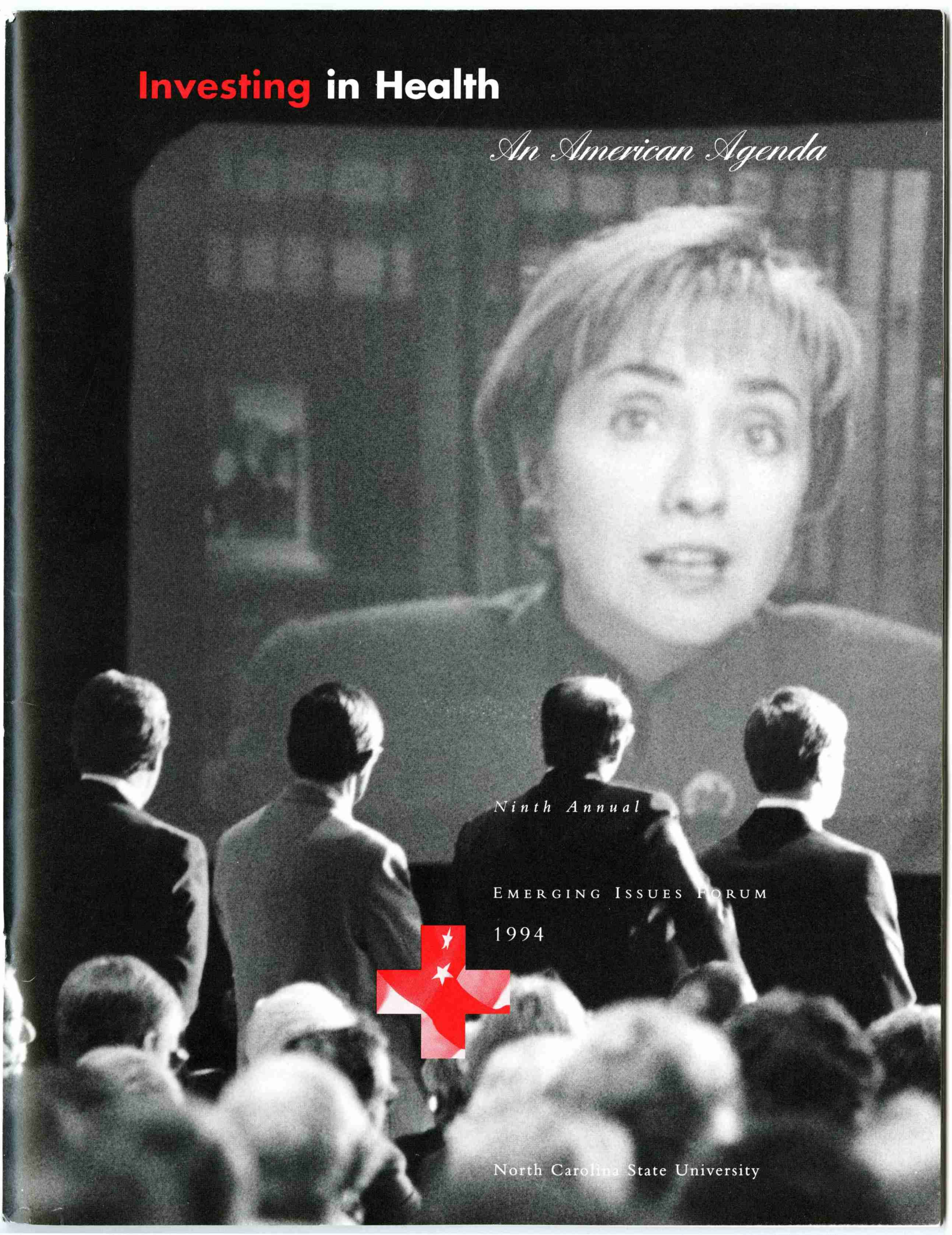
Investing in Health

An American Agenda



Ninth Annual

EMERGING ISSUES FORUM

1994

North Carolina State University

Investing in Health

An American Agenda

From the opening salvo to the closing challenge, the 1994 Emerging Issues Forum engaged participants in thoughtful discussion on the theme "Investing in Health: An American Agenda."

It opened with Chrisopher Conover of Duke University's Center for Health Policy Research and Education on the need for health reform: "The price of waiting is too high."

It closed with Washington Post columnist David Broder's analysis of the state of the republic: "Health care is a huge and important test, not just of the health care system, but of the political and governmental system."

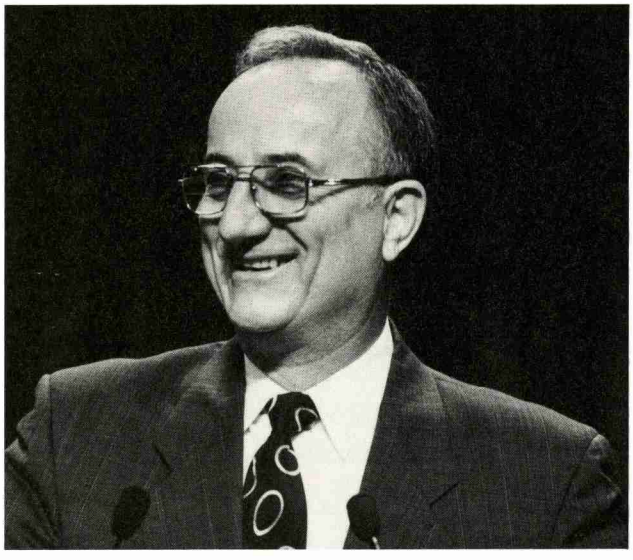
In between came Hillary Rodham Clinton, Surgeon General Joycelyn Elders, and a host of others, each with a thought-provoking message on the state of American health care and the potential for reform. Mrs. Clinton appeared courtesy of a two-way television link, arranged when icy weather forced her to cancel her scheduled trip to Raleigh.

Approximately 1,300 people attended all or part of the forum, held February 10-11 at the McKimmon Center on the campus of North Carolina State University in Raleigh. About 500 students participated from a satellite location at the Student Center Annex.

Thousands more were able to view parts of the conference. The UNC Center for Public Television taped Mrs. Clinton's afternoon appearance and broadcast it statewide during prime time. The C-SPAN network also broadcast Mrs. Clinton's keynote address and other segments of the conference, and the N.C. Agency for Public Telecommunications ran the conference on its Open Net line.

This report summarizes the major addresses of this two-day conference and offers some additional information designed to further discussion of the American health care system.

NCSU: *Commitment to health care*



North Carolina State University took great pleasure in sponsoring the 1994 Emerging Issues Forum. "Investing in Health" truly is an American agenda, as the conference theme states. Health is also a North Carolina State University agenda.

Approximately 650 of our students are enrolled in pre-medical and pre-dental programs. In addition, faculty in almost every college and department on this campus engage in health-related research. In chemistry, physics, textiles, veterinary medicine, biology, food science, engineering, and design, scientists are seeking answers that will prevent us from becoming ill, that will cure what ails us, and that will help us to live richer, fuller lives with those disabilities we cannot cure.

At the College of Textiles, for example, one group of researchers has advanced our understanding of brown lung disease. Others are studying new materials for use in sutures and surgical gowns.

In the College of Veterinary Medicine, faculty are investigating cancer therapies and multiple sclerosis. Others study animal diseases that resemble AIDS in humans.

Elsewhere on campus, researchers are gaining insight into diseases by learning more about how the body uses iron. They're studying how tumors develop. They're testing compounds that might deliver drugs more effectively and with fewer side effects.

Finally, computer scientists here are contributing vital skills for an experiment in advanced telemedicine.

We have important partners in this research. Our scientists work closely with leading schools of medicine—at Duke, Carolina, and Tulane, for example. And they receive funding from the National Institutes of Health, the National Institute of Environmental Health Sciences, the Environmental Protection Agency, and the National Institute of Occupational Safety and Health.

North Carolina State also works to make sure that the people who need health information get it. Toward this end, the Cooperative Extension Service operates the Rural Health Program to provide people throughout the state with accurate, up-to-date information on health and nutrition. In addition, North Carolina State and East Carolina University have established a program in agromedicine to improve the prevention and treatment of farm-related disease and injury.

All of this, of course, is just a sampling of our involvement in health care.

The 1994 Emerging Issues Forum demonstrates the resolve of this university not merely to provide answers but to help the people of North Carolina understand the issues in the current health care debate.

Health care reform: *A challenge that must be met*

Each year the Emerging Issues Forum focuses the attention of North Carolina's leadership on a single issue of national or international importance. Seldom has the issue been so timely as in 1994. Two weeks after President Bill Clinton challenged Congress to enact health care reform this year, the forum drew more than 1,300 people to Raleigh to discuss the topic "Investing in Health: An American Agenda."

Our discussion was not only timely, but critical. Health care reform is gripping the hearts and minds of the American people. These are people who have seen their medical bills go up and their insurance coverage go down. They are afraid that if they lose their job or if they change jobs, they will lose their health insurance and not be able to get any more. They are people forced into bankruptcy by one serious illness or accident. The American people are telling us that the system is broken and we must fix it.

