency for Health Care Policy and Research (AHCPR). One section of the law created within this agency a program of research on health outcomes and procedures. This research provides scientific information about the most effective medical strategies for practitioners, consumers, employers, educators and insurers.

In carrying out this directive, AHCPR is giving priority to those medical and surgical treatments and procedures for which large numbers of people are affected; there is uncertainty or controversy regarding a particular treatment; the associated risks or costs of treatment are high; the needs of Medicare beneficiaries are addressed; and data are available or can be readily developed.

Hence, through large, multidisciplinary projects we are examining back pain, benign prostatic hypertrophy, ischemic heart disease, biliary tract disease, hip fracture repair and osteoarthritis, diabetes, pneumonia, and cesarean section and other obstetrical procedures.

In addition, panels of health professionals and consumers have been convened to develop clinical practice guidelines for diagnosis and treatment of benign prostatic hyperplasia, visual impairment due to cataracts in the aging eye, urinary incontinence in adults, sickle cell anemia and many other health problems.

without employer-sponsored health insurance are simply priced out of the insurance market. Some must purchase their health care with after-tax, out-of-pocket dollars.

Cost pressures on *government* are intense. Health care costs, especially Medicaid, are the fastest growing segment of state budgets today. Providers, employers and the uninsured all look to their states for solutions to the health insurance problem. However, the growing demands of long-term care consume nearly half of Medicaid's dollars; spurred primarily by population changes, this forces difficult choices on the states. State legislators increasingly look to the federal government for assistance, or even wholesale take-over of their health care financing.

Cost pressures faced by *providers* are intense. To the extent that medical needs of the uninsured are met but exceed their ability to pay, providers absorb these costs as uncompensated care, (i.e., charity care and bad debt). And to the extent that the varied public payment programs under-compensate, providers must either absorb the loss or seek to shift it. The costs of uncompensated care often are passed on to those who *do* pay. The consequence is heavy economic pressure on health care providers (especially the public system), and charges that the system is unfair and in need of drastic overhaul.

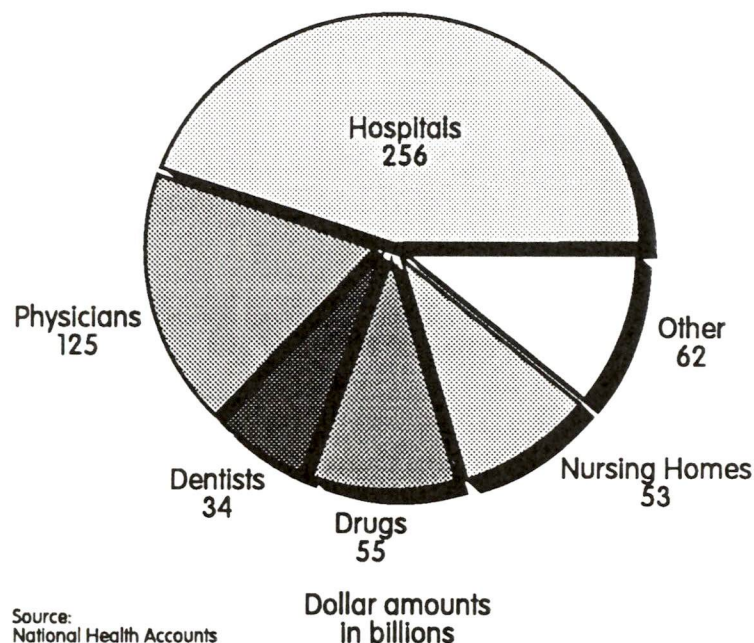
Yet, in the face of this array of growing pressure, we need to consider the various underlying forces and incentives which are fueling cost increases. Let me touch on several factors driving up costs: tax treatment of employer-provided health insurance, government oversight, and state mandates.

First, employer contributions to employment-based health insurance enjoy a unique status. These substitutions for taxable wages are tax-free to the employee. Because insurance is bought with untaxed dollars, it is economically reasonable for those who benefit most from the tax exclusion to buy more of it than something else for which payment must be made in after-tax dollars. So the tendency has been for employees to seek from employers more and more untaxed money to put into more and

more comprehensive coverage. The logical result is that overly "rich" insurance encourages over-utilization and discourages cost-consciousness.

But more importantly, what is the cost to the Federal government (and, ultimately, to the tax payer) of the subsidy this tax exclusion represents? This year it is \$58.6 billion, more than \$550 per insured employee. Is this subsidy equitable? Do we want to allocate our resources in a way which provides greater subsidy to the high-salaried employee than to those with lower wages?

Personal Health Expenditures in 1990 By Type of Expenditure



Second, the health care system and all its participants pay a further cost: government oversight. What some providers call the "micro-management" and "hassle" of my Department's

replacement there was a six-fold variation; for hip arthroplasty, an 11-fold variation; and for injection of hemorrhoids, a 26-fold variation.

As increasing numbers of studies confirmed these findings, this research raised a series of fundamental questions. Do these rates demonstrate over-utilization or under-utilization, or both? Are patients living in areas with high or low utilization rates suffering adverse consequences as a result of too many or too few medical services? In fact, how do we determine the most appropriate rate for any procedure or medical intervention?

Exploring these questions led to a second stage of research: "patient outcomes research." By drawing on large data bases, such as HCFA's Medicare files, researchers began to look at rates of mortality, re-hospitalization, and complications or disability following discharge from a hospital.

When supplemented by a review of medical records, patient outcomes research has the potential to provide important insights. Researchers will be able to assess the long-term benefit and risks of a particular procedure after hospital discharge; compare the long-term risks and benefits of different treatments for the same condition; and determine the health implications of over-utilization and under-utilization of specific procedures.

One subject of effectiveness research has seen the most substantial work to date — prostatectomy, the most frequent surgical procedure for male Medicare beneficiaries. Originally developed as an emergency procedure for men with acute and chronic urinary tract obstruction, the apparent safety of prostatectomy led physicians to increasingly recommend this operation as a prophylactic measure for patients with prostate enlargement without acute symptoms.

