OLD GENERIC SPEECH

(leave as is, per CFK)
GREETINGS, ETC.
I'M FINALLY GETTING USED TO THESE CLOTHES.

IT'S BEEN ABOUT A YEAR, NOW, SINCE I HUNG IN MY CLOSET

THE UNIFORM OF THE SURGEON GENERAL, NEVER TO PUT IT ON

AGAIN.

BUT I DON'T INTEND TO HANG UP THE CAUSES I TRIED TO

CHAMPION AS YOUR SURGEON GENERAL.

AND I'VE TAKEN ON A FEW MORE.
I INTEND TO CONTINUE TO SPEAK OUT WHEN I CAN TO IMPROVE THE HEALTH OF THE AMERICAN PEOPLE. AMERICANS ARE INTERESTED IN HEALTH. SOMETIMES I THINK THEY MAY BE EVEN OBSESSED BY HEALTH. MANY AMERICANS ARE CRITICAL ABOUT HEALTHCARE;

BUT NOT NEARLY AS MANY ARE KNOWLEDGEABLE.
DURING MY TENURE AS SURGEON GENERAL, I TRIED TO MAKE
THE PEOPLE OF THE COUNTRY KNOWLEDGEABLE SO THAT THEY
MIGHT BE CONSTRUCTIVELY CRITICAL.

I AM ATTEMPTING TO CONTINUE THAT IN MY ROLE AS A PRIVATE
CITIZEN.
I DON'T HAVE THE POWER OF A PUBLIC OFFICE NOW, BUT I DON'T HAVE ITS CONSTRAINTS EITHER.

EVEN AS SURGEON GENERAL I USED TO SAY SOMewhat FACETIOUSLY THAT I HAD NO POWER AND NO BUDGET.

THAT IS CORRECT.

BUT I ACCOMPLISHED MUCH BY SPENDING OTHER PEOPLE'S MONEY.

AND I HAD THE POWER OF MORAL SUASION TO CHANGE HEALTH POLICY.
WITH THE HELP OF THE AMERICAN PEOPLE --AND THEIR COMMON SENSE-- I FEEL I WAS ABLE TO HELP GET THIS COUNTRY MOVING TOWARD BETTER HEALTH.

I'M SURE SOME OF YOU WERE MY ALLIES, AND I THANK YOU.
SHORTLY AFTER I LEFT GOVERNMENT SERVICE I WAS ASKED BY N.B.C. TO DO FIVE PRIME TIME SHOWS ON THE STATE OF THE ART OF AMERICAN MEDICINE.

AS A FORMER PIONEER IN THE FIELD OF PEDIATRIC SURGERY, I THOUGHT IT WOULD BE FASCINATING TO BRING BEFORE THE AMERICAN PEOPLE THE FULL RANGE OF THINGS THAT MODERN MEDICINE COULD DO FOR THEM.

AND I'VE SEEN SOME BIG CHANGES SINCE I FIRST ENTERED MEDICINE A HALF-CENTURY AGO.
BUT MORE RECENTLY, DURING MY YEARS AS SURGEON GENERAL, I SAW ALL TOO CLEARLY THAT 37 MILLION AMERICANS COULD NOT AVOID THEMSELVES OF MODERN MEDICINE.

SO RATHER THAN FILM A SERIES ON GLITZY HIGH-TECH MEDICINE, I SHIFTED MY FOCUS TO THE REAL ISSUE FACING AMERICAN HEALTH:

THE STAGGERING PROBLEMS WITHIN OUR HEALTHCARE SYSTEM AND OUR HEALTH POLICY.
SOMETIMES I WONDER IF THERE SHOULD NOT HAVE BEEN
ANOTHER SURGEON GENERAL'S WARNING:

"WARNING! THE AMERICAN HEALTH CARE SYSTEM CAN BE
HAZARDOUS TO YOUR HEALTH!

IN A WORD --WE HAVE BIG PROBLEMS.
TO BEGIN WITH, THIS IS A TIME IN WHICH WE HAVE VERY HIGH EXPECTATIONS FOR MEDICINE AND HEALTH.

WE'VE PUT A GREAT DEAL OF FAITH INTO NEW TECHNOLOGIES, NEW PHARMACEUTICALS, NEW SURGICAL PROCEDURES, AND SO ON, AND WE CONTINUE TO HAVE FAITH IN WHAT I LIKE TO CALL THE MAGIC OF MEDICINE.
WE ROUTINELY EXPECT MIRACLES TO HAPPEN -- EVEN THOUGH

THE REAL WORLD OF MEDICINE ISN'T ALWAYS ABLE TO DELIVER.

BUT I THINK IT'S ALSO BECOMING CLEAR THAT THOSE HIGH

EXPECTATIONS ARE FAST OUT-RUNNING OUR ABILITY TO PAY

FOR THEM.
OTHER WORDS, TODAY IN OUR SOCIETY WE HAVE A CLEAR GAP BETWEEN WHAT WE WOULD LIKE TO SEE HAPPEN IN HEALTH CARE ... AND WHAT CAN REALISTICALLY HAPPEN IN HEALTH CARE.

AND SO THE AMERICAN PEOPLE ARE ENGAGED IN A DEBATE IN ABOUT ASPIRATIONS VERSUS RESOURCES.
WE HAVE A RISE IN THE NEW TECHNOLOGIES AVAILABLE TO PHYSICIANS,

BUT, AT THE SAME TIME, A DECLINE IN THEIR SIGNIFICANCE FOR A SUBSTANTIAL NUMBER OF PATIENTS.

OUR HEALTHCARE SYSTEM MAY FUNCTION WITH COMPASSION AND COMPETENCE --EVEN EXCELLENCE-- FOR SOME INDIVIDUALS.

BUT FOR TOO MANY AMERICANS OUR HEALTH CARE SYSTEM IS A TYRANNY, MORE A CURSE THAN A BLESSING.
I THINK I SEE THE PROBLEMS CLEARLY.
I KNOW I CAN MAKE SOME SUGGESTIONS.
I HOPE I CAN MAKE A DIFFERENCE.

BUT THERE IS NO PANACEA, NO MAGIC BULLET.

THERE ARE NO EASY ANSWERS, ONLY HARD CHOICES.
MANY AMERICANS ENTER OUR HEALTHCARE NONSYSTEM, NOT THROUGH A LOCAL DOCTOR, BUT THROUGH THE LOCAL EMERGENCY ROOM.

YOU CAN SEE AMERICA'S HEALTHCARE CRISIS IN ALL-TOO-VIVID DETAIL AT YOUR LOCAL HOSPITAL'S EMERGENCY ROOM.

BUT WHEN YOU WALK INTO THE EMERGENCY ROOM --OR GET WHEELED IN ON A STRETCHER-- YOU MIGHT THINK THAT INSTEAD YOU HAD ARRIVED AT AN OVERCROWDED BUS STATION WAITING ROOM.
OUR BELEAGUERED EMERGENCY ROOMS COPE WITH AN ANNUAL PATIENT LOAD OF 100 MILLION -- THAT'S ONLY A LITTLE LESS THAN HALF THE ENTIRE POPULATION!

AND THESE FRONT LINES OF AMERICAN MEDICINE REFLECT THE CONFUSION AND TRAUMA OF A BATTLE ZONE.
EMERGENCY ROOM OVERCROWDING STEMS FROM TWO GROWING PROBLEMS:

THE INSURANCE CRISIS AND THE DRUG CRISIS, IN THEIR MANY FORMS.

WE CAN SEE THEM BEST IN URBAN AREAS WHERE ON ANY DAY 600 PATIENTS WAIT IN EMERGENCY ROOMS, WAIT TO BE ADMITTED TO THE HOSPITAL.
FIRST, MORE AND MORE AMERICANS ARE UNINSURED, UNABLE
TO AFFORD PREVENTIVE CARE OR PRIMARY CARE FROM A
PERSONAL PHYSICIAN OR LOCAL CLINIC.

SO, WHEN THEY NEED MEDICAL CARE, THEY GO STRAIGHT TO
THE EMERGENCY ROOM.

BUT BY THE TIME THEY FINALLY TAKE THEMSELVES TO THE
EMERGENCY ROOM THEY ARE OFTEN SO SICK THAT THEY
REQUIRE HOSPITALIZATION.
HOWEVER, AS HOSPITALS GO BROKE,--AND DURING THE 1990s 2
OUT OF 5 HOSPITALS MAY CLOSE-- THE REMAINING BEDS
BECOME FILLED WITH VICTIMS OF DRUGS, AIDS, AND MENTAL
ILLNESS.

AND THESE NEW PATIENT OF THE 1980s AND 1990s STAY IN THOSE
HOSPITAL BEDS LONGER.
FOR EXAMPLE, IN NEW YORK CITY THE AVERAGE HOSPITALIZATION HAS INCREASED FROM 13 DAYS TO 26 DAYS. DRUG USE IN THAT CITY IN THE LAST TWO YEARS HAS LED TO A 35 PERCENT RISE IN MEDICAL COMPLICATIONS, AND A 60 PERCENT RISE IN PSYCHIATRIC COMPLICATIONS. IN THE SAME TWO YEARS, THE NUMBER OF CRACK BABIES HAS DOUBLED.
AND THERE ARE NO ACCURATE FIGURES ON THE DRAMATIC INCREASE IN TRAUMA DUE TO DRUG VIOLENCE. MEANWHILE, CITY DRUG TREATMENT CENTERS CAN TREAT ONLY 12% OF HEROIN AND COCAINE USERS.

THE PROBLEMS WORSEN EVERY DAY.
IN ADDITION TO THE DRUG USERS CROWDING NEW YORK HOSPITALS ARE THE SOARING NUMBERS OF MENTALLY ILL REQUIRING HOSPITAL TREATMENT. BETWEEN 1982 AND 1989 THE NUMBER OF EMOTIONALLY DISTURBED PEOPLE BROUGHT BY POLICE TO NEW YORK HOSPITALS INCREASED BY 60 PERCENT.
AND THEN THERE IS THE CRUSH OF AIDS. BY 1994 NEW YORK'S AIDS PATIENTS WILL REQUIRE 2300 ADDITIONAL BEDS. THAT'S THE EQUIVALENT OF 4 OR 5 NEW MEDIUM SIZE HOSPITALS.

BUT NO ONE IS BUILDING HOSPITALS THESE DAYS.

YES, NEW YORK CITY'S PROBLEMS ARE THE BIGGEST, BUT THESE FIGURES NEED ONLY MINOR PROPORTIONAL READJUSTMENT TO REFLECT A SIMILAR CRISIS IN MOST AMERICAN CITIES, LIKE ____

[HERE]_____.
IN OAKLAND CALIFORNIA, FOR INSTANCE, IN THE LAST TWO YEARS, THREE HOSPITALS AND A CLINIC THAT USED TO SERVE THE CITY'S POOR HAVE CLOSED THEIR DOORS. THAT LEAVES JUST ONE COUNTY HOSPITAL OPEN FOR THOSE OAKLAND RESIDENTS WHO CANNOT PAY FOR HEALTH CARE. ALTHOUGH THE HOSPITAL STAFF HAS NOT INCREASED, IN THE LAST TWO YEARS THE NUMBER OF PEOPLE WHO USED THAT EMERGENCY ROOM JUMPED FROM 55,000 TO 70,000. AND, TO MAKE THINGS WORSE, MANY OF THE NEW ARRIVALS HAVE NO INSURANCE AND NO MONEY.
SO, EMERGENCY ROOMS ARE OVERCROWDED AND UNDERPAID....THINK ABOUT THAT FOR A MINUTE... THAT'S NOT THE WAY IT USUALLY WORKS.

PLACES THAT ARE OVERCROWDED USUALLY AREN'T RUNNING OUT OF MONEY.