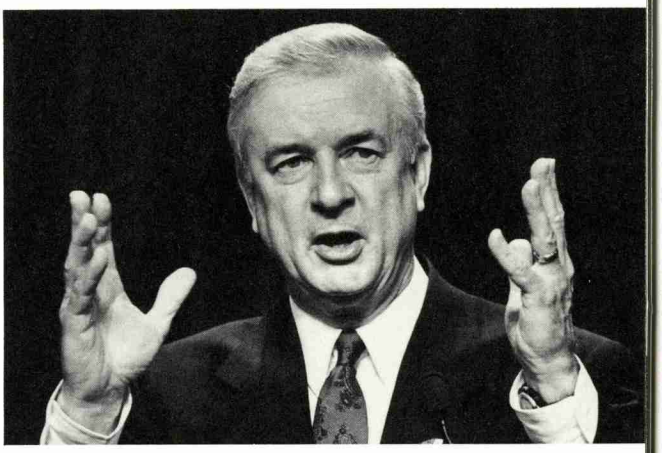
Statistics reinforce the message. Consider that we in America spend more on health care than any nation in the world — 15 percent of our Gross Domestic Product — yet people in approximately 20 other countries can expect to live longer than we do, they are less likely to suffer fatal heart disease than we are, and their children are less likely than ours to die in infancy.

The story is the same throughout the country. Nationally, more than 38 million Americans had no health insurance coverage during all or part of last year. Here in North Carolina, one million people had no health insurance. A quarter million of these North Carolinians were children, and more than 300,000 were women of child-bearing age. These people delay visiting the doctor when they're sick so they're sicker when they go and cost more to treat. And they are more likely to die.

The system is indeed broken. How to fix it is one of our nation's toughest, most complex problems. That's why, for our discussion, we brought in the experts—some of the same people who are leading the national debate: first lady Hillary Rodham Clinton; Surgeon General Joycelyn Elders; Bill Gradison, president of Health Insurance Association of America; Florida Gov. Lawton Chiles; and David Lawrence of the Kaiser Foundation Health Plans, among others.

We approached the issue from many angles. We learned about the competing reform proposals and discussed them from the point of view of the consumer, the physician, the insurance company, and the business owner. We stepped outside of specific reforms and talked about trends, values, and our way of life—all of which affect the demands placed on the health care system. We considered how national reform will affect us here in North Carolina. I am certain that each of us who attended came away with a better understanding of the issue and the possibilities for reform.

This understanding is vital for more reasons than we may have considered starting out. At our closing session, Washington Post columnist David Broder reminded us of the increasing erosion of public confidence in Congress. Few issues touch



"Our discussion was not only timely, but critical. Health care reform is gripping the hearts and minds of the American people."

—James B. Hunt, Jr., *governor of North Carolina*

"The public's voice has to be heard on this issue or more than health care will be damaged in this country. The whole concept of representative government will be damaged."

— David S. Broder, *Washington Post columnist*

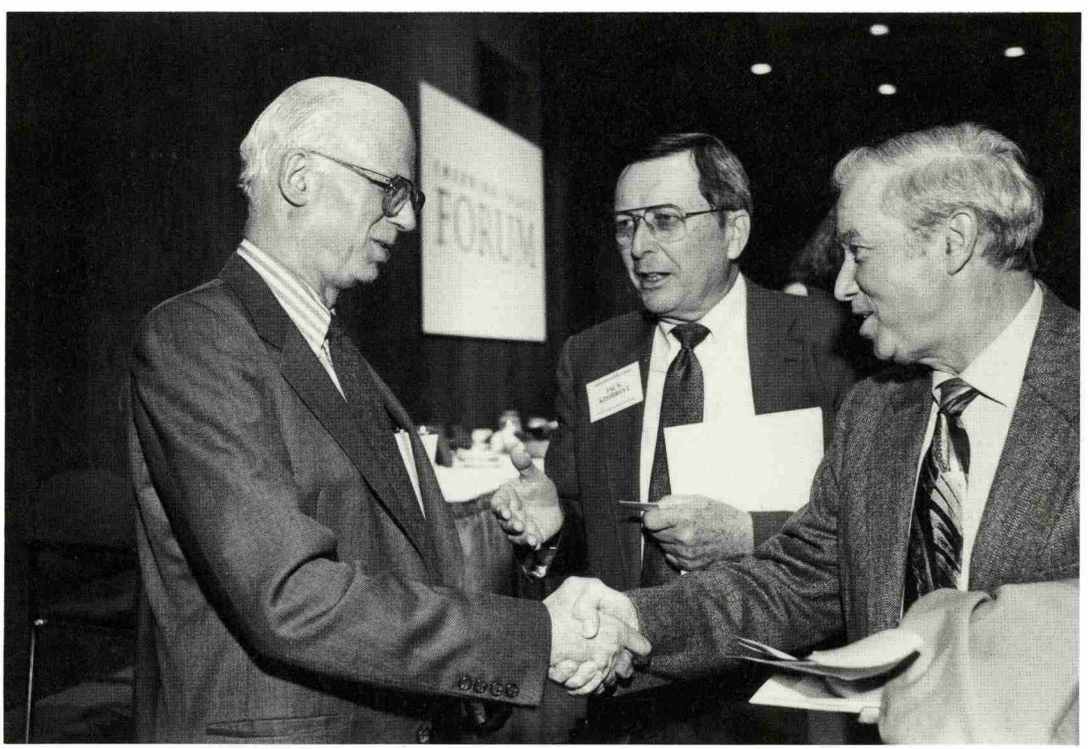
as many people as health care, but the American people are concerned that in this very complex and very personal issue, their voices will be drowned out once more by big business and special interest groups. The people must be brought into the discussion, given the tools to understand the proposals, and given the opportunity to be heard.

In words that sounded both ominous and honest, Broder said: "The public's voice has to be heard on this issue or more than health care will be damaged in this country. The whole concept of representative government will be damaged."

We cannot allow this challenge to go unmet. I am pleased that the 1994 Emerging Issues Forum has contributed to other efforts nationwide to let the people's voice be heard on health care. As we always do, we encourage those of you who joined us in Raleigh and others interested to use the discussions here as a springboard for discussions in your home communities. We will be pleased to make our publications, videotapes, and audio tapes available for your use.

Adlai Stevenson once said, "Americans have always assumed...that the application of enough energy and good will can make everything come out right." In facing the health care challenge and simultaneously the challenge to democracy, I am confident that we will summon up that energy and good will to overcome once more such a pressing national challenge.

David S. Broder greets Forum attendees.



Tinkering around the edges won't fix what's wrong

The Clinton Administration health care plan promises real reform, not just tinkering around the edges, first lady Hillary Rodham Clinton said.

She said she learned the necessity of reform during the year in which she traveled around the country collecting information as chair of the Task Force on National Health Care Reform. "We have the best doctors, the best health care professionals, the best hospitals and research institutions in the world," she said. "We also have probably the stupidest and most expensive way to finance health care in the world."

Clinton appeared at the forum over a live, two-way television connection. Icy weather had prevented her from traveling to Raleigh. (See accompanying article.) During the session, she took audience questions covering such issues as rural health care, Medicare, and the effect of health care reform on small businesses.

The nation needs to preserve and build on what is good and fix what is broken in the health care system, Clinton said during her prepared remarks. Outlining how the administration's plan for managed competition would accomplish these goals, she said it would:

- Provide every American guaranteed health care coverage from a private insurer or managed care provider.
- Create a standardized, comprehensive package that covers preventive care and prescription drugs.
- Make it illegal for a health care plan to drop people because they are sick or old.
- Eliminate lifetime limits on coverage.
- Require one standard claim form for all plans.

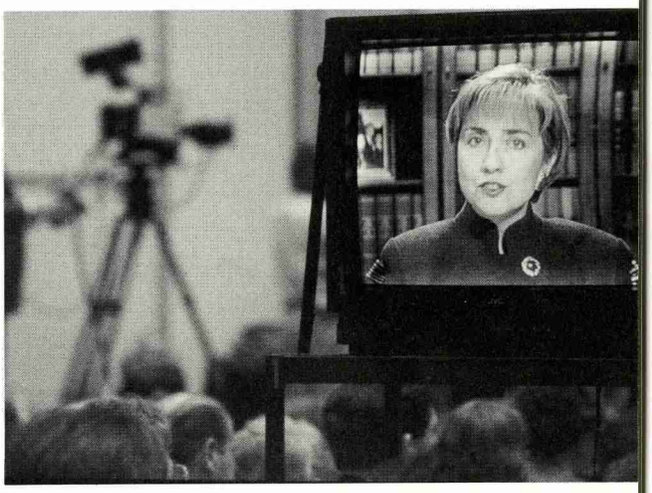
Most people will continue to get insurance coverage through their employers, Clinton said. The difference will be that each employer, or in some cases a regional alliance representing a larger group, will offer several plans for the individual or family to choose from.

"What we're hearing is that employers, under pressure to control costs, are eliminating choices for their workers," she told one questioner. "Under the president's plan, which doctor and which health plan you sign up for will be your choice, not your employer's and not your insurance company's."

All plans would cover specified services, including mental health care, and none could be canceled. "You pay a fair, affordable price for security," she said, "and when you get sick, you have health care that is always there, no matter what."

Physicians, hospitals, and other care-givers would also be allowed to choose which plans to join. And because the standard form would reduce paperwork, she said, "We can go back to using the doctor's offices and hospitals as places of healing, not monuments to paperwork and bureaucracy."