However, work by Dr. Jack Wennberg of Dartmouth, and others, with support from the Department of Health and Human Services, demonstrated that early surgery does not extend life expectancy, that the risks of prostatectomy are higher than previously suspected when death and disability after hospital

we don't know that works and what doesn't, and for whom it works and for whom it doesn't.

Unhappily, surrounded by 20th century technology, we find ourselves asking similar questions as did Hippocrates or Aristotle. This is not to say that modern medical treatments are guesswork or the practice of alchemy. But we do not have a perfect understanding of the human body and how to treat illnesses that strike. Today, around the world, there are biomedical researchers on voyages of discovery. And there are thousands of physicians, scanning the journals, waiting for new information that will benefit their patients. But there is insufficient information available that compares the effect of different approaches for specific conditions and their impact on the quality of life of the individual. We must use scientific approaches to discover which treatments are more effective for various conditions.

At The Department of Health and Human Services, we have worked to cultivate this research for almost two decades. The evolution of this enterprise is worth recounting briefly. It is, in many ways, a model of scientific inquiry.

The initial studies funded by the Department were known as "small area variations" research. While differences in the rates at which surgical and medical procedures are performed in different communities had long been recognized in the medical literature, this variation had always been attributed to differences in the composition of the population or other local variations. The research studies made an important contribution by demonstrating that these variations existed even after adjustments were made for underlying demographic or epidemiological factors.

The findings in many cases were quite dramatic. For example, researchers at RAND examined 123 procedures commonly performed on Medicare beneficiaries, of which 67 procedures showed at least a three-fold difference between those sites with the highest and the lowest rates of use. For a number of specific procedures, the variation was much higher: for total knee

oversight results from its role as protector of the public purse for health financing through Medicare and Medicaid. We are responsible for assuring that cost inefficiencies and fraud, waste and abuse are rooted out.

Third, state mandates on insurance are a factor driving up costs. Gabel and Jensen, in the Winter, 1989 issue of *Inquiry*, quantified the cost of mandated benefits and found them quite substantial. As many as one in six small firms that do not offer health insurance to their employees, the authors argued, would do so in a largely mandate-free system. The authors also concluded that about half of the large firms converting to self-insurance do so to avoid the cost consequences of mandates.

Lastly, as a physician, I have to note that physicians, have not played an entirely benign role. We face economic incentives which may modify our behavior. The September 3, 1990 issue of *Medical Economics* carried a lead story, "Earnings Make a Huge Breakthrough," with the sub-head, "1989 was a banner year for most M.D.s." In 1989, a year in which the inflation rate was 4.6 percent, the article reports that median *net* individual physician incomes rose by 12.5 percent — nearly three times the general inflation rate. *Only once* in 61 years has there been a greater percentage gain in physicians' net income.

***"We have to reconcile the need
to serve the patient with the
responsibility to avoid
unnecessary expense."***

I would like to be able to say the 12.5 percent income gain simply reflected physicians doing more for more people. Unfortunately, the survey's findings do not well accommodate that explanation — no significant increase in patient encounters was found from the prior year.

If we as a nation are ever to guarantee adequate health care to all — and I believe we should — we must somehow find a way of joining the patient's, the administrator's, and the payor's concerns for reasonable costs with the physician's dedication to the needs of individual patients. We have to reconcile the need to serve the patient with the responsibility to avoid unnecessary expense. Absent this, we are doomed to failure in achieving the morally appropriate goal of full access to needed medical care for every American.

INDIVIDUAL RESPONSIBILITY

The harsh truth is that a high percentage of the disease and disability afflicting the American people is a consequence of unwise choices of behavior and lifestyle. Those poor choices result in lives that are blighted, stunted, and less fulfilling, and they cause an unnecessary, costly drain on the resources available for health care.

"The harsh truth is that a high percentage of the disease and disability afflicting the American people is a consequence of unwise choices of behavior and lifestyle."

The decision to smoke, for instance, is responsible for one of every six deaths in America each year. The cumulative toll is 390,000 deaths per year, including 21 percent of heart disease deaths, 87 percent of lung cancer deaths, and 30 percent of all cancer deaths. In addition, smoking is responsible for 20 to 30 percent of low birth weight babies. Smoking costs our society over \$52 billion annually.

Investigators in the United States and around the world are increasing our knowledge and understanding about the human body and its interaction with our environment, and providing new tools to treat cancer, HIV infection and other diseases. As a result, biomedical research is rapidly revolutionizing the practice of medicine, with far-reaching implications for physicians, businessmen and policy-makers. Someday, through our effort to map the human genome, we may even have within our capability the prevention, treatment or correction of genetic defects.

In this age of specialization, there is more medical information available than one person could ever read, assimilate or apply. Yet, our knowledge about the effective application of these findings is still in an embryonic stage. We still lack considerable data concerning the functioning of the human body, in health *and* disease. So our attention must focus on improving our knowledge of medical treatment effectiveness. *Failing this, we will continue to spend enormous amounts of money on hundreds of health procedures without a clear understanding of their real effectiveness.*

There should be widespread support for effectiveness research. We have worked harder in the United States to determine the quality and effectiveness of medical treatments than in any other health care system around the world. Simply put, in the words of one commentator, "The (present health care) system does want to be better." That is why physicians and other providers, who have a tradition of jealously guarding their independence and autonomy, surrender so much data for outside review. There is an underlying assumption that this information will help health professionals improve their healing arts.

Many physicians now realize that information on treatment effectiveness is a cornerstone for modern practice. There is mounting evidence that much of the health care that we receive is unnecessary or inappropriate. *Some estimates claim that up to 40 percent of the procedures we use to treat certain diseases are inappropriate.* The problem is, for many medical treatments,

Third, *it is vital that the small group market be stabilized, so that the small businesses can get insurance at an affordable cost.* I believe that the HIAA proposals offer a useful starting point for actions to achieve increased stability. And we will want to draw important lessons from the efforts of states like Virginia and Connecticut, and from the other ongoing experiments.