MANY OF THE PEOPLE WHO FLOCK TO EMERGENCY ROOMS SIMPLY HAVE NO MONEY AND NO INSURANCE.
AND THOSE THAT ARE POOR ENOUGH TO QUALIFY FOR
MEDICAID OR OLD ENOUGH TO QUALIFY FOR MEDICARE POSE A
FINANCIAL PROBLEM FOR THE HOSPITAL BECAUSE THE
MEDICARE/MEDICAID PROSPECTIVE PAYMENT SYSTEMS DO NOT
USUALLY COVER THE HIGH COST OF EMERGENCY ROOM
MEDICINE.

THIS TEMPTS HOSPITAL ADMINISTRATORS TO CLOSE DOWN
THEIR EMERGENCY ROOMS, FORCING AREA RESIDENTS TO TAKE
LONGER AMBULANCE RIDES, AND PERHAPS LEADING TO
UNWARRANTED DEATHS FOR RICH AND POOR ALIKE.
THERE IS A ROUGH AND UNFORTUNATE DEMOCRATIC EQUALITY IN OVERCROWDED EMERGENCY ROOMS.
EVERYBODY GETS TREATED ALIKE.
IT DOESN'T MATTER IF YOU HAVE YOUR OWN INSURANCE,
MEDICARE, MEDICAID.... EVERY ONE GETS TREATED THE SAME IN THE EMERGENCY ROOM: YOU WAIT YOUR TURN.
Many Americans on Medicare, especially middle class Americans, --maybe some of you here-- think that they have the security of being assured hospital care if they suddenly need it.

In many places that is simply not true.

If they come to the emergency room, they wait on stretchers or chairs, sometimes for days, just like everyone else, just like those who are uninsured.
SOMETIMES PEOPLE WAITING IN AN EMERGENCY ROOM FOR A BED TO OPEN UP, EVEN PEOPLE WHO HAVE HAD HEART ATTACKS, GET SO FRUSTRATED AND RESTLESS THAT THEY JUST LEAVE, AFTER 24 OR EVEN 48 HOURS OF WAITING. THEY'D RATHER GO HOME, RISKING SUDDEN DEATH, THAN TOLERATE THE TERRIBLE ATMOSPHERE OF AN OVER-CROWDED EMERGENCY ROOM.
ER

EMERGENCY ROOM HEALTH PERSONNEL, THE WOMEN AND MEN WHO ARE THE SOLDIERS ON THE FRONT LINES OF AMERICAN HEALTHCARE, BECOME OVERWHELMED, NOT JUST WITH THEIR ENDLESS WORK, BUT WITH FRUSTRATION AND DISILLUSION. THEY KNOW THEY CAN'T DO FOR EACH PATIENT WHAT THEY SHOULD DO, AND EACH DAY MANY OF THEM WONDER IF THEY SHOULD GET OUT, CHANGE CAREERS BEFORE IT'S TOO LATE. ALL OF US SUFFER WHEN THESE PEOPLE ARE DRIVEN TO QUESTION THEIR CALLING.
LET'S FACE THE UNHAPPY FACTS.

RATIONING HAS COME TO AMERICAN HEALTHCARE IN OVERCROWDED EMERGENCY ROOMS.

RATIONING HAS COME AS A MATTER OF COURSE, WITHOUT ANY GREAT PHILOSOPHICAL DEBATE, WITHOUT ANYONE REALLY WANTING IT.
OF COURSE, ONCE A PATIENT FINALLY MAKES IT FROM THE
EMERGENCY ROOM TO THE RELATIVE COMFORT OF A HOSPITAL
BED, THE PROBLEMS AREN'T OVER.

MANY PATIENTS SUDDENLY ADMITTED TO A HOSPITAL LIE IN
THEIR BEDS, FRIGHTENED BY TERRIBLE QUESTIONS..... NOT
ONLY "WILL I RECOVER?"
BUT "HOW WILL I PAY FOR THIS?" "WILL MY INSURANCE PAY FOR THIS? WILL MY ILLNESS COST ME MY SAVINGS, MY HOUSE?"

THE AMERICAN PATCHWORK HEALTH INSURANCE SYSTEM DEFIES EASY DESCRIPTION, AND EVEN MORE DEFIES EASY CORRECTION OF ITS MANY PROBLEMS. BUT WE MUST CONFRONT THESE PROBLEMS HEAD-ON, AND WE MUST DO IT NOW.
OUR HIGH-TECH MEDICINE SAVES MANY LIVES, BUT HIGH TECH MEDICINE IS ALSO HIGH-COST MEDICINE.

EVERYONE COMPLAINS ABOUT THE SOARING COST OF HEALTHCARE IN THE UNITED STATES. YOU AND I HEAR A LOT ABOUT THE FEDERAL DEFICIT. BUT LAST YEAR ALONE WE SPENT MORE THAN FIVE TIMES THE FEDERAL DEFICIT ON HEALTH CARE IN THIS COUNTRY...$661 BILLION... MORE THAN WE SPENT ON EDUCATION AND DEFENSE COMBINED.
HEALTHCARE EXPENDITURES AMOUNTED TO OVER 11 PERCENT OF THE GROSS NATIONAL PRODUCT. IN 1960 HEALTHCARE SPENDING TOOK ONLY 5.3 PERCENT OF THE GNP.

NOW, I DON'T THINK THAT THERE IS ANY PERCENTAGE OF OUR GNP THAT IS A MAGIC NUMBER.

MAYBE IT IS APPROPRIATE TO SPEND 14% ON HEALTH CARE.

BUT WHATEVER WE SPEND, WE WANT TO SPEND IT ON HEALTHCARE, NOT ON RUNAWAY COSTS.
PART OF THE REASON FOR RUNAWAY COSTS IS INFLATION.

INFLATION IN THE COST OF HEALTH AND MEDICAL CARE CONSISTENTLY RUNS AT TWICE THE RATE OF INFLATION FOR THE ECONOMY IN GENERAL.

YET, THERE'S NOT A SHRED OF EVIDENCE TO PROVE THAT THE QUALITY OF CARE IS IMPROVING AT THE SAME RATE.
TO A HOSPITAL OR A DOCTOR RECENTLY, YOU'LL PROBABLY AGREE THAT HOSPITAL CARE AND PHYSICIAN CARE AREN'T TWICE AS GOOD AS THEY WERE EIGHT OR NINE YEARS AGO, EVEN THOUGH NOW THEY COST ABOUT TWICE AS MUCH. I CAN TELL YOU THAT MANY OF MY FRIENDS AND COLLEAGUES IN MEDICAL PRACTICE ARE TRYING TO DO WHAT THEY CAN TO INCREASE THE QUALITY OF CARE THEY DELIVER WITHOUT INCREASING THEIR COSTS.
BUT THEY ARGUE THAT THEY HAVE LITTLE OR NO CONTROL
OVER SOME OF THE INFLATIONARY THINGS THEY DO.

AND THAT'S TRUE.

I'VE BEEN THERE -- SO IT'S NOT JUST GIVING THEM THE BENEFIT
OF THE DOUBT.
BUT THE FACT STILL REMAINS THAT PHYSICIAN FEES ARE GOING UP, AND THEY DO ADD TO A BURDEN ON THE PUBLIC THAT IS BECOMING INSUPPORTABLE.

AND, AGAIN -- AS WITH HOSPITAL-BASED CARE -- THE AMERICAN PEOPLE HAVE NOT BEEN ASSURED, IN ANY RATIONAL AND MEASURABLE WAY,

THAT THE HIGHER COSTS OF A PHYSICIAN'S CARE WILL IN FACT BUY THEM A PROPORTIONATELY HIGHER QUALITY OF SUCH CARE.
WE SEEM TO HAVE, THEREFORE, A SYSTEM OF HEALTH CARE
THAT'S DISTINGUISHED BY A VIRTUAL ABSENCE OF SELF-
REGULATION ON THE PART OF THE PROVIDERS OF THAT HEALTH
CARE -- THAT IS, HOSPITALS AND PHYSICIANS -- AND
DISTINGUISHED AS WELL BY THE ABSENCE OF SUCH NATURAL
MARKETPLACE CONTROLS AS COMPETITION IN REGARD TO
PRICE, QUALITY, OR SERVICE.
I SAY THERE'S SOMETHING TERRIBLY WRONG WITH A SYSTEM OF HEALTH CARE THAT SPENDS MORE AND MORE MONEY TO SERVE FEWER AND FEWER PEOPLE.

IN THE PAST MOST AMERICANS TURNED CONFIDENTLY TO THEIR INSURANCE TO PAY THE HEALTHCARE BILL. BUT THOSE DAYS ARE OVER.
WE HAVE THREE GROUPS IN THIS COUNTRY:

THE INSURED, THE UNINSURED, AND THE UNINSURABLE.

THE LARGEST GROUP, FORTUNATELY, IS THE 160 MILLION AMERICANS WHOSE HEALTH INSURANCE IS PROVIDED THROUGH EMPLOYERS -THEIR OWN OR FAMILY MEMBERS--, AND THE SMALL FRACTION WHO PURCHASE THEIR OWN INSURANCE.
THESE PEOPLE USUALLY ENJOY ACCESS TO THE BEST MEDICINE
IN THE WORLD, AS LONG AS THEIR INSURANCE HOLDS OUT, OR
THEIR PREMIUMS ARE NOT RAISED BEYOND REACH.

BUT EACH YEAR THESE PRIVATELY INSURED AMERICANS SEEM
TO BE PAYING MORE AND MORE FOR INSURANCE THAT BUYS
THEM LESS AND LESS IN HEALTHCARE.
EMPLOYERS NOW ASK EMPLOYEES TO ASSUME MORE OF THE
COST OF HEALTHCARE, THROUGH HIGHER DEDUCTIBLES AND
CO-PAYMENT, OR GIVE UP CERTAIN SERVICES.

THEN EMPLOYEES DIG IN THEIR HEELS AND SAY. "NO!"
HEALTH BENEFITS WERE THE MAJOR REASON FOR 78 PERCENT OF THE WORKING MEN AND WOMEN WHO WENT OUT ON STRIKE LAST YEAR...PRODUCTION WORKERS AND MINERS AND PUBLIC EMPLOYEES AND TELEPHONE WORKERS AND SERVICE WORKERS AND SO ON.

EVERY ONE OF THOSE STRIKERS FELT THE PRESSURE IN THEIR FAMILIES AND IN THEIR HOMES. THEY ASKED FOR MORE MONEY IN HEALTH BENEFITS...AND MANAGEMENT SAID IT COULDN'T AFFORD TO PAY IT.

AND THEY CAN'T.
THE ISSUE THAT SENT PEOPLE TO THE PICKET LINES WAS NOT WAGES. IT WASN'T JOB SECURITY. IT WASN'T JOB SAFETY. IT WAS NOT ANY OF THOSE THINGS.

IT WAS THE COST OF HEALTH CARE.

AND FOR MOST OF THOSE WORKERS, IT WAS NOT FANCY HEALTH CARE EITHER.
AND WHAT IS THE OUTCOME, WHEN THOSE STRIKES ARE SETTLED AND OVER? I'LL TELL YOU WHAT HAPPENS.