Rural areas would benefit from the administration's plan in several ways, she told a questioner. First, she said, by providing coverage for everyone, it would create a stable financial base for the delivery of care in rural areas. It also would offer incentives for health care providers to locate in underserved areas and would increase reimbursement rates for rural hospitals, she said. Finally, she said, it would improve the support network for rural physicians through the use of



"We have the best doctors, the best health care professionals, the best hospitals and research institutions in the world. We also have probably the stupidest and most expensive way to finance health care."

— Hillary Rodham Clinton, *chair, Task Force on National Health Care Reform*

telecommunications and other technologies.

To another questioner, she acknowledged the financial struggles many small businesses face. The administration's plan does require all businesses to share responsibilty for covering their employees' health care, she said, but it does so in a way that would help smaller companies. Currently, many must pay 35 to 40 percent more than larger companies for the same insurance coverage, she said. The administration's buying pools would give them bargaining power to obtain lower premiums, she said. It also would subsidize the costs for very small businesses and for low-wage employees, she said. As a result, she said, it would cost companies only 30 cents an hour to insure an employee.

Clinton compared the speculation about the employer mandate with discussions that arise whenever Congress considers raising the minimum wage. "There's always hue and cry about the jobs that will be lost," she said, "but there's no evidence that it happens. Small businesses fail for a host of reasons, but not because of minimum wage."

The Clinton Administration wants to phase in the reforms so the system continues to run smoothly during the transition, she said. For example, it preserves Medicare, the government-sponsored health coverage for the elderly, as a separate system but adds coverage for prescription drugs and begins to provide for some long-term care. On the other hand, Medicaid, which pays for health care for the indigent, is included in the reform proposal.

"Medicare is now the only system of guaranteed health security for any group," she said. "At least we have that. We know there are problems with it, such as all the nitpicky paperwork and the reimbursement rate for primary care physicians, and we plan to address those. But we want to get the whole system up and running before we try to bring Medicare into managed competition. It's too big a challange to take on at the same time."

Several competing reform proposals also are being debated in Congress. Clinton cited what she considered to be differences between the president's approach and other proposals:

- The Clinton plan uses savings in the growth of Medicare to provide better health coverage for older Americans. She said other proposals use the savings to pay bills unrelated to health care.
- It spells out in the law a comprehensive benefits package with low deductibles. She said others provide either a basic package with high deductibles or leave coverage issues to a government board to decide after the law is passed.
- It outlaws all insurance discrimination based on illness or age. She said other plans may prevent insurance companies from dropping or excluding people, but they allow the premiums to increase with age and illness.

"We believe the president's approach is the best way to achieve the goal of guaranteed private insurance for every American that can never be taken away," she said.

U.S. first lady Hillary Rodham Clinton chaired President Clinton's Task Force on National Health Care Reform.

The Emerging Issues Forum launched its first teleconference.

The Secret Service said "no go," but Hillary Rodham Clinton appeared at the Emerging Issues Forum anyway.

An ice storm during the February conference forced Clinton to cancel plans to fly to Raleigh less than three hours before she was scheduled to appear at the forum. She showed up nonetheless and answered questions from the audience over a live, two-way television hookup arranged in only two hours.

It was made possible by a dauntless crew from the UNC Center for Public Television, a satellite truck from WRAL television, and a little good luck.

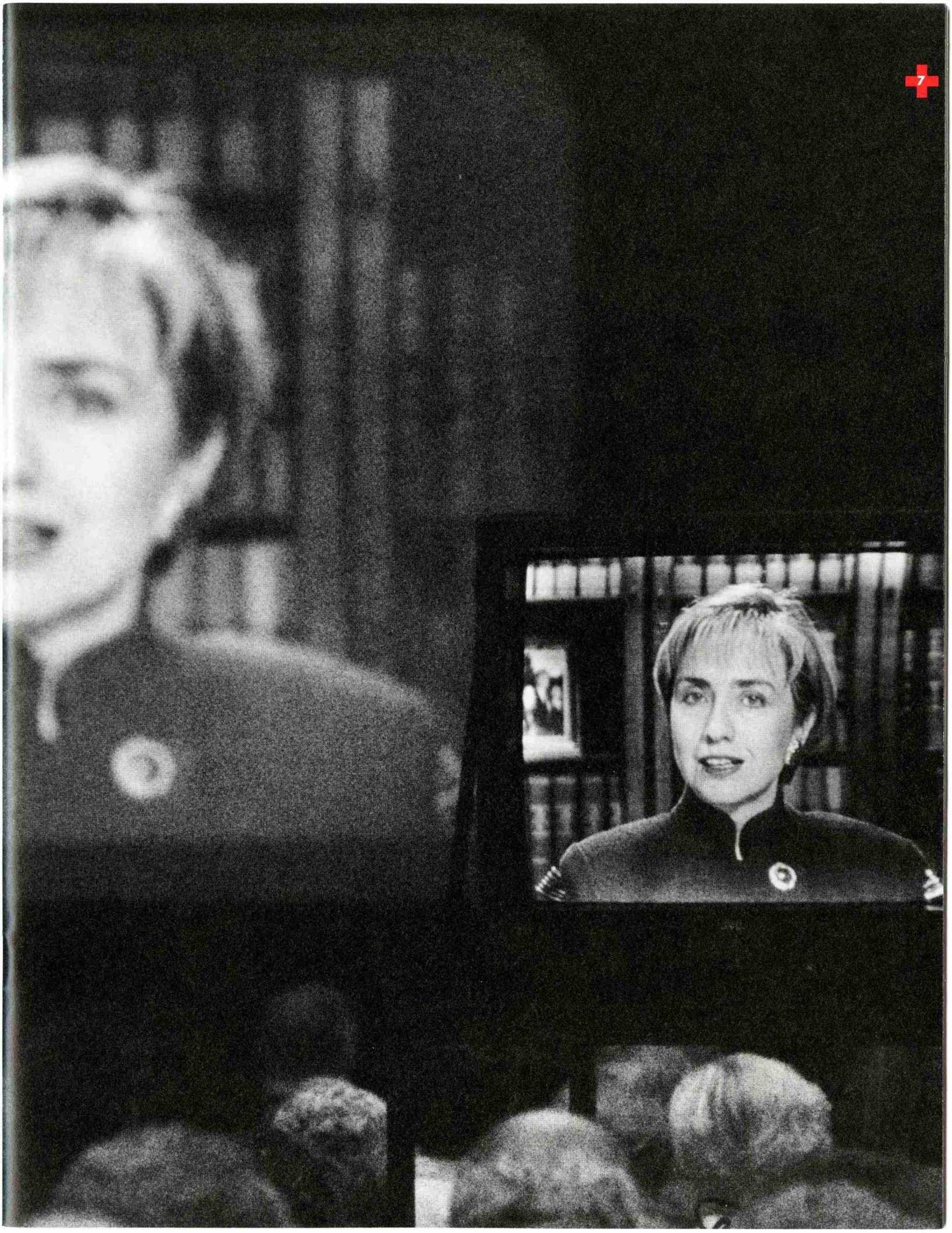
Clinton was scheduled to address the forum at 4:30 Thursday afternoon. At 2 p.m., forum chairman Gov. Jim Hunt received her call saying the Secret Service had put its foot down. Gov. Hunt offered an alternative: a satellite link. Clinton was willing, and the White House had the necessary equipment on its end. The question became whether it could be arranged in time at this end.

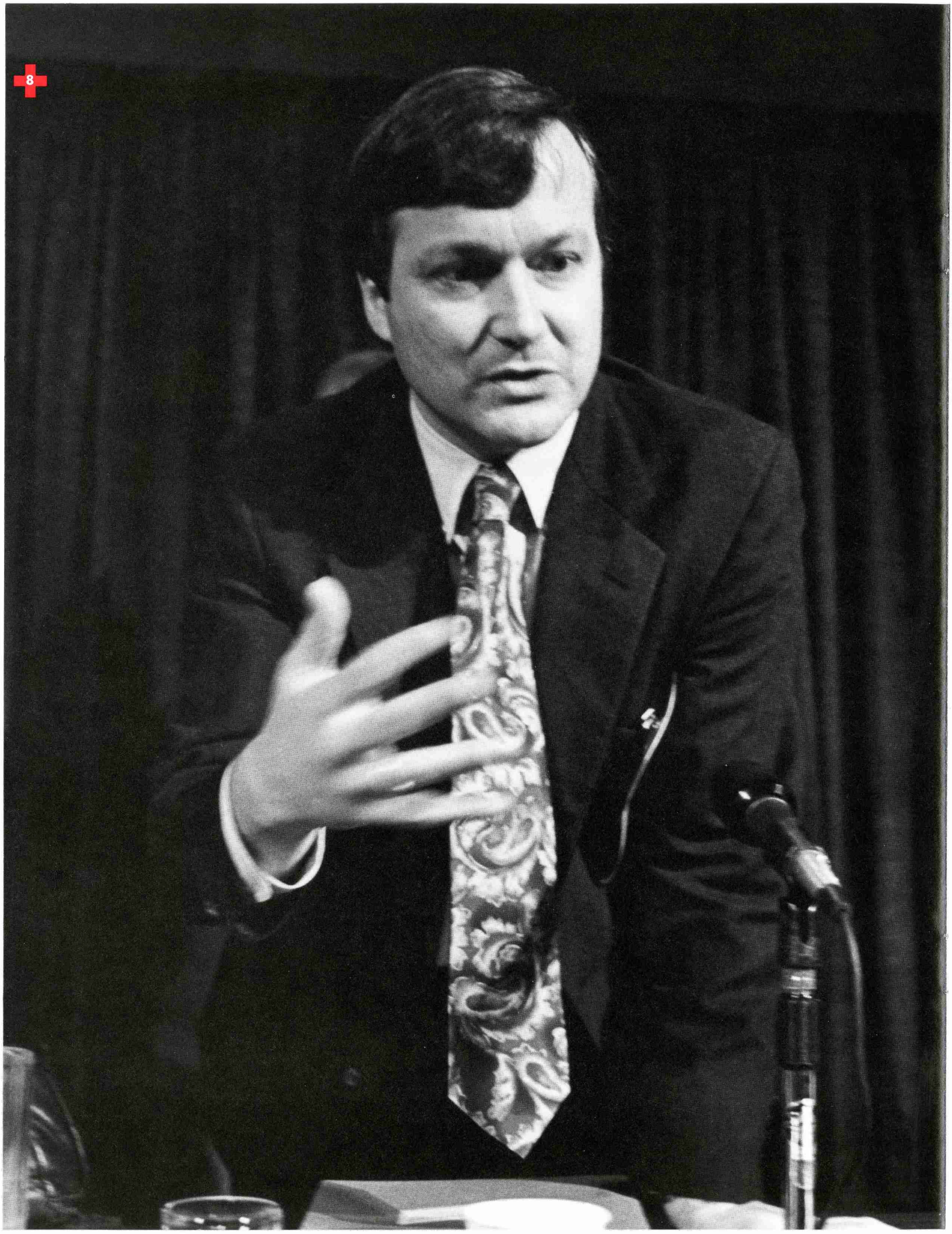
Forum director Betty Owen immediately put the question to UNC-TV producer Tim Ruffin and engineer Sam Garfield. The UNC-TV crew was already at the McKimmon Center videotaping the forum and was scheduled to broadcast Clinton's address statewide that evening. As it happened, WRAL had a satellite truck parked at the McKimmon Center in preparation for Clinton's appearance. If they could get permission to use WRAL's truck, Ruffin said, maybe, just maybe they could pull it off.