"...it is vital that the small group market be stabilized, so that the small businesses can get insurance at an affordable cost."

MEDICAL TREATMENT EFFECTIVENESS RESEARCH

The United States is the world leader in assuring high quality of care received by patients. A recent report in the New England Journal of Medicine argued that "Although other countries have quality-assurance mechanisms in place, often imported from the United States, none approach the degree of sophistication or the acceptance and leadership by physicians that is apparent here." Our work to continue this research and maintain our international edge may offer new opportunities to improve our understanding of the healing art. Medical treatment effectiveness research can improve quality of care and provide better health care for our citizens, and perhaps help reduce the escalating cost of care. *Medical treatment effectiveness research and other research strategies have a positive role in identifying the most effective and high-quality medical practices, and in promoting their effective use by physicians and other health care providers. This research is not just a helpful addition to our medical knowledge. It may be a significant leap forward, a major development in the practice of medicine, perhaps as revolutionary as the work of Harvey, Pasteur or Lister.*

Abuse of alcohol was responsible for one half of the 30,000 motor vehicle deaths in 1988, and 40 percent of the drownings. Drinking is a major cause of cirrhosis, the ninth leading cause of death in the United States; it has been linked to violence, homicide and suicide; and its costs to society amounted to some \$70 billion in 1989.

Improper diet and inadequate exercise are other major contributors to poor health outcomes. Poor diet is related to five of the ten leading causes of death in the U.S., including coronary heart disease, some types of cancer, stroke, and diabetes. Together, unhealthy diet and sedentary habits contribute to 300,000 to 400,000 deaths each year.

For children and youth, injuries are the leading cause of death. The lifetime costs of injuries were estimated to be \$158 billion in 1985.

Problems of behavior and lifestyle contribute to some of the leading health problems facing this nation, including infant mortality, heart disease, and cancer.

If we are to bring better lives to all Americans — and if we are to cope with the dramatic increases in health care costs in America — it will be necessary for us to address directly the problem of ill-advised choice of behavior and lifestyle. And taking on this challenge, carries us well into the difficult realms of ethics and culture.

Now, this is not a comfortable passage for physicians and health care professionals — nor for Americans in general. By our actions, it would appear that we would rather avoid the issue of appropriate, healthy behavior altogether. But clearly, our avoidance is ill-advised, both from the standpoints of healthy, fulfilling lives, and of financial costs.

Why do we approach health this way? In part, I believe, because we have seen such miraculous achievements in medical science that we believe it can, indeed, fix virtually any ailment. Our faith in medicine grows ever stronger as we push out the frontiers of

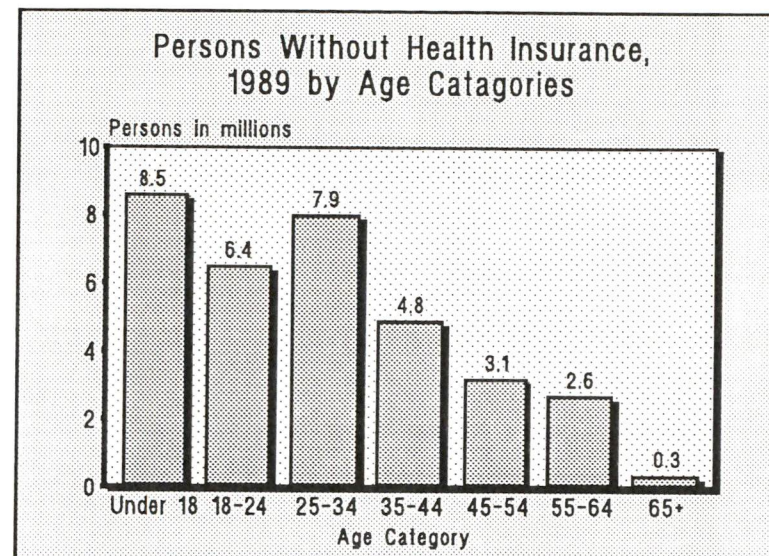
research, unveiling more of the secrets of life. Consequently, we have come to think of medicine as a safety net, strong and wide enough to catch all who fall from the high wire of an unhealthy lifestyle.

Even as our trust as a society in medical science grows, however, I am troubled by diminishing confidence in our willingness and ability as a society and individuals to make sound judgments about healthy human behavior and lifestyles. Linked to this declining faith in ethical and value judgment is an erosion of those institutions that have generated, shaped, and sustained our ethical and cultural standards — family, neighborhood, church, school, and voluntary associations. As a consequence of this institutional decline, we have fewer sources of instruction in healthy, constructive behavior.

As Secretary of Health and Human Services, every day, I see the tragic price of our cultural indifference —not only in the prevalence of preventable disease and injury, but also in the vast range of social problems afflicting the American people — drug and alcohol addiction, escalating child abuse and neglect, children born to unwed teen mothers, families abandoned or never formed. So many of these problems have their roots in the alienation, isolation, and lack of direction that follow from the collapse of societal standards, and the institutions that generate them. That is why I have travelled from one end of the country to the other, calling for a renewed sense of personal responsibility on the part of every American citizen —in short, a new “*culture of character*.”

By “character,” I mean the personal values and qualities encompassed by that sturdy, time-honored word — values like self-discipline, integrity, taking responsibility for one’s acts, respect for others, perseverance, moderation, and a commitment to serve others and the broader community.