MORE MONEY DOES GO INTO EMPLOYEE HEALTH BENEFITS, AND THOSE INCREASED COSTS ARE EXPRESSED IN THE MARKETPLACE AS HIGHER PRICES FOR THE GOODS WE PURCHASE AND OUR UTILITIES.
IN OTHER WORDS, OUR VAST SYSTEM OF HEALTH INSURANCE AND EMPLOYEE HEALTH BENEFIT PLANS HAS BECOME LITTLE MORE THAN A "PASS-ALONG" MECHANISM BY WHICH DOLLARS--TAKEN FROM THE AMERICAN PEOPLE IN THE OPEN MARKETPLACE--ARE PASSED ALONG AND PUT INTO THE POCKETS AND THE TREASURIES OF OUR RAVENOUS HEALTHCARE SYSTEM.
SINCE 1984 THE AVERAGE PREMIUMS FOR EMPLOYER-PROVIDED HEALTH INSURANCE HAVE APPROXIMATELY DOUBLED... TO $3,117 IN 1989, AND HAVE RISEN FROM 8 PERCENT OF BUSINESS PAYROLL COSTS TO 13.6 PERCENT LAST YEAR. BUSINESSES CAN'T ABSORB THESE COSTS AND ALSO EXPECT TO BE COMPETITIVE.
AND TELL ME, WHAT'S THE POINT OF BEING TOUGH ON TRADE
WITH THE JAPANESE, FOR EXAMPLE, WHEN RIGHT HERE AT
HOME WE MEEKLY GIVE OUR HEALTH PLANS THE 10
PERCENT...THE 12 PERCENT...OR THE 15 PERCENT ANNUAL
INCREASE THEY DEMAND.
THE TWO THIRDS OF OUR POPULATION COVERED BY EMPLOYER-
PURCHASED HEALTH INSURANCE ARE THE PEOPLE WHO HAVE
THE MOST CLOUT TO CHANGE THINGS FOR THE BETTER.
MANY OF YOU MAY BE AMONG THEM.
YOU ARE PART OF THE INSURED GROUP WHO CAN FORCE THE
REFORMS WE NEED.
BUT FIRST THESE PEOPLE MUST IDENTIFY THE LEADERSHIP TO 
BRING HEALTHCARE COST UNDER CONTROL.

IT IS NOT THE PRESENT LEADERSHIP.

THEY ARE THE ONES WHO GOT US INTO OUR CURRENT 
PROBLEMS OF PROFLIGACY AND POOR CARE.
NOT LONG AGO A COALITION OF BIG BUSINESS AND LABOR UNIONS FORMED TO ADDRESS THIS PROBLEM.

I THINK THAT THIS IS THE WRONG COALITION.

THE COALITION THAT NEEDS TO BE FORMED COMBINES BUSINESS AND ORGANIZED HEALTH CARE.
TOGETHER THEY CAN FORGE THE ALLIANCE THAT REWARDS HIGH QUALITY AND HIGH EFFICIENCY WITH MORE PATIENTS, RATHER THAN REWARDING POOR QUALITY CARE WITH DOLLARS AS WE DO NOW.

AND UNTIL THE PURCHASING PUBLIC "BUYS RIGHT" THE SITUATION WILL NOT CHANGE.
THEN THERE ARE THE INSURED AMERICANS WHO RELY UPON GOVERNMENT INSURANCE – MEDICARE FOR THE ELDERLY, MEDICAID FOR THE POOR-- TO MEET THEIR HEALTHCARE BILLS.

BUT THESE INSURANCE PLANS NO LONGER FILL THE BILL.
THE GRAYING OF AMERICA CARRIES A PRICE TAG... AS MEDICARE COSTS WILL DOUBLE BY 2020.

FIVE YEARS AGO AMERICA'S 1.3 MILLION NURSING HOME RESIDENTS COST US $31 BILLION; BY 2040, AS THE BABY BOOMERS REACH THEIR 70S AND 80S, 6 MILLION NURSING HOME RESIDENTS WILL COST $139 BILLION. HIP FRACTURE COSTS --IF UNCHECKED BY PREVENTION-- COULD GO FROM OUR CURRENT $1.6 BILLION ANNUALLY TO $6 BILLION IN 2040.
THE DEMOGRAPHIC TRENDS ARE RUNNING AGAINST US AS WE ATTEMPT TO MEET THESE COSTS.

TODAY, FOR EXAMPLE, FOR EACH PERSON WHO IS OVER THE AGE OF 65, THERE ARE 5 YOUNGER, TAX-PAYING WAGE-EARNERS TO PAY FOR THAT ONE PERSON'S MEDICARE COVERAGE.
IN ANOTHER 20 YEARS, HOWEVER, FOR EACH PERSON OVER THE
AGE OF 65, THERE WILL BE ONLY 3 YOUNGER, TAX-PAYING WAGE-
EARNERS CONTRIBUTING TO MEDICARE.

THAT MEANS THAT IN A CLIMATE OF SCARCITY, AMERICANS WILL
HAVE TO WORK OUT AN EQUITABLE SHARING OF NEEDED
MEDICAL RESOURCES BETWEEN ONE POPULATION GROUP THAT
IS GROWING -- THAT IS, THE ELDERLY, PEOPLE OVER THE AGE OF
65 -- AND THE POPULATION GROUP THAT IS COMPARATIVELY
SHRINKING -- THAT IS, CHILDREN UNDER THE AGE OF 18.
OVER THE YEARS I'VE DEALT WITH ADVOCATES FOR CHILDREN AND I'VE DEALT WITH ADVOCATES FOR THE ELDERLY. THEY ARE BOTH VERY DEDICATED AND VERY PERSUASIVE GROUPS. AND BOTH WILL BE QUITE RIGHTLY COMPETING FOR A LARGER PIECE OF A SMALLER PIE.

THIS HAS CHILLING ETHICAL IMPLICATIONS, AND WE MAKE SURE THAT OUR ECONOMICS BE DETERMINED BY OUR ETHICS, AND NOT THE OTHER WAY AROUND.
MEDICARE IS NOT WHAT MOST PEOPLE THINK.

IT IS NOT A SYSTEM THAT PROVIDES FOR THE HEALTHCARE COSTS OF THE ELDERLY.

THERE ARE MANY HOLES IN MEDICARE.

OLDER AMERICAN CITIZENS MUST FIRST MUST SPEND THEIR OWN MONEY BEFORE MEDICARE KICKS IN.

MEDICARE USUALLY DOESN'T PROVIDE THE DRUGS MANY ELDERLY NEED TO STAY ALIVE.
MOST CRITICAL, MEDICARE MAKES NO PROVISION FOR LONG-TERM CARE IN HOSPITALS OR NURSING HOMES.

ELDERLY PEOPLE AND THEIR GROWN CHILDREN ARE OFTEN SHOCKED WHEN THEY DISCOVER THAT WHEN THE AGING PARENT NEEDS NURSING HOME CARE, IT IS NOT COVERED BY MEDICARE.
FURTHERMORE, THERE IS NO PROVISION IN MEDICARE FOR THE
HOUSEHOLD HELPS THAT WOULD KEEP ELDERLY PEOPLE FROM
NEEDING A NURSING HOME, LIKE SOMEONE STOPPING BY ONCE
A DAY TO SPEND AN HOUR ON THE HEALTH AND HOUSEHOLD
CHORES THAT NEED TO BE ACCOMPLISHED TO KEEP THAT
PERSON OUT OF AN INSTITUTION.
THEN THERE IS MEDICAID, THE FEDERAL INSURANCE PROGRAM DESIGNED FOR THE POOR.

IF MEDICARE IS A DISAPPOINTMENT, MEDICAID IS A FRAUD.

MEDICAID IS A FRAUD BECAUSE MEDICAID EXCLUDES MOST OF THE POOR.... BY CALLING THEM TOO RICH.
IT IS THE INDIVIDUAL STATES THAT ADMINISTER MEDICAID, AND THE STATES CAN SET THE MAXIMUM INCOME LEVEL NEEDED TO QUALIFY FOR MEDICAID.

THIS HAS LED TO SHAMEFUL STANDARDS.

IN TEXAS, FOR INSTANCE, A FAMILY OF THREE WITH AN INCOME OF $3000 A YEAR IS TOO RICH TO QUALIFY FOR MEDICAID.
IN KENTUCKY THEY GO ALL THE WAY UP TO $3200 A YEAR FOR A FAMILY OF THREE BEFORE YOU ARE TOO RICH FOR MEDICAID.

WHOM DO THEY THINK THEY ARE KIDDING?
MEDICAID ALSO ALLOWS TERRIBLE DISPARITIES BETWEEN STATE SYSTEMS OF COVERAGE AND PAYMENT.

A PATIENT QUALIFYING FOR AN ORGAN TRANSPLANT IN ONE STATE MIGHT NOT RECEIVE EVEN BASIC MEDICAL SERVICES AS RESIDENT OF ADJOINING STATE.

MEDICAID NEEDS TO BE STANDARDIZED, EXPANDED AND REFORMED.

MEDICAID NEEDS TO EMBRACE FAMILIES RATHER THAN EXCLUDE THEM.
THEN THERE ARE THE UNINSURED, THE 12 TO 15 PERCENT OF OUR POPULATION -- THAT'S 33 TO 37 MILLION AMERICANS -- WHO ARE UNINSURED, UNDER-INSURED, OR ONLY SEASONALLY INSURED.

THEY'RE NOT OLD ENOUGH FOR MEDICARE AND NOT POOR ENOUGH FOR MEDICAID.
THESE ARE NOT PEOPLE ON WELFARE.

CONTRARY TO THE WHINING OF SOME CONSERVATIVE COLUMNISTS, THESE PEOPLE ARE NOT LOOKING FOR A HANDOUT.

90 PERCENT OF THE UNINSURED ARE WORKING PEOPLE, MANY WORKING AT SEVERAL JOBS, NONE OF WHICH PROVIDES A HEALTH PLAN.
RECENTLY RELEASED FIGURES INDICATE THAT ONE OUT OF EVERY EIGHT AMERICANS FALLS INTO THIS CATEGORY OF THE UNINSURED.

FOR BLACKS, THE FIGURES ARE WORSE, WITH ONE OUT OF FIVE BLACKS UNINSURED. AND IN THE HISPANIC POPULATION, ONE OUT OF EVERY FOUR PERSONS HAS NO HEALTH INSURANCE.

WHAT, THEN, DOES THIS "HEALTH CARE SYSTEM" OF OURS DO FOR THE UNINSURED?
AS YOU KNOW, IN THE VAST MAJORITY OF CASES THE ANSWER IS
... VERY LITTLE ... OR NOTHING. AND THEY ARE SUFFERING THE
CONSEQUENCES. STUDY AFTER STUDY INDICATES THE
CORRELATION BETWEEN NO MEDICAL INSURANCE AND SERIOUS
HEALTH PROBLEMS.

AND ALL OF US WILL SUFFER THE CONSEQUENCES TOO, BECAUSE
THE HEALTH PROBLEMS OF THE UNINSURED, IF IGNORED BY
SOCIETY NOW, WILL BE BORNE BY SOCIETY LATER.
FINALLY, AND TRAGICALLY, ARE THE UNINSURABLE: THE TWO
AND A HALF MILLION AMERICANS WITH SERIOUS MEDICAL
PROBLEMS WHO CAN'T EVEN BUY INSURANCE BECAUSE THEY ARE
CONSIDERED TO BE BAD RISKS.
AND NOW, WITH INCREASING FREQUENCY, SOME PATIENTS HAVE
THEIR INSURANCE PREMIUMS RAISED OUT OF SIGHT RIGHT IN
THE MIDDLE OF A SERIOUS ILLNESS.
IN JUST ONE OF MANY FAMILIES LIKE THIS THAT I KNOW, A BABY
WAS BORN WITH A HEART DEFECT REQUIRING FREQUENT
MEDICAL ATTENTION. BY THE TIME THE YOUNGSTER WAS TWO
YEARS OLD, THE FAMILY HEALTH INSURANCE PREMIUMS HAD
GONE FROM $198 A MONTH TO $1375 A MONTH, A SIX-FOLD
INCREASE.