Owen picked up the phone and called Jim Goodmon, president of Capitol Broadcasting, which owns WRAL. On an afternoon when offices all over Raleigh had started to shut down because of the weather, Goodmon answered his own phone.

After a brief explanation, Goodmon gave his approval. Then all the UNC-TV crew had to worry about was buying time on a satellite and figuring out how to handle the different hookups without getting the signals tangled—from the White House to the satellite, from the satellite to the McKimmon Center, from the McKimmon Center back to the satellite and the White House (so Clinton could see and hear the audience), from McKimmon to the UNC-TV studio, and from McKimmon to students watching from another location on the NCSU campus.

The crew worked. Betty Owen paced. At 4 p.m., Hunt got a thumbs up. The signal from the White House was coming through.





Universal coverage, system reform can save health dollars

Calling the current health care system a mess, Christopher Conover said the solution must combine universal coverage with system reform. The result for North Carolina, he said, would be $3 billion in savings over the next decade.

"In short," he said, "we can have our cake and eat it, too, but only if we are willing to undertake major reform of the system."

Before reaching his conclusion, Conover described the problems with the existing system and walked through the pros and cons of the major reform proposals under discussion.

He outlined three basic problems with the current system:

- **Inadequate access to health care caused by financial and geographic barriers.**

"The system is unraveling so fast that it is outstripping our best efforts to address it," Conover said. The number of uninsured North Carolinians has doubled over the last decade even though Medicaid coverage also has doubled, he said. Today, 1 million North Carolinians—mostly workers or family members of workers—lack any health insurance coverage. Nearly as many people are underinsured.

Inadequate insurance is increasingly a middle-class problem as rising costs force employers to reduce benefits, Conover said. Small companies are least able to afford health insurance for their workers because their rates often cost ten times those of large companies.

Just as some companies are at a disadvantage, so are some regions of the state. Conover said more than one-third of the state lacks sufficient numbers of health professionals to provide basic care for the population. Poverty levels run high in some of these areas, and as much as 20 percent of the people lack health insurance.

- **Excessive cost.**

The health care burden on the typical family—including insurance premiums, the health-related portion of taxes, and direct health care costs—has tripled since 1980, Conover said. To make matters worse, it's expected to double again by the year 2000.

The burden is great on the state as well. By the year 2000, he said, subsidized health care is expected to consume as much as 47 percent of the state budget. This will make it increasingly difficult to afford other state services. In addition, there is a hidden burden on the insured as costs are shifted to cover the uninsured. This cost-shifting increases the health bill of those who are insured by 25 percent.

A considerable portion of these costs are attributed to red tape (six percent) and other waste, such as unnecessary tests, medication, and hospital stays (20 to 33 percent). Despite its high visibility and obvious need of reform, Conover said, the malpractice system is not a major contributor to costs.

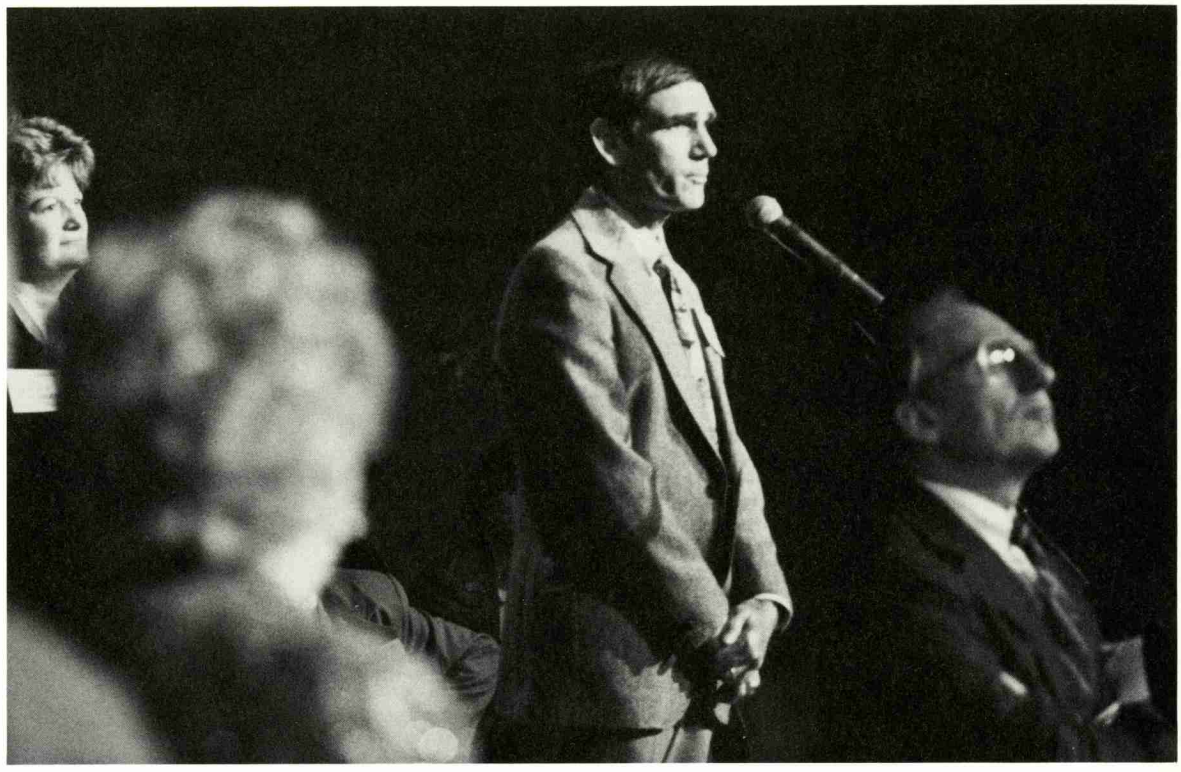
- **Uneven quality.**

The U.S. health care system favors treatment over prevention, Conover said. Lifestyle changes alone could achieve significant reductions in health care costs. In fact, 40 to 50

Speaker Dan Blue and Sarah Jordan enjoy an exchange.

"The president is not exaggerating in describing this as the most complicated policy problem since Social Security."

— Christopher J. Conover, *associate in research, Center for Health Policy Research and Education, Duke University*



"The system is unraveling so fast that it is outstripping our best efforts to address it."

— Christopher J. Conover, *associate in research, Center for Health Policy Research and Education, Duke University*

percent of costs are attributed to such lifestyle issues as use of seatbelts, tobacco, alcohol, and illegal drugs.

In addition, people who cannot afford health care scrimp on preventive and primary care. This delays care until conditions are more serious and more expensive to treat. The uninsured also are more likely to die needlessly.

Solutions to the health care crisis address two fundamental issues: Who gets covered? How are costs controlled?

If everyone is to be covered, Conover said, experience shows that it must be mandated. This can be handled through a single-payer system, through a mandate that employers provide at least some coverage, or through an individual mandate, which places the responsibility on the individual or family. "Although the president has drawn a line in the sand on this issue, the fact is that most of the alternative plans now under discussion do not guarantee universal coverage," Conover said.

For cost containment, most countries rely on price controls or global budgets. The other possibility being discussed here relies on market forces to hold down prices.