By “culture,” I mean these values that must be embraced as cornerstones of our society. I seek to remind Americans that we can best cultivate character in our citizens by reinvigorating and shoring up those institutions that teach and nurture values and



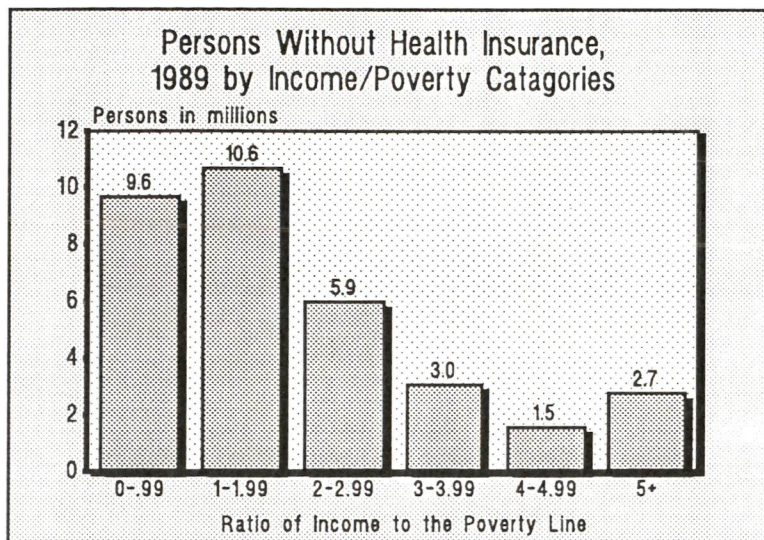
Source: ASPE tabulations of the March 1990 CPS

It is also important to note that there are large numbers of demonstration projects under way related to improving affordability. For example, several states have begun to suspend their mandated benefits to make basic insurance more affordable. For example, in Virginia, Blue Cross and Blue Shield plan a trial offer of a basic, no-frills policy at a cost *one-half* that of a standard major medical policy.

Let me summarize:

First, the group health insurance market is at the heart of our health care financing system, and it *should continue in this role*.

Second, while that market is fundamentally sound, maintaining its health, *expanding its coverage and introducing greater flexibility will require much hard work during the coming months and years. Perhaps the most important task will be controlling health care costs. It will require that everyone — families and insurers, health care providers and employers, and governments at all levels — everyone share equitably in this task.*



Source: ASPE tabulations of the March 1990 CPS

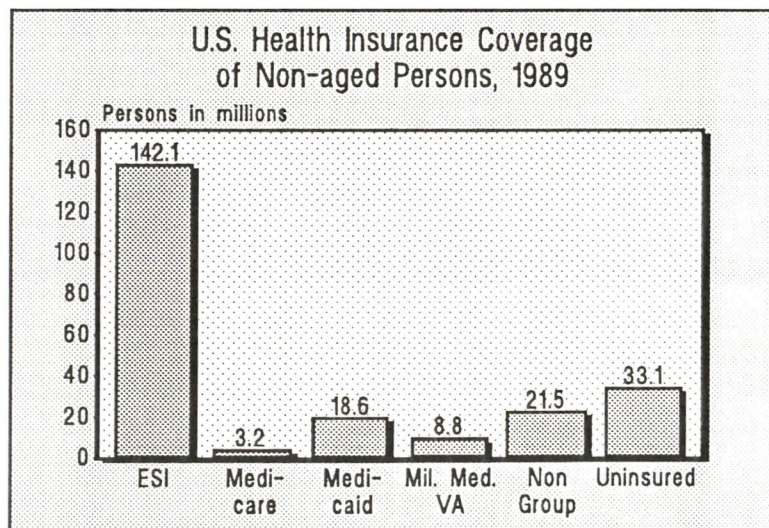
principles of healthy behavior, especially the institutions of family and community.

Translated into strategies that would mean healthier, longer lives for all citizens, a new culture of character calls upon Americans to end drug abuse; avoid the high risk behavior that spreads the AIDS virus; reduce consumption of alcohol; seek early prenatal care; improve eating habits; wear seat belts and take other necessary precautions; increase exercise; learn to resolve conflicts without resorting to violence; seek the necessary medical examinations and vaccinations; and, yes, stop smoking.

"Indeed, control of fewer than ten risk factors... could prevent between 40% and 70% of all premature deaths, a third of all cases of acute disability, and two-thirds of all cases of chronic disability."

By following these injunctions, studies have shown that we could eliminate 45 percent of deaths from cardiovascular disease, 23 percent of deaths from cancer, and more than 50 percent of the disabling complications of diabetes. *Indeed, control of fewer than ten risk factors, including the above — could prevent between 40% and 70% of all premature deaths, a third of all cases of acute disability, and two-thirds of all cases of chronic disability.*

Just as important, a new culture of character in America, nurtured by strengthened families and communities, would do much to alleviate the alienation, isolation and despair that fuel teen pregnancy, violence, drug and alcohol abuse and other social problems afflicting us. The lives of Americans would be healthier in every sense of the word.



Multiply Insured Persons are included more than once
Source: March 1991 CPS

Now, I have heard it said that my call to a new culture of character is in fact nothing more than a way of diverting attention from a Federal government and a society that refuses to provide the resources necessary for better health care for all Americans.

Certainly, poverty is linked to ill health and social dysfunction. But let us never be guilty of suggesting to our citizens that first they must be wealthier, *before* they can be healthier. In fact, many impoverished families and neighborhoods have sustained the values and institutions necessary for healthy, productive lives — lives that will eventually lead them out of poverty.

To suggest that our poor and minority citizens cannot improve their lives, by drawing on their own strong, traditional values and institutions, is not only inaccurate, it is patronizing and insulting. To counsel them to sit and wait patiently for massive new Federal (or other) programs is to counsel resignation, defeat, pessimism, and despair.

Ill-advised choices of behavior and lifestyle characterize all strata of American society. And so the call for a new culture of character applies with equal force to *all* Americans, regardless of income, race, sex, or other status.

Let me be clear about another aspect of the “culture of character.” It by no means puts the onus for healthy behavior exclusively on the individual, nor does it rely simply on a heightened sense of personal responsibility. That’s why our *culture* — the broader realm of social, economic, and political institutions which shape our lives — figures centrally in my message. We must mobilize all those institutions in the cause of healthier, more productive lives for our citizens.