HOW MANY OF YOU COULD AFFORD THAT KIND OF A JUMP?
THEY THOUGHT IT MUST BE A COMPUTER ERROR, BUT WERE TOLD COLDLY BY THE INSURANCE COMPANY THAT IF THEY DIDN'T LIKE IT, THEY COULD CANCEL THEIR INSURANCE. HOWEVER, NO OTHER COMPANY WOULD INSURE THEM BECAUSE THEIR YOUNGSTER HAD A "PRE-EXISTING CONDITION."
OTHER AFFLICTED AMERICANS WHO THOUGHT THEY WERE COVERED BY INSURANCE SUDDENLY DISCOVERED THAT THEIR INSURANCE COMPANIES WERE SIMPLY NOT PAYING THE BILLS. IN CALIFORNIA ALONE, 100,000 PEOPLE LOST THEIR INSURANCE IN 1989 BECAUSE THEIR INSURANCE COMPANIES HAVE GONE UNDER.

SOME OF THESE PEOPLE HAD ALREADY PAID AS MUCH AS $200,000 IN PREMIUMS OVER THE YEARS.
YOU HEAR SOME PEOPLE TALKING ABOUT "CLOSING THE GAP" BETWEEN THE HIGHLY INSURED AND THE UNINSURED. THAT CONJURES UP AN IMAGE OF THE TWO MOVING TOGETHER. THAT IS UNLIKELY.

THERE WILL ALWAYS BE SOME PEOPLE WHO CAN AFFORD A CERTAIN DEGREE BEYOND THE NORMAL STANDARD. THEY AREN'T ABOUT TO GIVE IT UP.
INSTEAD, WE NEED TO TALK ABOUT **BASIC RIGHTS TO INSURANCE** FOR HEALTHCARE FOR ALL OUR CITIZENS, AND PROVIDE THAT FOR THOSE UNCOVERED.

THESE PEOPLE ARE NOT LOOKING FOR A HANDOUT, BUT FOR AN INSURANCE POLICY THEY CAN AFFORD, ONE THAT WILL NOT LET THEM DOWN WHEN THEY NEED IT.
WE WILL NEVER REALLY SOLVE OUR HEALTHCARE PROBLEMS AND OUR INSURANCE PROBLEMS UNTIL WE DEAL WITH A DEEPER CAUSE.

AMERICAN HEALTH PROBLEMS STEM FROM DISEASE NOT ONLY OF THE BODY, BUT ALSO OF SOCIETY, ESPECIALLY THE DISEASE OF POVERTY.
POVERTY LIES AT THE ROOT OF MOST OF OUR PUBLIC HEALTH PROBLEMS: DRUG ABUSE, AIDS, ALCOHOL ABUSE, MALNUTRITION, SMOKING, COMMUNICABLE DISEASES.

THE EFFECTS OF POVERTY ON HEALTH CAN LINGER FOR A LONG TIME.
A recent study found that middle class blacks with a college education were twice as likely to deliver low birthweight babies than whites of similar education and income. The researchers came to the sobering conclusion that the effects of poverty as demonstrated in low birth weight can last for generations.
ONE IN THREE URBAN KIDS LIVES IN POVERTY, AND EVERY DAY IN AMERICA 100 CHILDREN DIE BEFORE THEIR FIRST BIRTHDAY. IN HARLEM THE INFANT MORTALITY RATE IS WORSE THAN IN PLACES IN THE THIRD WORLD.
A STAGGERING 1 IN 5 BABIES HAS BEEN EXPOSED TO DRUGS IN THE WOMB, AND 5% TEST POSITIVE FOR AIDS. 400,000 DRUG-EXPOSED BABIES ARE BORN EACH YEAR, CROWDING NEONATAL UNITS, COSTING US OVER $4 BILLION ANNUALLY.

OVERCROWDED PUBLIC CLINICS IN THE INNER CITY KEEP SICK PEOPLE WAITING AN AVERAGE OF 68 DAYS FOR AN APPOINTMENT.

AND OFTEN BY THE TIME THEY FINALLY SEE A DOCTOR, THEY ARE SO SICK THEY REQUIRE COSTLY HOSPITALIZATION.
POVERTY-RELATED HEALTH PROBLEMS PLAGUE RURAL AMERICA AS WELL AS URBAN AMERICA.

RURAL PATIENTS RECEIVE NO CARE; RURAL HOSPITALS RECEIVE NO REVENUE.

IN RURAL AREAS FROM TENNESSEE TO TEXAS, HOSPITALS ARE CLOSING THEIR DOORS AND DOCTORS ARE ABANDONING THEIR PRACTICES.
THE NATIONAL HEALTH SERVICE CORPS, A FEDERAL PROGRAM TO PLACE DOCTORS IN RURAL AREAS UNDERSERVED BY PHYSICIANS, HAD ITS BUDGET SLASHED BY MORE THAN $72 MILLION, AND THE NUMBER OF PHYSICIANS IT SUPPORTED IN RURAL AMERICA DROPPED FROM 1600 TO 120. THE FEW PUBLIC CLINICS THAT REMAIN ARE OVERBURDENED AND OFTEN DISTANT FROM THE PEOPLE WHO NEED THEM.
SO, PREGNANT WOMEN GO WITHOUT SEEING A DOCTOR, CHILDREN GO WITHOUT IMMUNIZATION, AND IN APPALACHIA PREVENTABLE DISEASES LIKE MEASLES RUN RAMPANT BECAUSE FAMILIES DON'T HAVE ACCESS TO IMMUNIZATION. THIS IS A SCANDAL.
IN OUR STRANGE, SHAMEFUL SOCIETY -- AN AFFLUENT SOCIETY WITH TERRIBLE POVERTY -- THE PRACTICE OF MEDICINE HAS BECOME COMPLICATED.

IT INVOLVES NOT ONLY DIAGNOSIS AND TREATMENT, BUT ALSO THE RELATIONSHIP BETWEEN HEALTH AND SOCIO-ECONOMIC FACTORS.

INCREASINGLY, PEOPLE LOOK TO MEDICINE TO SOLVE THESE DEEPER PROBLEMS, PROBLEMS THAT ARE BEYOND THE ABILITY OF MEDICINE OR DOCTORS TO SOLVE.
DOCTORS CANNOT ELIMINATE THE POVERTY FROM WHICH PATIENTS COME;

HEALTHCARE WORKERS CANNOT BRING BACK THE HUSBAND AND FATHER WHO HAS DESERTED THE WIFE AND CHILDREN.

DOCTORS CANNOT KEEP THEIR PATIENTS OFF DRUGS ONCE THEY LEAVE THE HOSPITAL.
MANY PHYSICIANS HAVE TOLD ME OF THEIR FRUSTRATION WHEN THEY RELEASE PATIENTS --WHOSE LIVES THEY HAVE JUST SAVED-- WITH IMPORTANT INSTRUCTIONS TO STOP USING DRUGS, TO STOP USING ALCOHOL, KNOWING FULL WELL THAT IN A MATTER OF HOURS THEIR PATIENTS WILL BE RIGHT BACK TO THE BEHAVIOR THAT SENT THEM TO THE HOSPITAL IN THE FIRST PLACE.
TRAGICALLY, IT IS THE CHILDREN OF POVERTY WHOSE HEALTH SUFFERS THE MOST.

OUR CHILDREN TODAY ARE A GENERATION AT RISK.

FOR THE FORGOTTEN CHILDREN OF THE INNER CITY AND RURAL AMERICA, WE NEED TO GUARANTEE ACCESS TO HEALTH CARE WITH ENOUGH HOSPITAL BEDS AND DOCTORS.
WE NEED NEIGHBORHOOD CLINICS THAT PROVIDE PATIENTS WITH THE KNOWLEDGE THEY NEED, AND TREAT THEM WITH DIGNITY, SO PREVENTIVE AND PRENATAL CARE TAKE PLACE.

WE NEED TO FREE OUR SOCIETY OF POVERTY, SO THAT ALL YOUNGSTERS, CAN LIVE TO BECOME THRIVING, HEALTHY, PRODUCTIVE AMERICANS, A GENERATION NOT AT RISK, BUT OF PROMISE.
THE DISRUPTION TO SOCIETY CAUSED BY THE ESCALATING COST OF HEALTH CARE IS SIMPLY UNCONSCIONABLE.

THOUSANDS AND THOUSANDS OF AMERICAN FAMILIES EACH YEAR ARE LITERALLY IMPOVERISHED BY THE AMERICAN HEALTH CARE SYSTEM.

WE CANNOT LET THAT CONTINUE.

WE ARE FRUSTRATED BECAUSE OUR HEALTH DOLLARS DON'T SEEM TO BE GOING FOR OUR HEALTH.

PEOPLE FUME WHEN THEY READ THAT HEALTHCARE ADMINISTRATION NOW CONSUMES ABOUT 22% OF HEALTHCARE SPENDING.
OUR CURRENT INSURANCE STRUCTURE OFTEN OPERATES LIKE A SHELL GAME, A NATIONAL DISGRACE.

DOCTOR'S OFFICES OFTEN SPEND MORE TIME ON THE INSURANCE FORMS THAN THE DOCTOR SPENT WITH THE PATIENT.

EVEN THE INSURANCE INDUSTRY ITSELF HAS BEGUN TO CALL FOR REGULATION AND REFORM.
EMPLOYERS SHOULD BE REQUIRED TO PROVIDE HEALTH INSURANCE, WITH APPROPRIATE COST-SHARING, HEALTH EDUCATION, AND FITNESS PROGRAMS. THE ECONOMIC IMPACT ON SMALL BUSINESS CAN AND MUST BE LESSENE BY TAX BREAKS AND RISK-POOLING.

OTHERWISE SMALL EMPLOYERS JUST DROP SOME EMPLOYEES FROM THE PAYROLL.
SOME OF THE STATES ARE WAY AHEAD OF THE FEDERAL GOVERNMENT IN DEALING WITH THE INSURANCE CRISIS. MASSACHUSETTS HAS INITIATED A PLAN REQUIRING EMPLOYERS TO CHOOSE BETWEEN PROVIDING EMPLOYEE INSURANCE COVERAGE OR PAYING A TAX TO PROVIDE IT.
IN HAWAII, THE ONLY STATE REQUIRING EMPLOYERS TO PROVIDE HEALTHCARE INSURANCE, 95 PERCENT OF THE STATE'S POPULATION HAS INSURED ACCESS TO HEALTHCARE.

CONSEQUENTLY, PREVENTIVE MEDICINE AND TIMELY TREATMENT HAVE BROUGHT HEALTH INSURANCE PREMIUMS TO DOWN TO WELL BELOW NATIONAL AVERAGE.

THEY HAVE LENGTHENED LIFE EXPECTANCY—PROBABLY DUE TO THEIR ENHANCED RISK REDUCTION THEY SPEND $2,172 / RESIDENT 11.1% 6.5%
THOSE NOT INCLUDED IN EMPLOYER-PROVIDED INSURANCE SHOULD BE ABLE TO HAVE ACCESS TO SIMILAR COVERAGE ACCORDING TO SLIDING SCALE COST-SHARING AND RISK-POOLING.

WE NEED TO EXPECT SOME FORMS OF TAX INCREASE IF WE ARE TO ACT ACCORDING TO OUR ETHICS, AND PROVIDE HEALTH INSURANCE FOR THOSE NOW UNINSURED.
WE CAN LOWER BOTH HEALTHCARE COST AND INSURANCE COST BY LINKING INSURANCE COVERAGE TO BEHAVIOR.