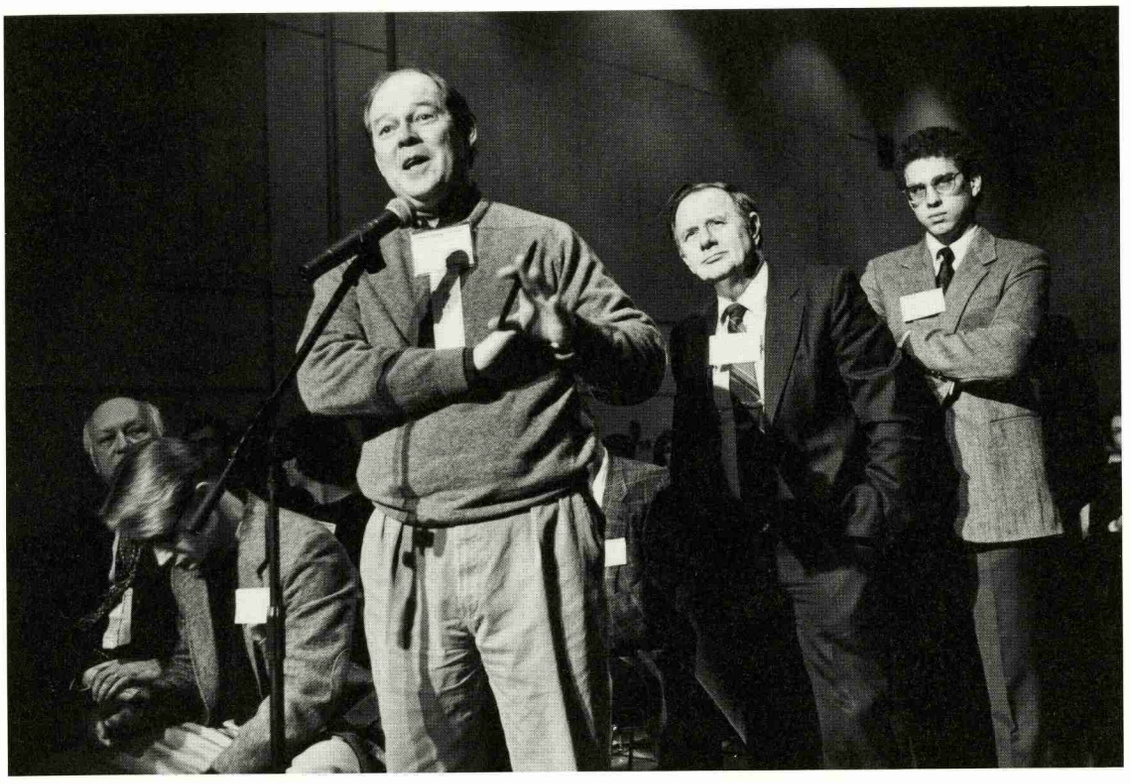
Although numerous proposals for improving the system have been put forward, Conover said they boil down to three basic approaches: single payer, managed competition, and insurance reform. He discussed those three approaches, along with their advantages and disadvantages.

Single payer

This is basically government insurance, often compared with the Canadian plan. The government, companies, and individuals would all contribute to a common pool, which would be used to pay for all health care services defined under a basic national package. The program could be set up to allow each state to administer its own plan.

Advantages

- It would be simple to administer.
- Consumers, or patients, could choose any health care provider they wished.
- The pool would have bargaining power to obtain lower rates from providers.



Disadvantages

- It would cause a major disruption of the current system.
- If the Canadian example proves true here, there could be long waits for elective procedures, and some types of care may be rationed.
- It may encourage inefficient use of some resources.

Managed competition

This method encourages competition among a number of health plans through large purchasing pools. Each pool, generally defined by geographic area, would select a variety of plans—such as health maintenance organizations or insurance—to compete in its area. Health care providers could join the plan they wished. Individuals or families then would choose which plan to join for the year, and the pool would pay the plan a flat fee to cover them. Families desiring plans with extra benefits could elect to pay an additional out-of-pocket fee for their premiums.

Advantages

- Consumers have more choice than under employer-selected plans.
- It encourages prevention and health promotion.
- It encourages cost-effective treatment.

Disadvantages

- This proposal has not been tested on a large scale and is difficult to explain to the public.
- It would add costs for regulation and information gathering/dissemination.
- The flat fee system provides an incentive to undertreat patients.

Key Statistics

In the United States:

- *In 1993, health care costs consumed approximately $940 million, or 14.4% of the Gross Domestic Product. (1)*
- *If current trends continue, U.S. health care will cost $1.6 trillion, or 20% of GDP, by the year 2000. (2)*
- *Two million Americans lose health insurance every month. (2)*
- *Two families out of every five have seen their health benefits reduced. (2)*
- *Estimates of waste (e.g., unnecessary procedures or days in the hospital) range from 19% to 33% of total health care spending.(3)*

Sources:
(1) Health Care Financing Administration
(2) Health Care Reform Project
(3) Duke University Center for Health Policy Research and Education

Among the nations of the world, the United States ranks:

- *No. 1 in health care spending.*
- *No. 20 in combatting fatal heart disease.*
- *No. 21 in infant mortality.*

Source: Health Care Reform Project

In North Carolina:

- *One million people have no health insurance. (1)*
- *Another million are inadequately covered by health insurance. (1)*
- *Of the uninsured, two-thirds hold full-time jobs or are family members of full-time job-holders. (2)*
- *In 1992, $15.4 billion was spent on health care. (2)*
- *The average hospital bill reflects a 27% mark-up to cover patients unable to pay for all or some of their hospital care. (1)*
- *If current trends continue, state residents will spend one-fourth of their total income on health care by the year 2030. (1)*

Sources:
(1) N.C. Institute of Medicine
(2) Duke University Center for Health Policy Research and Education

Insurance reform

Proposals for insurance reform expand on the current employer-based system of health insurance. Beyond that, they vary considerably, but most would simplify claim-filing by using a single standardized form that could be filed electronically; require that basic plans be made available to small groups and individuals; forbid insurers from denying or canceling coverage because of poor health; and provide government subsidies for low-income individuals.

Advantages

- It builds on the existing system.
- It addresses some of the problems of the small-group market.
- It avoids the dangers of excessive government regulation.

Disadvantages

- It does not guarantee insurance coverage for everyone.
- It retains the disadvantages of an employer-based system, such as limited choice for consumers, a loss of insurance between jobs, and higher premiums for small groups.
- It retains the cost-increasing bias of fee-for-service medicine.

"The president is not exaggerating in describing this as the most complicated policy problem since Social Security," Conover said. While all of the systems have flaws, he said, by combining universal coverage and reform, there is a realistic hope that Americans can have better quality health care at lower cost.

Christopher Conover is a research associate with the Duke University Center for Health Policy Research and Education.

Consumer group puts reform plans to five-point test

Families USA, a consumer group, has drawn up five principles for what American families want and need in health care reform, Judith Waxman said. They are:

- Health security, which guarantees coverage to all individuals regardless of health and employment status. "We need to have a health card that can never be taken away," she said.
- Comprehensive benefits. One serious illness can exceed a lifetime caps on benefits, she said.
- Fair and equitable financing. Everyone, individuals and employers, should contribute, she said.
- Enforceable cost containment. Spiraling costs are taking away wages, jobs, and opportunities, Waxman said. Unless costs can be controlled, she said, any system of guaranteed coverage will be eroded and lost over time.
- Reform now. "We want to see comprehensive reform in one package," she said. "Let's not nibble around the edges and then say we'll deal with it in another 20 or 30 years."

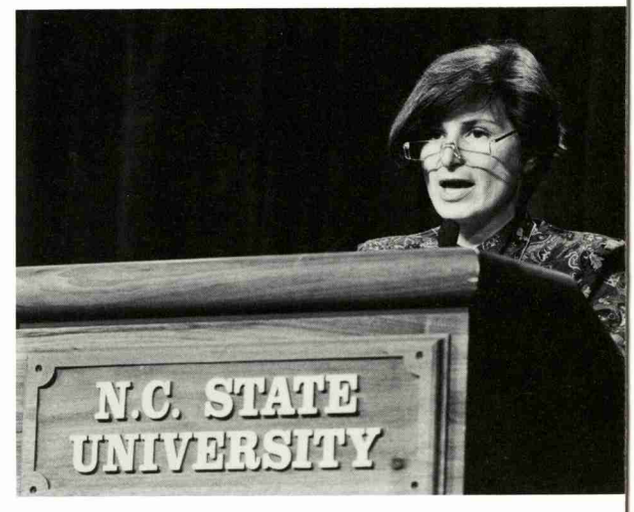
During the coming debate, she said, Families USA and other groups participating in the Health Care Reform Project will analyze the various proposals based on these five principles. The Cooper bill, a much publicized alternative to the Clinton proposal, fails the test, she said, because it does not guarantee universal coverage. A Congressional Budget Office analysis said that under the Cooper bill, 24 million people would be without coverage on any given day.

Two dynamics will push Congress to enact reform before adjourning for next fall's elections, Waxman said. The first is that Congress recognizes the problem and the public's concern. The second, she said, is President Clinton's insistence on comprehensive reform that guarantees coverage that can never been taken away.

Judith G. Waxman is director of government affairs for Families USA, a non-profit organization that advocates comprehensive reforms in health care on behalf of consumers.

"Let's not nibble around the edges and then say we'll deal with it in another 20 or 30 years."