The Federal government is playing a leadership role by marshalling all facets of society behind disease prevention and health promotion, as demonstrated most recently by our report of health goals for the nation, *Healthy People 2000*, a careful, thorough enunciation of certain clearly-defined health goals to be reached by the turn of the century. We are also working to

negotiating price arrangements, employers are prodding insurers to strengthen utilization review and other cost-containment techniques, and innovative new products are continuing to emerge. For these two groups, while there is considerable room for improvement, the strengths of the private insurance market outweigh the weaknesses. Again, in the William Mercer survey, three-quarters of the respondents answered that government should not regulate the price of medical treatment. And when asked whether costs were so out of control that some form of national health insurance is the answer, more than 80 percent responded “no.”

But the situation is quite different in the insurance market faced by small businesses. Even the Health Insurance Association of America has said “It is very clear that the market is increasingly becoming dysfunctional [and] there’s a perceived need to stabilize the market.”

The Health Insurance Association itself has taken an initial step to stabilize the market by proposing a series of industry-wide reforms that would move toward market stability. The proposed reforms would, among other steps, guarantee a small business the right to buy insurance; assure continuation of insurance even if employees become unhealthy or change employers or if employers changed insurers and would place some limits on both initial and renewal rates.

These proposals constitute a constructive and interesting basis for beginning discussions. But there remains a number of areas for the government and the industry to explore together — for example, whether each insurer will guarantee to cover any group that applies, and how to respond to the development of ever-narrower rate classes which could further fragment the market on the basis of health status. Similarly, we will want to weigh whether this is an appropriate area into which the federal government should become involved or, alternatively, if it should be left to the states in their traditional roles as regulators of insurance.

It is these groups which are at the greatest disadvantage in the search for health insurance, and it is within these groups that most of the uninsured workers and their dependents are found. For example, about one-third of the uninsured are either workers, or dependents of workers, in businesses with fewer than 25 employees.

Some of these small businesses are indifferent to insurance. Offering insurance is not necessary to attract the unskilled workforce they need. And some low-income employees would prefer all of their compensation as cash wages, rather than some as health insurance.

Other small firms might wish to provide health insurance to their workers. However, their business income (and their employees' cash wages) are too small to afford significant health insurance without some form of subsidy.

Finally, there are small firms actively interested in insurance who are in the marketplace to buy coverage. They find themselves offered insurance at attractively low one-year rates that exclude coverage for preexisting conditions. At the end of that year, however, they often face premium increases of forty to eighty percent or more, even if they have filed no claims.

This is what produces much of the churning in this market, as small businesses bounce from insurer to insurer looking for the lowest possible rates. And one of the by-products of chasing lower rates is that employees or their dependents who have chronic conditions are perpetually excluded from coverage.

At this juncture, one might accept the conclusion that private insurance is an unsound and unworkable basis for broad-scale health insurance in the coming decades. *Yet a balanced view requires us to recall the strengths of private insurance.*

Again, consider the three groups we have identified. The large group market is solid even though, like other parts of the market, it is bedeviled by exploding health care prices. In the medium-sized market, insurance buyers and sellers are

elevate the status of preventive services in our approach to health care delivery and health policy reform.

More broadly, the Federal government today is working to revitalize institutions like the family and local community, which cultivate healthier, life-sustaining values. This approach carries us beyond the attitude of the 80s, when government retreated from active social policy.

We now know that Federal programs are most effective when they work through, and help to reinforce, active, indigenous community groups. And so today, we are providing resources and assistance to community coalitions that are striving to prevent the spread of AIDS; halt drug and alcohol abuse; provide early childhood development programs; counsel young minority males; reduce violence; bring expectant mothers into prenatal care programs; and a vast range of other activities.

Workplace America also has a role to play in building a new culture of character. Businesses must become far more attentive to the health and lifestyle of their employees, both by discouraging unhealthy behavior like smoking and drug and alcohol abuse, and by encouraging positive behavior, like exercise and proper diet.

Equally important, some corporations must be held accountable when they undertake actions that erode the culture of character. Heavily promoting alcohol and tobacco sales in low-income communities is one such reprehensible act.

The media and cultural leadership groups also have a vital role to play in shaping a new culture of character in America. If they can help us celebrate solid values and institutions, then Americans will be far more likely to adopt healthy lifestyles.

A step in the right direction is the dramatic turn-about in Hollywood's and Madison Avenue's treatment of drug use. Where once it was accepted, today it is the target of a highly effective, voluntary multi-million dollar prevention campaign.

This is a good example of what can be accomplished, if our media leaders can be mobilized behind healthier lifestyles.

Finally, within my own profession of medicine, health promotion and disease prevention must play a much larger role. We must work to redress the imbalance in health care expenditures devoted to promoting health versus treating disease — currently, only 4 percent of total expenditures go to prevention — and we must make prevention a central part of the improved primary health care that we are striving to make available to all Americans. Above all, physicians must overcome their reluctance to venture into the personal, private behaviors of those to whom they minister, in order to give them thoughtful counsel about the effect their choices have on their health.

"We must have the courage to point out the dangers of unhealthy, self-destructive behaviors in those around us, as well as voice approval for their healthy behaviors."

This brings me to one final comment about my vision for a new culture of character in America. It is a culture in which we not only are more careful about our own health behavior, but also more attentive to the behavior of those around us — our family members, friends, neighbors, and coworkers.

We must have the courage to point out the dangers of unhealthy, self-destructive behaviors in those around us, as well as voice approval for their healthy behaviors. And when these judgments are rendered — not out of smugness, or self-righteousness, or condemnation, but out of compassion, concern, and love — when they come in the spirit of family and friendship — then the message of a new culture of character will have discovered its most effective and profound voice.

As a consequence of the splintering of the workplace group market, there are roughly three types of businesses, each with different problems.