IT MAKES SENSE TO VOID OR REDUCE INSURANCE COVERAGE FOR PEOPLE WHO PRACTICE HIGH RISK BEHAVIOR: NOT WEARING MOTORCYCLE HELMETS, NOT BUCKLING SEATBELTS, DRIVING AFTER DRINKING, AND YES, CONTINUING TO SMOKE.
WHY SHOULD THE REST OF US SUBSIDIZE THE INSURANCE
COVERAGE OF PEOPLE WHO KNOWINGLY AND CONTINUALLY
PLACE THEMSELVES AT GREATER RISK FOR ILLNESS?

EVEN HIGHER TOBACCO AND ALCOHOL TAXES SHOULD BE
DEMANDED TO PAY FOR HEALTHCARE COSTS ATTRIBUTED TO
THOSE DEADLY SUBSTANCES.
ON THE POSITIVE SIDE, WE NEED INSURANCE PROGRAMS THAT ENCOURAGE PREVENTIVE HEALTHCARE.

IT IS ABSURD FOR INSURANCE TO COUGH UP $150,000 TO REMOVE A CANCEROUS LUNG, BUT NOT PAY $64 OR $200 FOR A SMOKING CESSATION PROGRAM.
NO ONE CAN DOUBT MY COMMITMENT TO CUTTING
HEALTHCARE COSTS, TO GETTING RID OF MISMANAGEMENT,
WASTE, AND FRAUD.

BUT I AM DEEPLY DISTURBED AND EVEN FRIGHTENED WHEN
THIS IS ATTEMPTED BY MISGUIDED INTERFERENCE IN THE
DOCTOR-PATIENT RELATIONSHIP.
WHEN YOU GO TO SEE YOUR DOCTOR, YOU MAY THINK THAT
THERE ARE ONLY TWO OF YOU IN THE ROOM.

BUT YOU ARE MISTAKEN.

THERE ARE OTHER DOCTORS AND NURSES, UNSEEN, BUT SPYING
ON YOU, REALLY FUNCTIONING AS CLERKS FROM A DISTANCE.
IN AN ATTEMPT TO CONTROL MEDICARE COSTS, THE FEDERAL GOVERNMENT HAS HIRED PRIVATE FIRMS WHOSE JOB IT IS TO SECOND-GUESS PHYSICIAN DECISIONS IN ORDER TO CUT COST.

IF YOU NEED LIFE-SAVING BRAIN SURGERY, YOUR BRAIN SURGEON MAY FIND HIMSELF OR HERSELF ON THE PHONE TO A DOCTOR --NOT A BRAIN SURGEON-- IN FRONT OF A COMPUTER HUNDREDS OF MILES AWAY TRYING TO PERSUADE YOUR SURGEON TO SAVE A FEW BUCKS BY SCHEDULING 10 HOUR BRAIN SURGERY IN THE AFTERNOON, JUST SO THE PATIENT DOESN'T STAY IN THE HOSPITAL THE NIGHT BEFORE THE PROCEDURE.
MOST PHYSICIANS ARE TRAINED TO ADVOCATE THEIR PATIENTS INTERESTS, AND THEY ARE BETTER AT CLINICAL DECISIONS THAN ECONOMIC DECISIONS.

ALL TOO OFTEN THESE INTERFERING REGULATORS FORCE DOCTORS TO FIGHT FOR WHAT IS BEST FOR THEIR PATIENTS, TO SPEND TIME ON THE PHONE OR WRITING LETTERS, TIME THAT WOULD BE BETTER SPENT WITH THEIR PATIENTS.
THE HEALTH CARE FINANCING ADMINISTRATION, THE AGENCY IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES THAT ADMINISTERS MEDICARE AND MEDICAID, SET UP A PROGRAM IN GEORGIA THAT FORCES DOCTORS TO DEAL EACH DAY WITH REVIEW AGENCIES THAT SEEM TO ASSUME EACH DOCTOR IS A CROOK, THAT EACH RELATIONSHIP WITH A PATIENT IS FRAUDULENT UNLESS PROVEN OTHERWISE.
THE GOVERNMENT AGENCY WAS SO PLEASED BY THE HARASSING ATTACKS UPON DOCTORS THAT THEY AWARDED THE HARASSERS YET ANOTHER CONTRACT, THIS TIME HARASSING CIVILIAN PHYSICIANS WHO GIVE MILITARY PERSONNEL MEDICAL CARE UNAVAILABLE ON MILITARY BASES UNDER THE CHAMPUS PROGRAM.

IN SOME STATES INSURANCE REGULATORS CAN ADVANCE THEIR OWN CAREERS ONLY BY LODGING FRAUDULENT CHARGES AGAINST DEDICATED PHYSICIANS.
NO ONE IS MORE DETERMINED THAN I AM TO RID MEDICINE OF OVERCHARGING AND INCOMPETENT PRACTITIONERS, BUT THIS CANNOT BE DONE BY REGULATORS HARASSING PHYSICIANS, DESTROYING THE ESSENTIAL TRUST IN THE DOCTOR-PATIENT RELATIONSHIP.
COST CONTROL SHOULD NOT MEAN REMOTE CONTROL MEDICINE.

I DON'T LIKE THE IDEA OF A DOCTOR THOUSANDS OF MILES AWAY MAKING DECISIONS FOR PATIENTS HE DOESN'T KNOW.

I DON'T WANT TO SEE MEDICINE TURNED INTO A PUBLIC UTILITY, OVER-REGULATED AND UNDER-RESPONSIVE TO THE NEEDS OF INDIVIDUAL PATIENTS. WE MUST RESTORE THE HEALING BOND OF TRUST BETWEEN DOCTOR AND PATIENT.
SOME STATES ARE ATTEMPTING TO DEAL WITH THE CRISIS IN THE COST OF HEALTHCARE AND HEALTH INSURANCE THROUGH DELIBERATE RATIONING OF HEALTHCARE.

WHILE MOST OF US DETEST THE VERY NOTION OF RATIONED HEALTHCARE, SOME ADVOCATES ARE DEMANDING IT AS THE WAVE OF THE FUTURE.
PERHAPS THE OREGON PLAN HAS RECEIVED THE MOST ATTENTION.

THE OREGON LEGISLATURE RELEASED A PROPOSAL CALLING FOR A PRIORITY LISTING OF THE MEDICAL DIAGNOSES FOR WHICH MEDICAID WOULD FOOT THE BILL.
THE IDEA BEHIND THE RATIONING WAS TO REFUSE MEDICAID EXPENDITURES FOR EXPENSIVE PROCEDURES LIKE ORGAN TRANSPLANTS IN ORDER TO PROVIDE THE 400,000 OREGONIANS WITHOUT MEDICAL INSURANCE A BASIC LEVEL OF MEDICAL CARE, ESPECIALLY PREGNATAL CARE, AND CHILDHOOD IMMUNIZATIONS.
SO, THE COMPUTER RANKED 1,600 MEDICAL PROCEDURES ON A
COST/BENEFIT BASIS. THOSE AT THE BOTTOM OF THE LIST, LIKE
LIVER TRANSPLANTS, NO LONGER QUALIFIED FOR MEDICAID
COVERAGE.

IT DIDN'T TAKE LONG FOR THE COLD LOGIC OF THE PROPOSAL
TO PROVOKE A WARM-HEARTED HUMAN OUTCRY.
NOT EVERYONE AGREED WITH THE RANKINGS, MUCH LESS THE ENTIRE CONCEPT OF RATIONING.

THE OREGON RANKING OF DIAGNOSES PLACED MANY AIDS-RELATED ILLNESS AT THE BOTTOM OF THE LIST. THAT PROBABLY CAME FROM EARLY DETERMINATION OF HIV AS SHORT-TERM TERMINAL DISEASE. BUT INCREASINGLY AIDS IS VIEWED AS A LONG-TERM ILLNESS, AND HIV PATIENTS SHOULD NOT AUTOMATICALLY BE VIEWED AS MORE EXPENDABLE THAN OTHER PERSONS WITH LONGTERM CHRONIC DISEASES.
WHEN PROONENTS OF THE RATIONING PLAN ARGUED THAT
"COMMUNITY VALUES" MIGHT HELP SORT OUT THE RANKINGS IT
MADE MANY PEOPLE SHUDDER.
AFTER ALL, "COMMUNITY VALUES" BURNED DOWN THE HOUSE OF
THE LITTLE HEMOPHILIC BOYS WITH AIDS IN ARCADIA,
FLORIDA, AND "COMMUNITY VALUES" DROVE RYAN WHITE FROM
KOKOMO, INDIANA.
THE OREGON PLAN WOULD ALLOW BIZARRE INEQUITIES.

SINCE OREGON HAS THE ONLY CERTIFIED TRANSPLANT CENTER IN THE NORTHWEST, OUT-OF-STATIONS WITH OUT-OF-STATE MEDICAID CAN GO THERE, BUT OREGONIANS ON MEDICAID ARE DENIED ACCESS.
MORE THAN ONE POOR OREGON FAMILY WAS REDUCED TO
BEGGING WITH TIN CUPS AT GROCERY STORES AND MAKING
DESPERATE APPEALS ON TV TO GET MONEY FOR TRANSPLANTS
FOR THEIR CHILDREN.

WHEN THE MONEY DIDN'T COME IN THE CHILDREN WENT
WITHOUT TREATMENT, AND DIED....
AND THEY DIED IN A STATE THAT SPENDS MORE MONEY
ADMINISTERING ITS MEDICAID THAN ALMOST ANY OTHER IN THE COUNTRY: $40 MILLION.
I'VE HEARD OF NO PLAN TO REDUCE THESE COSTS.
IN OREGON, MANY ARE ASKING HOW CAN YOU LOOK THE
PARENT OF A DYING CHILD IN THE EYE AND SAY, NO
TRANSPLANT FOR YOU, IT'S TOO EXPENSIVE.
CRITICS SAY ALL THIS IS REALLY A WAY OF FINDING A WAY TO
DO LESS FOR NEEDIEST.

THIS PLAN TAKES FROM THE POOR TO GIVE TO THE POOR.
IT TAKES FROM THE POOR TO GIVE TO THE POOR BECAUSE IT APPLIES ONLY TO MEDICAID COVERAGE, THAT OFFERED THE POOREST OREGONIANS. IF YOU HAVE MONEY OR PRIVATE INSURANCE IN OREGON, YOUR HEALTH CARE IS NOT RATIONED.
OTHER STATES ARE TOYING WITH RATIONING.

PENNSYLVANIA DECIDED RECENTLY THAT IT COST TOO MUCH TO PROVIDE 800 STATE MENTAL PATIENTS WITH A NEW DRUG (CLORAZIL) THAT MIGHT ALLOW THEM TO RECOVER. SO ONLY 210 WOULD GET THE DRUG. HOW WOULD THEY DECIDE WHO WOULD GET THE DRUG? OFFICIALS SAID THEY WOULD USE A LOTTERY. NOT SURPRISINGLY, FAMILIES AND PSYCHIATRISTS WERE OUTRAGED.
I KNOW WE HAVE HARD CHOICES TO MAKE.

I KNOW WE ARE TROUBLED BY RISING ASPIRATIONS AND DECLINING RESOURCES.

BUT THESE STATE RATIONING PLANS GO AGAINST OUR GRAIN.

A SOCIETY THAT SPENDS MILLIONS ON LAWN CARE CAN FIND THE RESOURCES TO PROVIDE LIFE-GIVING NECESSARY CARE TO ITS POOREST MEMBERS.
TO MAKE SURE WE ALL GET MORE FOR OUR HEALTHCARE DOLLAR, FOR OUR INSURANCE COVERAGE, WE NEED MORE OPEN COMMUNICATION ABOUT THE QUALITY AND EFFICIENCY OF HEALTHCARE.

WE NEED TO END THE CONSPIRACY OF SILENCE.
WE NEED TO KNOW WHERE PEOPLE CAN GET HIGH-QUALITY AND EFFICIENT CARE.