— Judith Waxman, *director of government affairs, Families USA*



Emphasis on prevention to cure 'sick care system'

For U.S. Surgeon General Joycelyn Elders, one of the great aspects of President Clinton's health care reform proposal is that it will force the nation for the first time to invest in health.

"For too long, we have not had a health care system in our country," she said. "What we have had is a very expensive sick care system."

True reform will force the nation to spend money wisely on programs that prevent the problems that drive up costs, she said. It will also require personal responsibility.

Elders pointed to projections that health care costs will reach $1 trillion annually by the year 2000. Many of those costs are preventable. According to Elders, half of all premature deaths are related to social and behavioral choices. Drug and alcohol abuse cost the nation $110 billion in health care each year. Violence runs up another $80 billion in medical bills. Teen pregnancy—including AFDC, WIC, and Medicaid payments—costs the United States $28 billion a year.

Only one percent of health care dollars go to prevention, she said. As a result, diseases such as tuberculosis and congenital syphilis are on the rise. "We used to have good prevention programs for those," Elders said, "but we eradicated the programs before we eradicated the diseases."

She cited three important areas of responsibility for public health departments under reform:

- Data collection and research. This will, among other benefits, give physicians better measurements for outcome-based treatment, she said.
- Access to care for underserved populations. "Before we can have adequate health care for everyone, we must have an adequate system of education, outreach, information, facilities, and providers," Elders said.
- Core public health functions. These include surveillance and control of injuries and communicable diseases, environmental protection, public education, accountability and quality assurance for medical care, public laboratories for health and environmental testing, and training for public health professionals.

Elders also touched on problems in rural North Carolina when she included transportation as a key to access. "Although health care reform will work to increase the supply of practitioners, practice sites, practice networks, and health plans in underserved areas, I have often said it is far cheaper and easier to train bus drivers than it is doctors," she said. "I believe we are going to have to accept the fact that there are some places where medically trained professionals are not willing to live due to lifestyle differences. That is why transportation becomes a key component of health care reform."

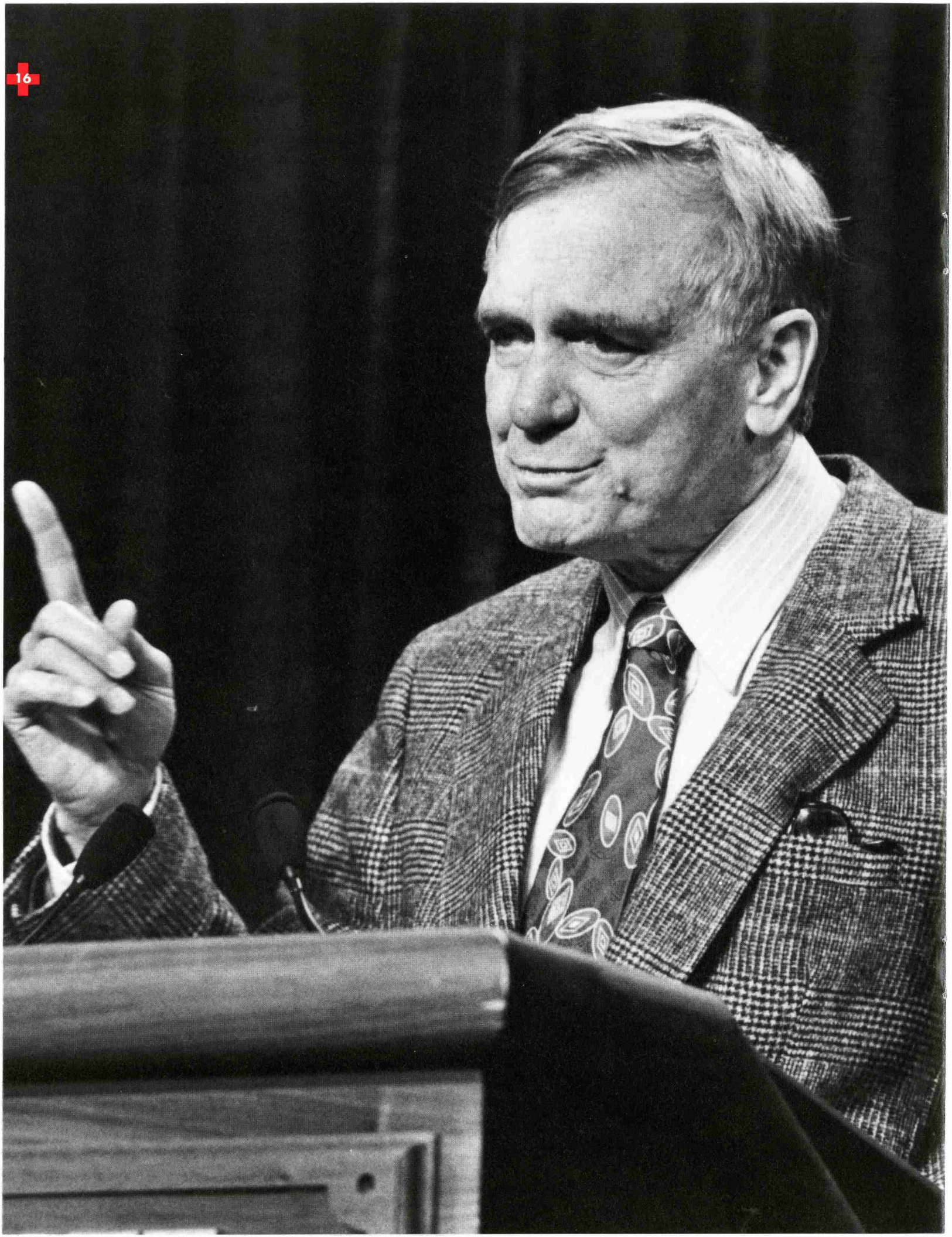
Citing North Carolina's breast cancer awareness and screening program, Elders called on health care professionals to use existing networks—including churches—to help educate the poor about healthful lifestyle choices and disease prevention. "We have to work together," she said. "We must invest in the poor and empower people to take care of themselves."

Dr. M. Joycelyn Elders is United States surgeon general and a pediatric endocrinologist.

"For too long, we have not had a health care system in our country. What we have had is a very expensive sick care system."

— U.S. Surgeon General Joycelyn Elders


ELDERS



Costs force Florida to pioneer health care reform

Florida could not wait for national health care reform, Gov. Lawton Chiles said. With nearly 20 percent of its population uninsured and some of the highest medical care costs in the country, the state was having to make drastic cuts in education, public safety, and human services to cover its growing health care bill.

The state legislature tackled the problem in 1991, when it enacted the first of a series of reforms that will ensure access for all and control costs. "We proved in Florida that when partisan interests are laid aside, great things can be accomplished," he said.

Chiles called national reform guaranteeing access to health care essential, but noted that any reform ultimately will be implemented at the state level. "Health care is one of the few remaining major industries in the country that is both produced and consumed at the local level," he said.

Florida's reforms have led to a form of managed competition similar to what President Clinton has proposed. It began with a system of managed care for Medicaid recipients, which pays physicians a flat rate per patient rather than paying on a fee-for-service basis. This saved more than $100 million over two years.

Then, last year, the legislature set up a voluntary system of eleven Community Health Purchasing Alliances. These alliances pool the purchasing power of businesses with up to 50 employees, individuals, state employees, and Medicaid recipients to get better deals on health insurance. The alliances set minimum standards for policies and then invite insurance companies to submit bids for the coverage.

Even before the system went into effect, Chiles said, some benefits were obvious, including greater cooperation among health care providers and slower growth in health insurance premiums. "People who say there is no crisis are misreading what's happening now," Chiles said. "Health care costs and insurance rates are rising more slowly because of the public concern that has been shown and the steps already taken."

Finally, savings from early reforms have enabled the state to set up a program called Florida Health Security that will provide private insurance for individuals making up to two and one-half times the federal poverty level. It will involve expanding managed care programs, reforming the reimbursement system, and obtaining waivers from some federal Medicaid rules. Although the program is voluntary now, Chiles said, eventually it will have to include a mandate for coverage.

Chiles praised the Clinton plan for allowing states like Florida the flexibility to continue their own reform processes, and he pressed the urgency of reform. He cited family bankruptcies, business problems, the growing federal deficit, and state budget cuts as evidence of the need to control costs. Universal coverage is a necessary element, he said. Without it, cost shifting and inflationary spiral will continue.

Looking back on his experience in Congress before becoming governor, he said: "In the Senate, we thought we couldn't give coverage to all until we could control costs. Now I see it's the other way around. Because of cost-shifting, we can't control costs until we have everyone covered."

Lawton Chiles is governor of Florida and chairman of the National Commission to Prevent Infant Mortality. Previously, he served 16 years in the U.S. Senate.

"In the Senate, we thought we couldn't give coverage to all until we could control costs. Now I see it's the other way around. Because of cost-shifting, we can't control costs until we have everyone covered."

— Lawton Chiles, *governor of Florida*

"America is a nation that knows what it wants, but not what it can afford. We want government services without taxes and health care without cost. We know our rights and privileges, but not our duties and responsibilities. There is a recklessness about American public policy where no one wants to tell the American public that they cannot have it all."

— Richard D. Lamm, *director, Center for Public Policy and Contemporary Issues, University of Denver*

Limited resources call for adjusting expectations

Americans cannot have it all, Richard Lamm said. At the same time that the cost of health care has spiraled, with new procedures and devices introduced every year, he said, earnings have dropped and economic growth has slowed. "We have, alas, invented more health care than we can afford to deliver to everyone," Lamm said.