The first are those firms that self-insure. Since the passage in 1973 of the Employee Retirement Security Act, large employers have increasingly self-insured (in part because it enables them to escape state-mandated benefits). Today, 70% of firms having more than 5,000 employees insure themselves instead of buying commercial health insurance. For these firms, the main problem is sharply rising costs per service and burgeoning use of health services. Many of these firms have introduced cost containment measures to try to restrain cost growth. In a 1990 survey, William A. Mercer, Inc. surveyed the 5,000 largest U.S. employers and found that 75 percent have implemented utilization review (a 50% increase from 5 years earlier), 75 percent have shifted more of the costs to their employees to increase cost-consciousness, and 70% are restricting reimbursement for services considered to be unnecessary. More than 80% are offering either health maintenance organizations or preferred provider service arrangements.

However, in spite of some success with these early efforts at cost containment, costs continue to rise sharply, and frustration has led to some very vocal calls for some sort of national health plan.

A second set of businesses needing workplace insurance is composed of large- and medium-sized firms that continue to buy commercial health insurance. These firms face often dramatically rising premiums related to rising health care costs. Like the self-insuring firms, these companies have been active in the search for cost containment mechanisms.

The third set of businesses in the workplace health insurance market — that part hardest hit by the dissolution of community rating — consists of small groups, groups with employees who are chronically-ill, and groups in higher-risk industries. The importance of the small business market cannot be overstated: 89% of U.S. firms have fewer than 25 employees, and about one-third of all U.S. workers are in such small companies.

segmentation" — the identification and avoidance of risky applicants. Insurers began to be more diligent in examining the health condition of applicants for coverage. They administered lengthy questionnaires, required statements from physicians, and even mandated physical examinations.

As health status information became increasingly available, insurers began to charge extra premiums for certain conditions, such as a history of allergies or colitis or back strain. As well, they began to exclude certain problems from coverage — for instance, cataracts, bad knees, or hemorrhoids. They denied coverage altogether when an individual had a history of an illness like diabetes or emphysema.

Based on aggregate experience with claims histories, insurers began to simply "redline" or exclude in advance whole industries or occupations, such as hazardous work like ranching; low-paying work like beauty salons or gas stations; and businesses with higher-than-average claims like medical or dental practices.

Against this tapestry of market fragmentation, other forces began to affect the ability of businesses even to afford health insurance for their workers.

Health care costs began to outpace growth in corporate and personal incomes. Many firms began to find that the fastest growing share of their health care costs was among their retirees, and because of commitments made when the retirees were workers, their benefits and costs were very hard to control.

States increasingly mandated that all insurance contracts must cover certain people, conditions, benefits or health care providers. The costs of these mandates were substantial: in the state of Maryland, which has more than 30 mandates (the largest number in the nation), Blue Cross/Blue Shield estimated that mandates accounted for 13 percent (or \$64 million) of all health services dollars they paid in 1989.

My plea for a new culture of character, a new ethic of personal responsibility, is by no means intended to be a substitute for the changes that we must make in our broader system of health care. Government will have to be more active on behalf of those who are underserved by current health care arrangements — especially our poor and minority citizens.

But I believe that, as we struggle to overcome the barriers to healthier lives for all our citizens, we can learn much from the experience of the Black community in America. That experience teaches us that progress and reform are most likely to come when we pursue a two-fold strategy: first, strive to change the external circumstances that are unjust and hold us back; and, second, strive to reinforce the strength of character necessary to survive and prosper in spite of adverse circumstances.

Neither strategy in isolation is sufficient; both strategies together will bring significant progress and reform. Frederick Douglas, for example, worked not only to abolish the social circumstance of slavery; but also sought to build better individuals, by emphasizing the importance of character. "With character we can be powerful," he proclaimed. "Nothing can harm us so long as we have character."

*"A new culture of
character... is an essential,
crucial part of the answer."*

In our time, the outstanding leaders of our community continue to pursue both strategies simultaneously. Dr. Martin Luther King, Jr., resolutely pursued changes in society's laws and institutions, so that one day his children would not be judged by the color of their skin. But at the same time, he worked to prepare people for the day when they would be judged by the "content of their character."

Similarly, Jesse Jackson's quest for social and economic change in the larger society is joined inseparably to a call for personal reform, for better character. As he put it, "When you drink liquor, and when you take drugs, and when you *sell* drugs, and when you shoot people and when you rob people . . . nobody can save *you* but *you* from yourself."

So today, as we search for ways to ensure that our expenditures for health care are wisely spent, and not squandered treating unnecessary and preventable disease — more importantly, as we search for ways to bring healthier, safer, more fulfilling and productive lives to all our citizens — let us pursue both strategies at once. Let us not only seek ways to change and improve our health care system — let us search for ways to improve ourselves — our behavior and lifestyles, our values, indeed, our very character.

A new culture of character is not the entire answer to the health care dilemmas we face. But it is an essential, crucial part of the answer. It is a vital key to better lives for all Americans.

HEALTH CARE FOR THE POOR

The principle issue relating to health care for the poor is access. But much of the national discussion has focused too narrowly on solving the problem of uninsurance. While insurance is a necessary part of the discussion, it is too broad to allow for a cogent examination of the particular problems facing the poor.

The current re-examination of the American health care system has come to be driven by, and dominated by, a symptom of our current difficulties, rather than by their underlying causes. The symptom, so frequently cited, is the 30 to 35 million Americans who lack health insurance. The number itself — 33 million for convenience — has been imbued with intrinsic substance and its own reality. But the mythology which has grown up around the

their insurance. Most individuals paid similar premiums regardless of the condition of their health. Thus, healthy groups bore some of the costs of the less healthy. Where subsidies were needed in order to make insurance affordable for unhealthy or low-income workers, those subsidies came from within the community pool.

In the mid-1950s, this market began to come apart. Commercial life and casualty companies entered the health insurance field and offered competition to "the Blues" by developing a new approach to rating — called "experience rating." Through application of this technique, commercial insurers were able to offer lower rates to healthy groups. This touched off a centrifugal effect that broke up the community-rated market. For example, healthy groups began to pursue the lower prices offered by commercial insurers, and they withdrew from the community-rated system.

In turn, the average rates in the community pools began to rise, and as the rates increased, more and more groups sought the lower rates commercial insurers were offering.