THEN THE PATIENTS WILL DESERT THE POOR QUALITY, INEFFECTIVE SYSTEMS THAT WILL HAVE TO IMPROVE OR PERISH.
QUALITY, AND EFFICIENCY ARE DIFFICULT TO MEASURE. BUT THEY ARE MORE IMPORTANT THAN MERE QUANTITY.

WE ARE DEVELOPING TOOLS TO MEASURE MEDICAL NECESSITY, APPROPRIATENESS, EFFECTIVENESS AND OF COURSE OUTCOMES.

IN FIVE YEARS I DON'T BELIEVE A KNOWLEDGEABLE PATIENT WILL GO ELECTIVELY TO A HOSPITAL IF KNOWING THE BARMING AVERAGE OF BOTH HOSPITAL AND PHYSICIAN FOR ME OR HIS/HER DT.

THAT'S PROPHETIC—SIGN OF LINCOLN: NOSES.
WE CAN COMPARE, FOR EXAMPLE, THE CARDIAC SURGERY
OUTCOMES OF ALL THE HOSPITALS IN A STATE, AND SEE WHICH
HOSPITALS --AND WHICH PHYSICIANS-- HAVE MORTALITY RATES
ABOVE NORMAL, AFTER ALLOWING FOR VARIATION IN PATIENT
RISK FACTORS.

THIS INFORMATION IS THEN SHARED WITH THE PUBLIC, AND THE
APPROPRIATE STEPS TAKEN TO SOLVE THE PROBLEMS.
AT FIRST, HOSPITALS AND DOCTORS DON'T LIKE THIS INVASION OF PRIVACY, BEING PLACED IN A FISH GLOBE.

BUT THIS SCRUTINY AND PUBLIC ACCOUNTABILITY IS HERE TO STAY.

AND I'VE NOTICED THAT THE ONES WHO SQUAWK THE LOUDEST AT FIRST ARE THE FIRST TO BRING THEIR OUTCOMES TO THE NORMAL RANGE.
THERE ARE OTHER AREAS WHERE WE NEED CHANGES IN LAW AND PUBLIC POLICY.

WE MUST REFORM THE MALPRACTICE MESS, THE TORTURED TORT SYSTEM THAT FORCES DOCTORS AND PATIENTS TO VIEW EACH OTHER AS LEGAL ADVERSARIES.
WE CAN'T HAVE DOCTORS WONDERING IF THEY'LL NEXT SEE THEIR PATIENTS IN COURT, FLANKED BY THEIR LAWYERS.

IN A LEGAL CLIMATE WHERE ANYTHING SHORT OF PERFECTION IS GROUNDS FOR A SUIT, SOME PATIENTS HAVE GONE TO THE HOSPITAL WITH THEIR LAWYERS IN TOW.
MALPRACTICE SUITS CORRUPT BASIC EMOTIONAL CLIMATE OF MEDICINE, MAKING THE DOCTOR AFRAID OF THE PERSON SHE OR HE WANTS TO HELP.

BETWEEN 1981 AND 1986, NUMBER OF MALPRACTICE SUITS TRIPLED, AND AVERAGE JURY AWARD QUADRUPLED (FROM $400,000 TO $1.76 MILLION). NO WONDER COSTLY MALPRACTICE INSURANCE FORCES DOCTORS TO MAKE INSURANCE PREMIUMS, NOT THE COST OF MEDICAL CARE, THE BASIS FOR THEIR FEE STRUCTURE.
MALPRACTICE DOES EXIST, AND WHERE THERE IS MALPRACTICE --BAD, OR NEGLIGENT PRACTICE-- RESTITUTION AND COMPENSATION ARE IN ORDER.

MEDICINE MUST RID ITSELF OF THE BAD APPLES THAT BRING JUSTIFIED CRITICISM TO THE PROFESSION.

YET MANY MALPRACTICE SUITS ARE BROUGHT BECAUSE A TRAGEDY HAS OCCURRED, IN SPITE OF THE DOCTOR'S BEST EFFORTS.
OUR CURRENT SYSTEM DOES NOT SERVE THE PATIENT WELL.

EVERY INAPPROPRIATE MALPRACTICE SUIT DRIVES UP THE COST OF MEDICINE FOR ALL PATIENTS AND DOCTORS ALIKE, WHILE NEGLIGENT DOCTORS CONTINUE TO PRACTICE AND SOME VERY GOOD DOCTORS LEAVE.
THE MALPRACTICE MESS IS WORST IN OBSTETRICS.

ALTHOUGH MODERN OBSTETRICS OFFERS BIRTH SAFER THAN EVER FOR MOTHER AND BABY, THE CURRENT ASSUMPTION THAT EVERY BABY WILL BE PERFECT HAS LED TO A MALPRACTICE CRISIS.

PEOPLE ASSUME THAT WHEN THEY PAY AN OBSTETRICIAN, THEY ARE BUYING A PERFECT BABY.
BUT LIFE --AND BIRTH-- DOES NOT WORK THAT WAY.

OBSTETRICIANS ARE SO OFTEN THREATENED WITH SUITS THAT
THEM ARE FORCED TO PRACTICE DEFENSIVE MEDICINE,
ORDERING FOR EACH PATIENT A BATTERY OF OFTEN
UNNECESSARY AND ALWAYS COSTLY TESTS.

AND THERE HAS BEEN A DRAMATIC INCREASE IN CAESARIAN
SECTIONS SIMPLY BECAUSE OBSTETRICIANS FEAR WAITING OUT
THE NATURAL BIRTH PROCESS.
THIS SITUATION, CAUGHT BETWEEN MALPRACTICE SUITS AND UNNECESSARY CAESARIAN OPERATIONS HAS LED MANY OBSTETRICIANS SIMPLY TO LEAVE THE SPECIALTY FOR WHICH THEY WERE TRAINED.

AGAIN, THE AMERICAN PEOPLE ARE THE REAL LOSERS.
IN WEST VIRGINIA, FOR EXAMPLE, YOU CAN'T PRACTICE MEDICINE WITHOUT MALPRACTICE INSURANCE.

THE CHEAPEST POLICY AN OBSTETRICIAN CAN BUY IS $40,000, AND THAT COVERS 50 BABIES -- BUT NOT 51 BABIES -- DELIVERED PER YEAR.

THAT AMOUNTS TO AN INSURANCE COST OF $800 PER BABY,.... AND NO ONE IN APPALACHIA CAN AFFORD TO PAY FOR AN $800 DELIVERY.

DO YOU WONDER WHY THERE ARE ALMOST NO OBSTETRICIANS IN APPALACHIA?
MOST DOCTORS WHO ARE SUED FOR MALPRACTICE DON'T "PRACTICE MAL".

MOST MALPRACTICE SUITS TODAY ARE FOR MALOCCURRENCE.

I'LL USE MYSELF AS AN EXAMPLE. I'M 73. IF I HAD MY GALL BLADDER OPERATED ON TOMORROW, AND SUFFERED A HEART ATTACK ON THE OPERATING TABLE AND DIED, IT WOULD BE WHAT YOU USED TO CALL AN "ACT OF GOD."
YOU EXPECT IT TO HAPPEN TO A CERTAIN NUMBER OF 73 YEAR OLDS UNDER THAT KIND OF STRESS.

BUT NOW THE TENDENCY IS TO BLAME SOMEONE.

WAS THE ANESTHESIA RIGHT?

DID THE SURGEON GO TOO SLOW? TOO FAST?

LET'S SUE; MAYBE WE CAN GET SOMETHING.
MALPRACTICE REFORM IS DIFFICULT TO GET BECAUSE CONGRESS AND STATE LEGISLATURES INCLUDE SO MANY LAWYERS, AND THEY AREN'T LIKELY TO ACT AGAINST THEIR OWN.

BUT WE MUST DEMAND REFORM.

WE MUST ELIMINATE AWARDS FOR ALLEGED PAIN AND SUFFERING, AND WE MUST DO AWAY WITH CONTINGENCY FEES WHICH CLOG THE COURTS, BLACKMAIL PHYSICIANS, AND PROMPT INSURANCE COMPANIES TO SPEND OUR MONEY OUT OF COURT JUST TO GET IT OVER.
WE NEED TO GET PAST THE STAND-OFF BETWEEN DOCTORS AND LAWYERS.

I'M SURE THAT BOTH THE DOCTOR AND THE PATIENT WOULD PREFER TO HAVE THAT OLD RELATIONSHIP OF TRUST THEY USED TO HAVE,

A RELATIONSHIP THAT IS UNFORTUNATELY BECOMING CHANGED TO A PROVIDER-CONSUMER RELATIONSHIP.
I realize that there are some built-in problems.

People aren't happy about being ill, needing to go to a physician.

Having to pay a high price for it makes it even more unpleasant. But we need to subordinate the economic aspect of the relationship to the climate of trust between the doctor and the patient.
IF THE PATIENT THINKS OF HIMSELF PRIMARILY AS A
CONSUMER, GETTING THE MOST FOR HIS MONEY, SHOPPING
AROUND FOR A DOCTOR WHO CHARGES $5 LESS FOR AN OFFICE
VISIT, HE AUTOMATICALLY PUTS THE DOCTOR IN THE ROLE OF
THE SELLER, GETTING THE MOST FOR HIS SERVICES.
IF THE DOCTOR IS PRIMARILY CONCERNED ABOUT COLLECTING HIS FEE, HE AUTOMATICALLY AROUSES THE CONSUMER MENTALITY IN HIS PATIENT. WE CAN'T HAVE PATIENTS WONDERING IF THEIR TREATMENT IS DETERMINED BY THE DOCTORS FINANCES.
THE DOCTOR-PATIENT RELATIONSHIP CAN BE RESTORED.

BUT IT WILL TAKE COMMITMENT BY PEOPLE ON BOTH SIDES OF THE STETHOSCOPE.

ALTHOUGH WE MUST HOLD OUR PHYSICIANS TO THE HIGHEST STANDARDS, WE MUST REALIZE THAT HEALING AND RECOVERY ARE NOT PERFECT.
THE HEALTH CARE SYSTEM IN AMERICA TODAY IS A TERRIBLE MORAL BURDEN FOR SOCIETY TO BEAR, IN THAT THE SYSTEM DOES NOT RESPOND AT ALL TO SOME 12 TO AS HIGH AS 15 PERCENT OF OUR POPULATION.

AND IT IS A TERRIBLE ECONOMIC BURDEN FOR SOCIETY TO BEAR, IN THAT THE SYSTEM SATISFIES ITS OWN UNCONTROLLED NEEDS AT THE EXPENSE OF EVERY OTHER SECTOR OF AMERICAN SOCIETY.
WE NEED TO CHANGE THAT SYSTEM.

NOT JUST A LITTLE CHANGE HERE AND A LITTLE CHANGE THERE.

WE NEED TO BRING ABOUT A PROFOUND CHANGE, ACROSS-THE-BOARD, IN THE WAY WE MAKE MEDICAL AND HEALTH CARE AVAILABLE TO ALL OUR CITIZENS.

BUT CAN WE DO IT?
WE NEED TO TAKE SOME IMAGINATIVE STEPS.

FOR EXAMPLE, WE NEED TO SOLVE THE PROBLEM CAUSED BY

THE ENORMOUS EDUCATION DEBT THAT MOST YOUNG DOCTORS

HAVE TO SHOULDER AS SOON AS THEY BEGIN PRACTICING

MEDICINE.

MOST MEDICAL STUDENTS GRADUATE FROM MEDICAL SCHOOL

WITH A DEBT THAT SHAPES THEIR PRACTICE OF MEDICINE FOR

THE NEXT 20 YEARS.
GRADUATES OF LAND GRANT SCHOOLS, SUCH AS THE UNIVERSITY OF IOWA, MIGHT BE OWE BETWEEN $45,000 AND $65,000, WHILE GRADUATES FROM A SCHOOL LIKE BROWN, DARTMOUTH, GEORGETOWN, OR GEORGE WASHINGTON OWE OVER $150,000.