Both individuals and governments have had to shift more of their resources to health care during the past 20 years. During that time, Lamm said, the average worker's paycheck dropped in terms of buying power. If health care costs had held steady with the Consumer Price Index, he said, that worker would have made $1,000 more in 1993 than in 1973. Looking at government, he said federal health care spending in 1965 equaled education spending. In 1993, he said, health care spending equaled spending for education, defense, prisons, farm subsidies, food stamps, and foreign aid.

The new era of limited resources must force the nation to ask itself hard questions in determining the level of medical care it can afford, Lamm said. Some of those questions deal with policies in an aging society.

Today, 80 percent of Americans live past 65, and the fastest growing population is people over 100. But Lamm said many medical advances have added years without restoring health. He cited a study showing that between 1951 and 1978, Canadians added six years to average life expectancy, but that they lived five of those years with severe disability.

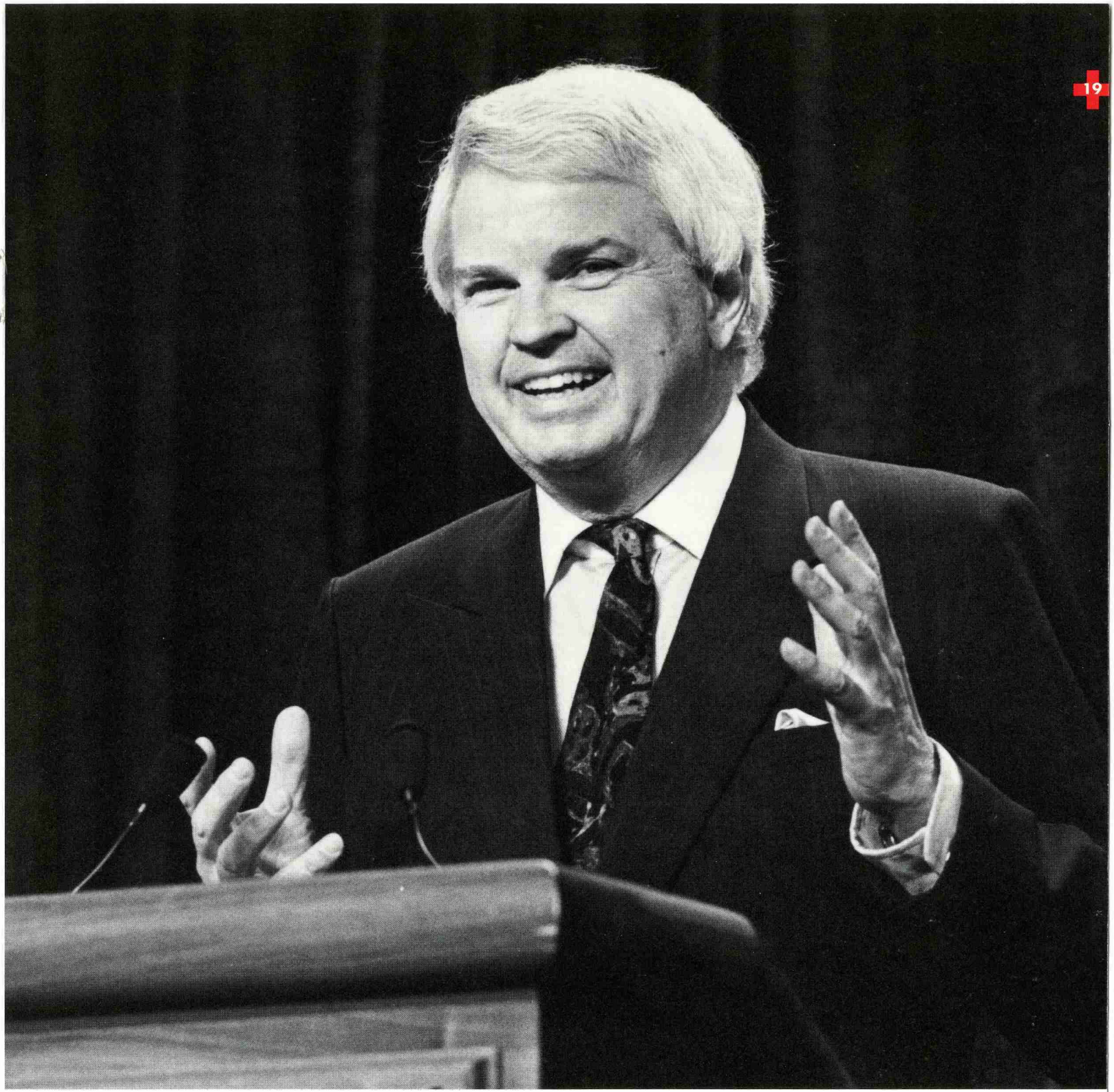
"There is no cure for old age," Lamm said, "nor is there a cure for the chronic and degenerative diseases that attend old age."

Current policies also create intergenerational inequity, he said. The elderly make up 12.5 percent of the population but receive 61 percent of government expenditures and 75 percent of health care spending. The federal debt—now at $4.4 trillion and rising—has further compromised the future of today's youth, he said. "We're not being fair to our children," Lamm said.

Despite all the United States spends on health care, Lamm said, more Americans lack medical care than do citizens of any other developed nation. This state could be alleviated if Americans would recognize the trade-offs and set priorities, he said.

He offered specific suggestions:

- Focus on the quality of life rather than quantity. "It would be nice to have both, but in a world of choices, we need to make sure we do not spend our limited resources for a pain-racked last week in an ICU."
- Favor children over the elderly. Lamm recommended raising the retirement age from 65 to 70, taxing Social Security and Medicare, balancing the federal budget, and giving the president a line item veto. He also would make age a consideration in the delivery of health care. Everyone, regardless of age, should receive kind, loving health care, he said, but when it comes to expensive procedures, a 10-year-old deserves more consideration than a 90-year-old.



- Choose cost-effective alternatives. For example, Lamm would choose preventive care over curative and low-cost procedures over high-cost.

"I believe," he said, "that a society can improve its health dramatically once it admits that it cannot do everything and starts to ask: How do I spend my money to buy the most health?"

Richard Lamm is director of the Center for Public Policy and Contemporary Issues at the University of Denver and former governor of Colorado.

Aggressive search for cures upholds American tradition

Saying "the dual drivers of economy and politics" have pushed America to a health care crossroads, David Barry pointed the way he hopes the country will travel—down the path of aggressive research to cure disease.

"Should we follow the path of our forefathers and mothers to ensure that the next generation will not fall ill to the diseases that will take us?" he asked. "Or should we instead concede that human life span is limited, as is our ability to interfere with nature's devastating impact on us and our children? Should we go full speed ahead in finding new cures or should we limit our support of medical science only to that which we believe we can afford and instead concentrate more on ensuring that the medical treatments we now have be fairly distributed?"

Barry chose the former route. He based his reasoning not only on treatments already discovered, but on promising research now under way. There is hope for curing metastatic cancer, multiple sclerosis, cystic fibrosis, AIDS, and other killers, he said. "We cannot afford *not* to travel this road," he said.

Barry defended his industry against criticisms over costs. He suggested that the public is simply more aware of the cost of drugs than of other medical expenses because they are not covered under many insurance plans, including Medicare.

Americans spend less on drugs than do other developed nations, he said. Only 9 percent of U.S. health dollars go to pharmaceuticals compared with 15 to 20 percent in Europe and Japan, he said.

Drugs can be highly cost effective, he said. "Less expensive drugs and vaccines have eliminated the need for people to spend months and years in costly TB sanitaria, institutions for the chronically insane, or pediatric wards lined with iron lungs," he said.
The road Barry recommends will not be inexpensive. He said the pharmaceutical industry currently spends about $11 billion a year on biomedical research, and it costs more than $350 million to bring a new drug to the market. But to do any less, he said, "is clearly against every principle and spirit of the Americans with Disabilities Act, the Orphan Drug Act, our hearts, and the dreams of our parents."

Dr. David W. Barry is vice president for research, development, and medical affairs at Burroughs Wellcome Company.

"We will need to spend as much on gene therapy as we did on scud missiles if our children and grandchildren are to profit from this Brave New World product of biotechnology."

— David M. Barry, M.D., *vice president of research, development and medical affairs, Burroughs Wellcome Company*

Technology can save lives, reduce costs in farflung outposts

In many discussions of health care, technology becomes a villain. It is depicted as a means of prolonging life when the quality of life is questionable and as a major reason for spiraling health care costs.

But when a patient's access to a doctor makes the difference in survival, technology can be more of a solution than a problem, Paul Gorman said. Sometimes it can lower costs, he said.

Gorman drew most of his examples from military experience and research. He described, for example, a telemedicine service that links overseas field operations with Walter Reed Army Medical Center in Washington. It allows doctors in the field to communicate with any variety of specialists, transmitting color photographs and medical records in addition to holding two-way telephone conferences. All of this takes place over readily available telephone systems using $60,000 worth of commercially available equipment.

The technology paid for itself with only one case in Somalia, he said. Doctors in Somalia had tentatively diagnosed a facial rash as lupus. Treatment would have required transferring the soldier to an Army hospital in Europe. Working over the telemedicine hookup, however, doctors at Walter Reed determined the rash to be contact dermatitis, treatable with a topical ointment.