As more groups left the community, the community pools (and the Blue Cross plans that insured them) became progressively more overloaded with unhealthy, high-cost groups. In turn their community rates rose sharply because the subsidies of healthier groups were gone, eliminating a key factor in keeping rates artificially low.

In self-defense, lest they be left with only the high-cost groups, many Blue Cross plans began to emulate the practices of commercial competitors — that is, they declined coverage for certain medical conditions and raised their rates for certain unhealthy groups. Large groups incurred lower administrative costs and small groups had higher administrative costs.

But the dismembering of the community pools was only the first act in the effort to avoid high risks and the search for competitive advantage. Over time, commercial insurers became increasingly adept at practicing what is called "risk

because of it, many families face such limited financial access to health insurance that they do not use the health care system wisely. They lack continuity of care, and their care is marked by costly inefficiencies. Employers who insure their workers and are trying to control their own costs find that they are paying for people who are not insured because providers are forced to shift costs. And, governments at all levels bicker with each other over categorical restrictions that limit program flexibility and, especially in these austere times, over funding levels.

But over and over again, I am convinced that part of our solution must be to return to the elements of fundamental strength in this system. Competition produces quality, innovation and personal choice that produces variety and value. *In my view, the challenge is that we must work to extend the benefits of this system to all Americans.*

As I surveyed our health financing system evaluating its soundness, I have carefully examined that feature of the financing landscape that has, for over fifty years, formed the rootstock of the system — private health insurance. Developed as an outgrowth of the Great Depression, private health insurance took root in the workplace during the Second World War and grew sharply during the Post-War period. In 1940, 12 million Americans had private health insurance protection for hospital costs; by 1960, that number had increased ten-fold to 122 million; by the late 1980's, some 190 million people had private health insurance coverage of hospital care, and the system was paying nearly \$100 billion in total annual claims.

Certain problems have accompanied this growth, and it is worth reviewing the history of this evolution because it illuminates several current problems.

During the late 1940's through the early 1950's, the Blue Cross and Blue Shield organizations wrote most private group health insurance, and health insurance premium rates were set using what was called "community rating." Under this approach, regardless of the type of work or the age and health status within the group, most groups paid the same average rate for

number of uninsured has diverted us from the fundamental problem — lack of access to health care.

Why do I say the number of uninsured is a symptom, a diversion? There are several reasons, having to do with both the composition of the uninsured, and with the reference to "quick fix" proposals to overcome lack of insurance, rather than the real issue of access.

But citing this 33 million figure actually retards the effort to expand access. It misleads us to conclude that everyone who is uninsured does not have access to quality health care, or the reverse — that everyone who is insured does have that access. Neither is true.

Let me dispel several myths: many of the uninsured are *not* poor; the uninsured are *not* without care; and by itself insurance is *not* a sufficient condition to assure care for all Americans.

The first myth is that the uninsured and the poor are the same. The fact is that *most of the uninsured, nearly three-quarters, are workers or their dependents.* Why is this significant? Because employment-based health insurance is the dominant source of coverage for the under-65 population in this country. Employer plans cover two-thirds of Americans under 65, and nearly three-quarters of all workers. And, more significantly, because of tax subsidies, the effective cost to workers of employment based coverage is roughly half the cost of equivalent coverage when paid for outside the workplace. Thus, for low-income workers, absence of employment-based insurance is tantamount to being priced out of the insurance market.

A major problem is that, of the 33 million uninsured, most work in jobs in which insurance is not offered. By one estimate, 90 percent of uninsured workers are *not offered* health insurance by their employers. So the problem for most of the uninsured is *not* that they are poor, but that their employers do not offer health insurance, usually because the employers themselves cannot afford to do so.

But since roughly a third of the uninsured, mostly non-working, fall below the poverty line, they simply cannot afford insurance. For them, Medicaid and other programs for the poor become their only option — the safety net.

Another third have jobs and a cash income which, although steady and significant, is not substantial. Their earnings fall between 100 percent and 200 percent of the poverty line, and so many cannot afford insurance. For these so-called “working poor,” the high cost forces them to choose between health insurance premiums and food, between the security of coverage at a later date and the immediate need to pay the heating bill.

For the final third without insurance, the issue is not necessarily poverty. Some may have pre-existing conditions which make them uninsurable. Most simply choose not to buy insurance. Some of these are persons willing take a risk, who may feel indestructible, and who may decide to forego the expense of insurance.

While you and I may debate the wisdom of their choices, there are seven million uninsured with annual income above \$36,000 for a family of four. These are not persons who generally need or should be provided federally financed insurance. With few exceptions, they generally have financial access to care if they want it. Ultimately, they can afford health care when needed.

Hence, the first myth that needs to be dispelled is that lack of insurance is an accurate proxy for lack of income, and that the uninsured are uniformly poor.

A second myth is that the uninsured do not receive care. First, many of us have no need for medical intervention. *For those who do, most get the services they need.* To be sure, for many of the uninsured in need of medical services, the range of their choices may be limited. But it is a matter of fact that where services are available, they are available to people with or without insurance.

And it is here, too, where we must work to end racial and ethnic barriers to access, addressing disparities in minority health. Our 1992 budget request for minority health programs is \$682 million. In part, these programs are designed to increase awareness and outreach in the minority community. But until we make this a top priority in our minority communities — a personal and community priority for each and every man and woman, boy and girl — our low-income and minority citizens will continue to confront higher rates of cancer, heart disease, hypertension, stroke, HIV infection and many other preventable diseases.

In short, all Americans should have needed health care. The road to reform must include providing effective access to an expanded system of public *and* private access: financial access and effective access. Together we must overcome barriers of high costs, programmatic restrictions, inadequate medical personnel, inadequate resources and ethnic barriers. And as part of that effort, we must expand and improve the public/private primary care delivery system and strengthen the foundations of public health.

THE ROLE OF PRIVATE INSURANCE

Of course, changes must be made to broaden access to insurance and to reduce fragmentation in the health financing system. But we are far from consensus on the nature and extent of the changes needed. For some people, the health financing structure is so marked by dissatisfaction, so fundamentally and comprehensively flawed, that the only course is to throw out everything and begin all over with something entirely new.