IT'S EASY TO SEE WHAT HAPPENS.
THE YOUNG DOCTOR WHO AT ONE TIME WANTED TO GO INTO
FAMILY PRACTICE, PERHAPS RETURNING TO SERVE THE PEOPLE
WHERE SHE OR HE GREW UP, INSTEAD IS TEMPTED INTO A
LUCRATIVE SPECIALTY THAT WILL ALLOW HIM TO EARN AN
INCOME HIGH ENOUGH TO PAY OFF THAT DEBT MORE QUICKLY.
SO WE GET STILL ANOTHER NEUROSURGEON OR ORTHOPEDIST IN THE SUBURBS, AND WE DON'T GET THAT FAMILY PRACTITIONER WE SO DESPERATELY NEED IN A SMALL TOWN OR IN THE INNER CITY.

I HAVE A SUGGESTION ABOUT THIS.
WHEN A MEDICAL STUDENT GRADUATES, AN ACCOUNT COULD BE
ESTABLISHED BY THE FEDERAL GOVERNMENT, AND EVERY TIME
THE DOCTOR SEES AN UNINSURED PATIENT WITHOUT CHARGE,
THAT DEBT IS LOWERED BY THE AMOUNT EQUIVALENT TO A FAIR
COMPENSATION FOR THAT SERVICE.
THIS SOLUTION HAS SEVERAL ADVANTAGES: IT'S GRADUAL; IT DOESN'T REQUIRE A BIG OUTLAY BEFOREHAND; IT OFFERS CARE TO THE UNINSURED WHO NEED IT; IT PHYSICIANS TO OFFER CARE WITHOUT FEE; AND IT LOWERS THE DOCTOR'S DEBT. IT SEEMS TO ME THAT EVERYBODY GAINS.

WE NEED TO DO SOMETHING, TO DO MANY THINGS, BECAUSE
WE ARE AT A CROSSROADS. WE CANNOT AFFORD TO DO NOTHING,
TO CONTINUE BUSINESS AS USUAL.
THE PRESSURE FOR RADICAL CHANGE IS COMING FROM ALL DIRECTIONS:
FROM MEMBERS OF CONGRESS, FROM BUSINESS, FROM LABOR,
AND FROM THE GENERAL PUBLIC.
INCREASINGLY WE HEAR THE DEMAND FOR RESTRUCTURING THE FINANCING AND DELIVERY OF HEALTHCARE IN THE UNITED STATES.
EVEN SOME BUSINESS LEADERS WHO NORMALLY CRINGE AT THE
THOUGHT OF GOVERNMENT INTERVENTION OR REGULATION
FIND THEMSELVES CALLING FOR A SYSTEM OF NATIONAL
HEALTH CARE AS A SOLUTION TO RISING INSURANCE COSTS.
MANY PEOPLE WERE SURPRISED WHEN LAST APRIL THE AMERICAN COLLEGE OF PHYSICIANS, THE NATION'S SECOND LARGEST MEDICAL SOCIETY, CALLED FOR A NATIONALLY-FUNDED HEALTH PROGRAM, BREAKING A LONG TRADITION OF OPPOSITION TO ANYTHING REMOTELY RESEMBLING "SOCIALIZED MEDICINE".
FRUSTRATION WITH OUR SYSTEM LEADS SOME PEOPLE TO SEE GREENER GRASS ON THE OTHER SIDE OF THE FENCE.

RECENTLY I'VE NOTICED A STRANGE INTEREST IN THE CANADIAN SYSTEM.

EVERYWHERE I GO PEOPLE SAY TO ME, "WE NEED THE CANADIAN SYSTEM." SO I SAY, "TELL ME, WHAT IS IT YOU LIKE ABOUT THE CANADIAN SYSTEM."
THEY ALWAYS ANSWER, "I DON'T REALLY KNOW, BUT IT'S A GOOD SYSTEM."

THE GROWING INFATUATION WITH FOREIGN NATIONAL HEALTH SERVICES IS BASED MORE UPON DISSATISFACTION WITH OUR SYSTEM THAN UPON UNDERSTANDING OF ANOTHER ONE.
MOST AMERICANS DO NOT REALIZE THAT ANY NATIONAL HEALTH SERVICE, IS BASED UPON PLANNED SCARCITY.

EXPERIENCE THE WORLD OVER HAS SHOWN THAT WHEN GOVERNMENT ECONOMIC CONTROLS ARE APPLIED TO HEALTH, THEY PROVE --IN TIME-- TO BE DETRIMENTAL.

EVENTUALLY THERE IS AN EROSION OF QUALITY, PRODUCTIVITY, INNOVATION, AND CREATIVITY.
THIS IS ESPECIALLY TRUE OF RESEARCH.

AMERICANS DESIRE, NOT ONLY AFFORDABLE HEALTH CARE, BUT
ALSO MEDICAL ADVANCES.

BUT MEDICAL RESEARCH IS NOT CHEAP, AND SOMEONE MUST
PAY FOR IT. AMERICANS ARE NOT LIKELY TO TOLERATE
HEALTHCARE SAVINGS IF IT MEANS SKIMPING ON AIDS OR
ALZHEIMER'S RESEARCH.
NATIONAL SYSTEMS OF HEALTHCARE EVENTUALLY BECOME BUREAUCRATIC, UNRESPONSIVE TO PATIENTS, AND FINALLY THEY BRING RATIONING AND WAITING IN LINES.

AMERICANS DO NOT PATIENTLY QUE UP FOR ANYTHING, ESPECIALLY FOR MEDICAL CARE.
THE "PLAIN VANILLA" CANADIAN SYSTEM, ATTRACTIVE AT FIRST TO AMERICANS, IS BECOMING LESS ATTRACTIVE TO MANY CANADIANS. BECAUSE RESOURCES ARE LIMITED, ON PURPOSE, THE AVAILABILITY OF SERVICES IS MUCH LOWER THAN IN THE US, AND THE WAITING PERIOD MUCH LONGER. THE OTTAWA CITIZEN (2/4/89) REPORTED THAT IN BRITISH COLUMBIA, IN 1988, 24 PEOPLE DIED WHILE THEY WAITED FOR HEART SURGERY, BECAUSE THE WAITING TIME FOR BY-PASS OPERATIONS CAN BE 6 TO 8 MONTHS.

A FEW FIGURES DEMONSTRATE THE DIFFERENCE IN AVAILABILITY OR SERVICES IN CANADA AND THE UNITED STATES:

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<tr>
<td># OF SITES</td>
<td>POP PER SITE</td>
<td># OF SITES</td>
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<tr>
<td>OPEN HEART SURGERY</td>
<td>11</td>
<td>2364</td>
</tr>
<tr>
<td>CARDIAC CATH</td>
<td>31</td>
<td>839</td>
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<td>MRI</td>
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<td>2167</td>
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IT WAS NOT UNCOMMON TO FIND THOSE CANADIANS WHO CAN AFFORD AMERICAN MEDICINE SLIPPING ACROSS THE BORDER TO PHYSICIANS IN BOSTON, BUFFALO, CHICAGO, AND SEATTLE. NOW THE CANADIAN GOVERNMENT PAYS FOR CARDIAC SURGERY AT 70% OF WHAT THE HOSPITAL CHARGES.
I DO NOT FAVOR TOTALLY SCRAPPING THE SYSTEM WE HAVE NOW;

BECAUSE OF ITS DIVERSITY, IT IS POTENTIALLY THE BEST IN THE WORLD.

ONE WAY TO GET THINGS MOVING IN THE RIGHT DIRECTION IS THROUGH A PRESIDENTIAL COMMISSION, A COMMISSION THAT WOULD MAKE DECISIONS AND MAKE A DIFFERENCE, NOT JUST ISSUE ONE MORE REPORT.
I URGED THIS IN A PRIVATE CONVERSATION WITH GEORGE BUSH IN AUGUST 1988, SEVERAL MONTHS BEFORE HIS ELECTION TO THE PRESIDENCY.

AND I'VE MADE THE SAME SUGGESTION IN EDITORIALS IN NEWSWEEK AND FROM MANY PLATFORMS AROUND THE COUNTRY.
WHEN I MET WITH THE PRESIDENT I TOLD HIM THAT A NUMBER OF WEALTHY REPUBLICANS, CONCERNED ABOUT THE HEALTHCARE CRISIS, HAD AGREED TO FOOT THE BILL FOR THE COMMISSION, AS LONG AS IT INVOLVED BOTH DEMOCRATIC AND REPUBLICAN CONGRESSMEN --NOT THEIR STAFFERS-- WHO WOULD TAKE THE COMMISSIONS RECOMMENDATIONS BACK TO CONGRESS FOR DISCUSSION, A VOTE, AND THEN IMPLEMENTATION.
THEY ALSO WANTED THE COMMISSION TO AVOID SPINNING ITS WHEELS, AND TO DEAL WITH A PROPOSED AGENDA OF NINE POSSIBLE SOLUTIONS, TO MAKE DECISIONS, AND GET TO WORK ON IMPLEMENTING THEM.

THE PRESIDENT GAVE ME NO ANSWER.
AND AS FAR AS I CAN TELL, NOTHING IS BEING DONE ON THE FEDERAL LEVEL TO ADDRESS THE NATIONAL HEALTHCARE CRISIS.

CHEERLEADING SPEECHES WON'T DO.

RECENTLY THE SECRETARY OF HEALTH AND HUMAN SERVICES SAID WE NEED A CULTURE OF CHARACTER. THAT'S A NOBLE ASPIRATION. BUT IT WON'T SOLVE OUR HEALTHCARE PROBLEMS.
WE CAN DELAY NO LONGER.

THE OPPORTUNITY IS NOW.

THE TIME IS SHORT.

THE STAKES ARE HIGH.

THE ALTERNATIVES UNDESIRABLE.
IT REMAINS TO BE SEEN WHETHER OR NOT THE PRIVATE SECTOR SEIZES THIS ONE AND ONLY OPPORTUNITY.

WE'LL SEE.

WE ALL NEED TO BE A PART OF THE EFFORT.

BUT THERE IS NO QUICK FIX.

FROM HERE TO THERE COULD TAKE A DECADE, BUT WE'D IMPROVE YEAR BY YEAR ALONG THE WAY.
FINALLY, AS MY GOOD FRIEND DR. TIMOTHY JOHNSON SAYS, WHEN WE SAY HEALTHCARE, WE ALL TOO OFTEN MEAN HEALTHCURE. AND WE PUT TOO MUCH EMPHASIS ON CURING, TOO LITTLE ON CARING. WE NEED TO DO MORE ABOUT THE TIMES WE CAN'T PROVIDE THE CURE, BUT STILL CAN PROVIDE THE CARE.
CURING CAN COST BILLIONS, CARING COMES FROM HEART AND SOUL.

I'D LIKE TO THINK THAT WHETHER OR NOT WE HAVE FEWER BILLIONS, WE'LL NEVER RUN OUT OF HEART AND SOUL.

THANK YOU.
IN THE MEANTIME, YOU CAN DO YOUR PART TO MAKE SURE THAT YOU DON'T NEED TO USE THE HEALTHCARE SYSTEM, BY PRACTICING PERSONAL DISEASE PREVENTION AND HEALTH PROMOTION.

IN ONE OF HIS PLAYS, GEORGE BERNARD SHAW ASKED WHY WE PAY DOCTORS TO TAKE A LEG OFF BUT WE DON'T PAY THEM TO KEEP A LEG ON. NOW, ALMOST 80 YEARS HAVE PASSED AND WE STILL HAVEN'T COME UP WITH A GOOD ANSWER.
OUR TECHNOLOGY-DRIVEN REIMBURSEMENT SYSTEM --
WHETHER BY GOVERNMENT OR OUT-OF-POCKET -- IS STILL
PREDICATED ON TAKING THE LEG OFF.
SOME OF US ARE TRYING TO CHALLENGE THAT THINKING. WE ARE ATTEMPTING A NEW AMERICAN REVOLUTION.

THIS REVOLUTION IS MORE IMPORTANT THAN THE NEEDED REVOLUTION IN THE STRUCTURE OF HEALTH CARE OR IN THE FINANCING OF HEALTH CARE.

THIS REVOLUTION CHANGES EVERYDAY INDIVIDUAL BEHAVIOR.
YOU ARE A PART OF THAT REVOLUTION, AND YOU'LL IMPROVE THE HEALTH OF THE AMERICAN PEOPLE --AS WELL AS YOUR OWN HEALTH-- IF YOU PLAY YOUR PART.

TWO CONCEPTS FORM THE BASIS FOR THIS REVOLUTION.

FIRST, YOUR HEALTH AND THE HEALTH OF THOSE WHO COME TO YOU PROFESSIONALLY WILL DEPEND MOSTLY UPON THE PREVENTION OF DISEASE AND DISABILITY AND THE PROMOTION OF GOOD HEALTH.
SOME ANALYSTS EVEN SAY THAT PREVENTION AND HEALTH PROMOTION CAN POSTPONE UP TO 70 PERCENT OF ALL PREMATURE DEATHS, WHEREAS THE TRADITIONAL CURATIVE AND REPARATIVE APPROACH OF MEDICINE CAN POSTPONE NO MORE THAN 10 TO 15 PERCENT OF SUCH DEATHS. EVEN IF THEY'RE ONLY HALF RIGHT, THAT'S QUITE A DIFFERENCE IN SOCIAL PAY-OFFS.
SECOND WE HAVE COME TO REALIZE THAT THESE TWO APPROACHES TO HEALTH -- THAT IS, DISEASE PREVENTION AND HEALTH PROMOTION -- ARE THE PRIMARY RESPONSIBILITIES OF EACH INDIVIDUAL.

THAT MEANS YOU!

PHYSICIANS AND THERAPISTS AND PHARMACISTS AND NURSES MUST PROVIDE AMERICANS WITH INFORMATION, SERVICE, AND EXAMPLES. BUT THE CRITICAL CHOICES REST WITH EACH INDIVIDUAL. AND THEY ARE FREE CHOICES IN NEARLY EVERY CASE, NOT MANDATED BY LAW -- AT LEAST NOT YET.
THIS TWO-FOLD CHANGE IN THE WAY WE LOOK AT HEALTH IN AMERICA HAS NOT YET BEEN FULLY ABSORBED BY THE AMERICAN PEOPLE, ALTHOUGH THEY SEEM WILLING ENOUGH TO LEARN.

NOW, IT'S TRUE THAT AMERICAN PUBLIC HEALTH HAS ALWAYS HAD A STRONG PREVENTIVE BASE:

WE WERE BROUGHT UP ON VACCINATION PROGRAMS AND WATER FLUORIDATION AND BLOOD PRESSURE CHECK-UPS AND SO ON.
NEVERTHELESS, I THINK THE OVERALL PERCEPTION AMONG THE AMERICAN PEOPLE IS STILL AN OLD-FASHIONED ONE: THAT IS, THAT PUBLIC HEALTH AND MEDICAL AND NURSING PERSONNEL ARE REALLY ON THE JOB TO PATCH YOU UP IF YOU GET HURT OR TO CURE YOU IF YOU GET SICK. IN OTHER WORDS, THE PATIENT IS PASSIVE AND THE HEALTH SYSTEM IS THE ONLY ACTIVE PARTY.
I think the public still adheres to the idea that the patient is supposed to "follow the doctor's orders."

Of course, by "following the doctor's orders," the patient will do those things that will help him or her regain the lost status of full health.
WE IN THE PUBLIC HEALTH PROFESSIONS HAVE BEEN
DILIGENTLY TRYING TO TURN THAT CONVENTIONAL WISDOM
AROUND. AND I THINK WE ARE!

HEALTHCARE IS NOT SYNONYMOUS WITH DOCTORS AND
HOSPITALS. HEALTHCARE MEANS PREVENTION TOO. REMEMBER,
THE MOST FREQUENT CAUSES OF PREMATURE MORTALITY ARE:
SMOKING, DRINKING TOO MUCH, NOT WEARING A SEATBELTS.
YOU CAN TAKE CARE OF THESE PROBLEMS FOR YOURSELF.
THIS MEANS WE HAVE TO MAKE A COMMITMENT TO HEALTH EDUCATION THAT IS FAR GREATER THAN THE ROUTINE AND ALMOST CEREMONIAL ATTENTION WE USUALLY GIVE IT.

THIS MEANS WE NEED TO TAKE VERY SERIOUSLY THE NEEDS OF OUR SCHOOLS AND COLLEGES TO DELIVER TO THEIR STUDENTS A COHERENT, CONSISTENT, AND UNDERSTANDABLE PUBLIC HEALTH MESSAGE.
AND I THINK THIS ALSO MEANS WE NEED TO UNDERSTAND AND NURTURE THE PATCHWORK OF SELF-HELP AND GROUP-SUPPORT MECHANISMS THAT HAVE POPPED UP SPONTANEOUSLY AND PROFUSELY AMONG THE GENERAL PUBLIC OVER THE PAST DECADE OR SO.
SOMETHING --LIKE PREVENTIVE HEALTHCARE-- THAT MAKES YOU FEEL BETTER AND SAVES YOU MONEY SHOULD CATCH ON.

AMERICANS, AS EMPLOYERS AND EMPLOYEES HAVE COME TO REALIZE THAT HEALTHY WORKERS SAVE EVERYONE MONEY.

THEY SAVE EMPLOYERS MONEY IN HEALTH BENEFITS PAID, THEY SAVE EMPLOYEES MONEY IN INSURANCE COSTS.
THE JOHNSON & JOHNSON COMPANY, KNOWN FOR SELLING
HEALTH PRODUCTS, DECIDED TO SELL HEALTH TO ITS OWN
WORKERS, BY INSTITUTING A WELLNESS PROGRAM AIMED TO
DECREASE HEALTHCARE COSTS BY CHANGES IN EMPLOYEE
EATING HABIT AND EXERCISE. IN A CONTROLLED STUDY, THEY
FOUND THAT DURING THE FIRST YEAR, THE WELLNESS PROGRAM
COST MORE THAN IT SAVED, THE SECOND YEAR IT BROKE EVEN,
THE THIRD YEAR IT MADE ENOUGH TO PAY BACK THE FIRST
YEAR LOSSES.

THEIR GOALS WERE PRETTY SIMPLE, PRETTY BASIC: STOP
SMOKING, EAT LESS FAT, MORE FRUIT, BUCKLE UP, GET SOME
EXERCISE.
I think we're making great strides in the anti-smoking area.

The percentage of the adult population who smokes is steadily declining and that's excellent.

There's also been a drop in the consumption of hard liquor, with a shift to beer and wine -- or better still, fruit juice and water. As a result, there's been a dramatic drop in chronic liver disease and cirrhosis mortality in general.
PEOPLE SEEM TO BE EATING LESS FAT, PARTICULARLY SATURATED FAT AND CHOLESTEROL. THE DROP IN CIGARETTE SMOKING AND THE REDUCTIONS IN FAT IN THE AVERAGE PERSON'S DIET HAVE COMBINED TO CONTRIBUTE TO THE DECLINE IN HEART DISEASE AND STROKE DEATHS OVER THE PAST 10 TO 15 YEARS AS WELL. THERE'S NO DOUBT ABOUT THAT.
WHEN WE CONVINCE OURSELVES TO EAT A PROPER DIET,
TO SAY "NO!" TO DRUGS LIKE ALCOHOL AND NICOTINE,
WE TAKE CHARGE OF OUR HEALTH.

DON'T RELY COMPLETELY ON HIGH-COST HIGH-TECH MEDICINE
TO SAVE YOUR LIFE.
OR AS SOME PEOPLE SAY:

"YOU CAN AFFORD PREVENTION ... YOU CANNOT AFFORD A QUADRUPLE BY-PASS."

TO BORROW A MOTTO FROM AN EARLIER AGE:

"LIVING WELL IS THE BEST REVENGE."
LIVING WELL ... LIVING SENSIBLY ... LIVING A HEALTHY LIFESTYLE ... LIVING ACCORDING TO AN ETHIC OF PREVENTION ...

THIS IS YOUR "BEST REVENGE" AGAINST THE 3 D'S OF DISCOMFORT, DISEASE, AND DISABILITY.

AND IT'S YOUR BEST HEDGE AGAINST THE 4TH AND FINAL D:

DEATH ITSELF.
I CALL UPON THE AMERICAN PEOPLE TO DEMONSTRATE THEIR
COMMON SENSE BY TAKING UP THE CAUSE OF HEALTH
PROMOTION AND DISEASE PREVENTION THROUGH SENSIBLE
PERSONAL CHOICES.

WHEN I WAS SURGEON GENERAL I WAS INVOLVED IN A NUMBER
OF COMPLEX PUBLIC HEALTH ISSUES: SMOKING, OF
COURSE...AND THE "BABY DOE" ISSUE...AND THE RISE OF THE AIDS
EPIDEMIC...AND DRUNK DRIVING AND FETAL ALCOHOL
SYNDROME...INTERPERSONAL VIOLENCE. . . AND ORGAN
TRANSPLANTATION...AND SEVERAL MORE.
BUT IN EACH CASE, TO A GREATER OR LESSER DEGREE, I LOOKED TO THE AMERICAN PEOPLE FOR THEIR UNDERSTANDING AND SUPPORT--THEIR EMOTIONAL, INTELLECTUAL, SOCIAL, AND POLITICAL SUPPORT--BECAUSE I CAME TO KNOW THAT THEY WOULD MAKE THE DIFFERENCE BETWEEN PROGRESS...AND FAILURE.

TAKE CHARGE OF YOUR OWN HEALTH.....AND URGE THE PEOPLE CLOSE TO YOU TO DO THE SAME.
NOW I' D LIKE TO SAY A FEW WORDS ABOUT A TOPIC THAT MAY
SEEM REMOTE TO MOST OF YOU, BUT WILL SEEM IMMEDIATE
SOONER THAN YOU THINK: AGING.

AS I LOOK ACROSS THIS AUDIENCE I DON'T SEE ANYONE WHO
LOOKS ELDERLY.
humorous lines: in section on aging; use elsewhere if not speaking on aging:

FORTUNATELY SOME OF US OLDER FOLKS MUST HAVE GOOD GENES, BECAUSE WE'VE LIVED SO MANY YEARS BEFORE THESE HELPFUL HEALTH WARNINGS. WE'VE EATEN FAR TOO MUCH LARD, NEVER JOGGED UNLESS WE WERE LATE FOR A TRAIN, THOUGHT FIBER WAS PART OF CLOTHING NOT DIET, AND WE'VE MADE IT TO OLD-AGE. OF COURSE, IF WE'D KNOWN WE'D LIVE SO LONG, WE'D HAVE TAKEN BETTER CARE OF OURSELVES.

*******

I'VE DECIDED THAT BIRTHDAYS ARE GOOD FOR YOU. THE PEOPLE WHO HAVE THE MOST OF THEM LIVE LONGEST.

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[COPuple WHO WENT TO HEAVEN........OAT BRAN]