True, the current health care system is fragmented, with multiple public and private insurance programs, categorical federal grants, appropriated funds from state and local governments, private philanthropy, provider-managed cross-subsidies, and out-of-pocket payments. Despite this fragmentation, indeed

request we have a new initiative to organize and develop community-oriented programs to reduce barriers to appropriate prenatal and perinatal care for pregnant women and infants in 10 areas. Over \$170 million will be directed in 1992 to these target areas.

We also must work to increase the number of health care professionals in underserved areas. We must urge our medical students and other health care professionals, many of whom are originally from these areas, to practice their healing arts where they are so desperately needed.

But I do not mean to suggest that new physicians from minority or rural communities can or should be expected to bear an unfair share. We need, as well, to maintain, through the medical education process, the enthusiasm and dedication which brought and continues to bring most students to medical school in the first place: the desire to help; the desire to improve the condition of the sick, the poor, the elderly; the desire that the world should be a better place for our having passed through it.

For our part, HHS is working to end the paucity of health care personnel in underserved areas. Because of the high rate of service in these areas by minority health professionals, we have increased the availability of financial opportunities for disadvantaged students who are under-represented in the health professions. So our 1992 budget request of \$157 million is an increase of more than 30 percent over the previous year. This money will be used to expand the National Health Service Corps recruitment program, to expand the Health Professions Student Loan program, and to establish a new Federal construction program to enable minority health professions educational institutions to improve their research facilities.

Our dollars alone will not overcome the problem of too few minority, rural and other health professionals through whom real access to care can come for their own communities. We can, and will increase educational grants, but it is the commitment of every local educational system where the encouragement, the mentoring, the leading by example and the vision must emerge.

It is important to be aware that Medicaid was not intended to provide health insurance for all the poor. By legislative design, it covers only those who are *both* income eligible and so-called "categorically" eligible: that is, the aged, blind, disabled, pregnant, those under 21 or in certain families with children who do not have parental support.

Those without insurance and those not Medicaid-eligible show up as charity cases at community non-profit hospitals and in hospital emergency rooms. They also use free or heavily discounted services at local public hospitals and health department clinics. They may go to Federal, state or local

"The belief that... putting an insurance card in every pocket will cure all our health care ills is false prophecy from those preaching easy solutions. "

programs, such as community or migrant health centers. In short, they receive charity care or their costs get rolled into unreimbursed provider "bad debt."

Because the present publicly supported system is a patchwork, a mosaic without a clear picture, order or form, the real problem, contrary to the myth that the uninsured do not receive care, is that the search for care is difficult, time consuming and too often demeaning. The system available to those without other options is incoherent, undirected, fragmented, chaotic, and sometimes insufficient. There is little continuity of care, and virtually no emphasis on preventive services or follow-through. Consequently, too often, the poor delay treatment until it becomes absolutely necessary, and then treatment is more intrusive and more costly and recovery is less satisfactory.

A third myth is that insurance is sufficient to provide access for all Americans. *The belief that, by itself, putting an insurance card in every pocket will cure all our health care ills is false*

prophecy from those preaching easy solutions. But that perspective is erroneous because insurance, alone, does not and will not assure access. Insurance alone will not remove lack of access in the many rural and inner city areas which are without providers, nor will it overcome socioeconomic barriers and other constraints that are impeding access for many.

If we are interested in clarity, we must instead outline some principles that should guide a more cogent examination of our national response to the needs of the poor. Logic and realism tell me that *the answer to improved access for the poor has to lie in Federal, state and local programs targeted to the conditions and needs of the poor; in redefined priorities, favoring access and delivery; in consensus development and coalition building around the effective integration of services and management of care; and in a growing partnership among citizens, taxpayers, providers, and payers.* This consensus will lead to actions which reflect the particularities of regional circumstances requiring unique solutions. Hard decisions and compromises will be required from all.

"All Americans must have access to high quality care, but it cannot be done simply by the Federal government writing a check."

Our Fiscal Year 1992 Federal budget moves in this direction. It does so in part by proposing to extend flexible resources to the states, in part by helping to fill current gaps, and in part by making a first move toward increased responsibility for the wealthy to pay their own way.

We must turn the debate to confront squarely the issue of access itself. We must work to broaden access, to make the health care system more open, affordable, coherent, and effective; and we must do it in innovative ways. All Americans must have access

to high quality care, but it cannot be done simply by the Federal government writing a check.

We need to look to the proven creativity of state, regional and private sector leadership that is already evident, such as the primary care consortium of Dade County; the Central Alabama Perinatal Care System; the Seattle Obstetrical Care Project; the activities of the Robert Wood Johnson Foundation working with state, local and private groups; and the Council of Smaller Enterprises in Cleveland.

Certainly, lower costs are essential. That will require all of us — patients, physicians, insurers, employers, hospital administrators, and policy-makers — to find ways to make the system more efficient without compromising its effectiveness. In Medicare, our Prospective Payment System and Physician Payment Reform efforts are steps in the right direction.

As well, our programs for the poor must be more coherent and more "user friendly." We know that we must reform and expand Medicaid and other programs so that the needs of the poor are met. Physicians, hospitals, philanthropic organizations, advocacy groups, state and local health officials and policy-makers all have a role. Each community has different needs, so programs must become, and remain, flexible.

This Administration continues to try to meet this goal. For example, until reforms were enacted last year, only one in three poor women of childbearing age was covered by Medicaid. A lack of access to prenatal care is associated with poor birth outcomes. However, we worked with the Congress to greatly expand Medicaid to cover all pregnant women and children up to age 6 in families with incomes up to 133 percent of the poverty level — opening coverage to over one million *more* women and children.

In addition, last year we devoted more than \$5 billion to infant and child health services and research. But we have determined that additional funds, specifically targeted to unique local needs, would save more of our babies. Therefore, in our 1992 budget