"Keeping that one soldier in his unit, on his job, instead of in the medical evacuation system, paid for the equipment at both ends twice over," Gorman said.

He described several other examples of telemedicine, including long-distance surgery. While some of the technology is still under development, others already are in use and and can be applied equally well in civilian medicine. They may be particularly valuable for rural areas, which lack ready access to medical teaching centers, he said.

Paul F. Gorman is a retired general in the U.S. Army and a visiting professor at the University of Virginia.

N.C. programs reach out to rural areas.

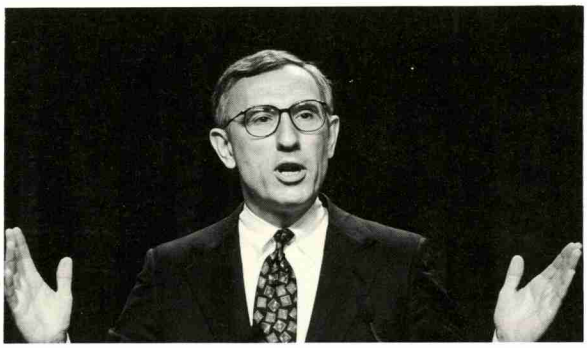
Physicians and other health care professionals are in short supply in many rural areas. The reasons are complex but generally relate to poor economic conditions.

In North Carolina, several state and federal programs are attempting to address this problem with at least some success. Between 1970 and 1990, the ratio of physicians per 10,000 population increased from 4.5 to 8 in North Carolina's 75 rural counties. During this same period, the national ratio rose from about 4.75 to 6.

Part of the credit goes to the North Carolina Area Health Education Centers (AHEC) Program, coordinated by the University of North Carolina at Chapel Hill but involving all four of the state's medical schools. AHEC has established nine regional health education centers that provide community-based, outpatient training of medical residents. Among its other activities, AHEC also holds clinics around the state to give local physicians and patients the opportunity to consult with medical specialists, assigns students for part of their training to rural hospitals and physicians offices, and sponsors continuing education courses for health professionals. AHEC sponsors similar programs for students in dentistry, nursing, pharmacy, and public health.

Three other state and federal programs provide funding for medical clinics in underserved areas. The state Office of Rural Health has established 52 rural health centers. Federal funds support 26 community and migrant health centers. These centers provide primary care with fees based on a sliding scale according to ability to pay.

Reform should reward responsible behavior



Most health reform proposals are missing the biggest issue, according to Lanty Smith.

"Health care costs in a developed society, and specifically in the United States, are clearly lifestyle driven more than any other single factor," he said. "These issues center on the individual, and the leading proposals for reform pay scant attention to requiring and rewarding individual initiative."

Smith cited statistics showing that 51 percent of deaths are related to lifestyle issues, such as violence, smoking, and alcohol and drug use. By ignoring individual responsibility, current reform proposals continue a set of problems that began in 1941, when Congress first allowed businesses to count employee health insurance as a tax-deductible expense. This action, plus a system of third-party payments for health-care costs, removes individuals from the economic consequences of their actions, he said.

Despite the problems in the existing system, Smith said, reform must be undertaken cautiously. Size alone demands it, he said, noting that the U.S. health care system equals the world's seventh largest economy.

"Reforming the U.S. health care industry is analogous to reforming simultaneously the steel industry, the textile industry, the electronics industry, all of the mining industry, and then throwing in the computer industry for good measure," he said.

Smith defined three issues that he said North Carolina should address in the health care debate.

The first is universal coverage. The business community should favor universal coverage through an individual mandate, he said. It is necessary for true cost containment, he said, because without it, cost-shifting creates too many inefficiencies. It is also, he said, the socially responsible thing to do.

The second issue to be addressed concerns how rapidly to achieve universal coverage and how to pay for it. "Phase it in and pay for it directly, right up front," he said. "Call it taxes, call it whatever it may be, but on the table where we can all see it and assess it and say, 'Is that the right thing do do?' "

Finally, he said, is the question of whether the state should lead or follow federal government. Smith's answer: Lead, adopting both universal coverage and reform of medical malpractice.

"I believe that if we were to adopt this approach, we would receive accolades not only as an even better state in which to do business," he said, "but we would again earn that label, which we hold very proudly, of being a very progressive and leading state in our union."

Lanty L. Smith is chairman and chief executive officer of Precision Fabrics Group, Inc.

"Reforming the U.S. health care industry is analogous to reforming simultaneously the steel industry, the textile industry, the electronics industry, all of the mining industry, and then throwing in the computer industry for good measure."

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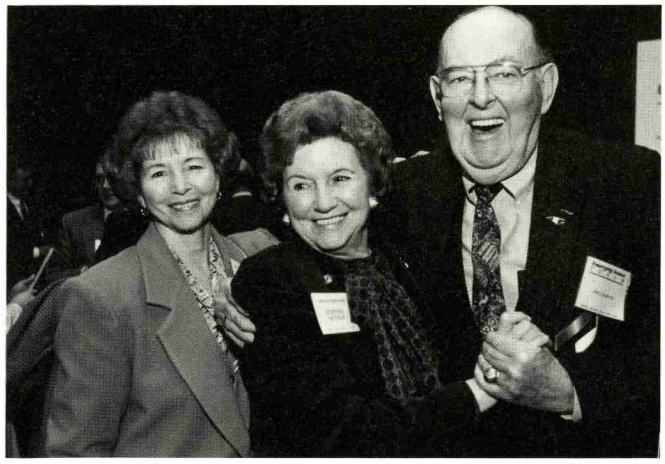


Commissioner Jim Graham and friends.

"The opportunities to improve quality and lower costs are substantial. You can have it both ways."

— David M. Lawrence, *chairman and CEO, Kaiser Foundation Health Plans, Inc. and Kaiser Foundation Hospitals.*


David Lawrence

Health care reform is underway, bringing lower costs

Americans do not have to wait for major reform of the health care system, David Lawrence said. It is already going on.

At its root, he said, is the shifting power between health care givers and purchasers. Those purchasers — individuals, corporations, and small businesses — are demanding accountability, organization, improved quality, and lower costs.

The result, he said, is that the inflation rate for medical care has slowed. "Many would argue that it's in anticipation of health care reform," he said, "but the underlying changes going on in the cost structures throughout American medicine have been significant and are the result of the kinds of pressure that purchasers are bringing to bear on the system."

As these changes take place, Lawrence said, the goal in the national health care debate is "to provide boundaries, direction, leadership, and stimulus in the appropriate way to keep this kind of revolution going on."

He looked at the national debate from two perspectives. The patient, he said, has five basic demands of health care reform:

First is the ability to choose and pay for a health care plan.

Second, he needs solid information on which to base his choice.

Third, he wants to make an informed choice among physicians. "Informed choice," Lawrence said, "means understanding how physicians have been included or excluded from a plan, what the criteria are for making that decision, and what the evidence is that physicians have been practicing and continue to grow in their practices in terms of quality and service."

Fourth, he wants to be able to see a physician when he needs to and to be followed by that same physician.

Finally, he said, people need to know they can obtain the care they need when they need it, without difficulties and without substantial financial penalty. This, Lawrence said, includes seeing specialists as needed, receiving education concerning health care and prevention and, when the time comes, receiving hospice care.

From the public policy point of view, Lawrence saw two major objectives.

First, reform needs to promote organization. "If you had to fly in an airline that's organized the way the health care system is, you'd take a bus," he said. Any reform plan should make sure the system is integrated for improved quality and cost performance, he said.

Second, reform should stimulate ongoing improvements. In other industries, a focus on quality has resulted in better prices, he said, and medicine should be no different. For example, the variability in doctors' skills results in higher costs from misdiagnosis and inappropriate treatment.

"The opportunities to improve quality and lower costs are substantial," Lawrence said. "You *can* have it both ways."

Dr. David M. Lawrence is chairman and chief executive officer of Kaiser Foundation Health Plans, Inc. and Kaiser Foundation Hospitals, which offer managed health care in 16 states plus the District of Columbia.

"If you had to fly in an airline that's organized the way the health care system is, you'd take a bus."

— David M. Lawrence, *chairman and CEO, Kaiser Foundation Health Plans, Inc. and Kaiser Foundation Hospitals.*

Insurance industry seeks passage of reform legislation

Speaking for the insurance industry, Bill Gradison said the worst possible outcome of the health care debate would be no legislation at all. The industry cannot serve the public adequately amid the current uncertainty, he said.

"It is time to get past the rhetoric and get down to cases," he said. "It is time for collaboration, cooperation, consultation, and compromise."

Coming to the negotiating table, he said, his organization agrees with President Clinton's plan on seven points:

- universal coverage.
- ending discrimination based on pre-existing conditions.
- portability, that is, a person's insurance should stay with him even if he changes jobs or loses his job.
- subsidies for small businesses and the poor.
- a uniform claims form to reduce confusion and paperwork.
- malpractice reform.
- a mandate that businesses pay something.

On the last point, he said, "Our reasoning was that in order to encourage economical choices, both the employer and the employee should have some money in it."

The association disagrees with the president in four areas, Gradison said.

First, it supports voluntary rather than mandatory health alliances. People may want to buy some types of plans not approved by the alliances, he said, and they should be allowed to do so using their own money. "We believe that the life and death of our companies should be in the hands of the people who pay the premiums, businesses and individuals, not in the hands of a government agency," he said.

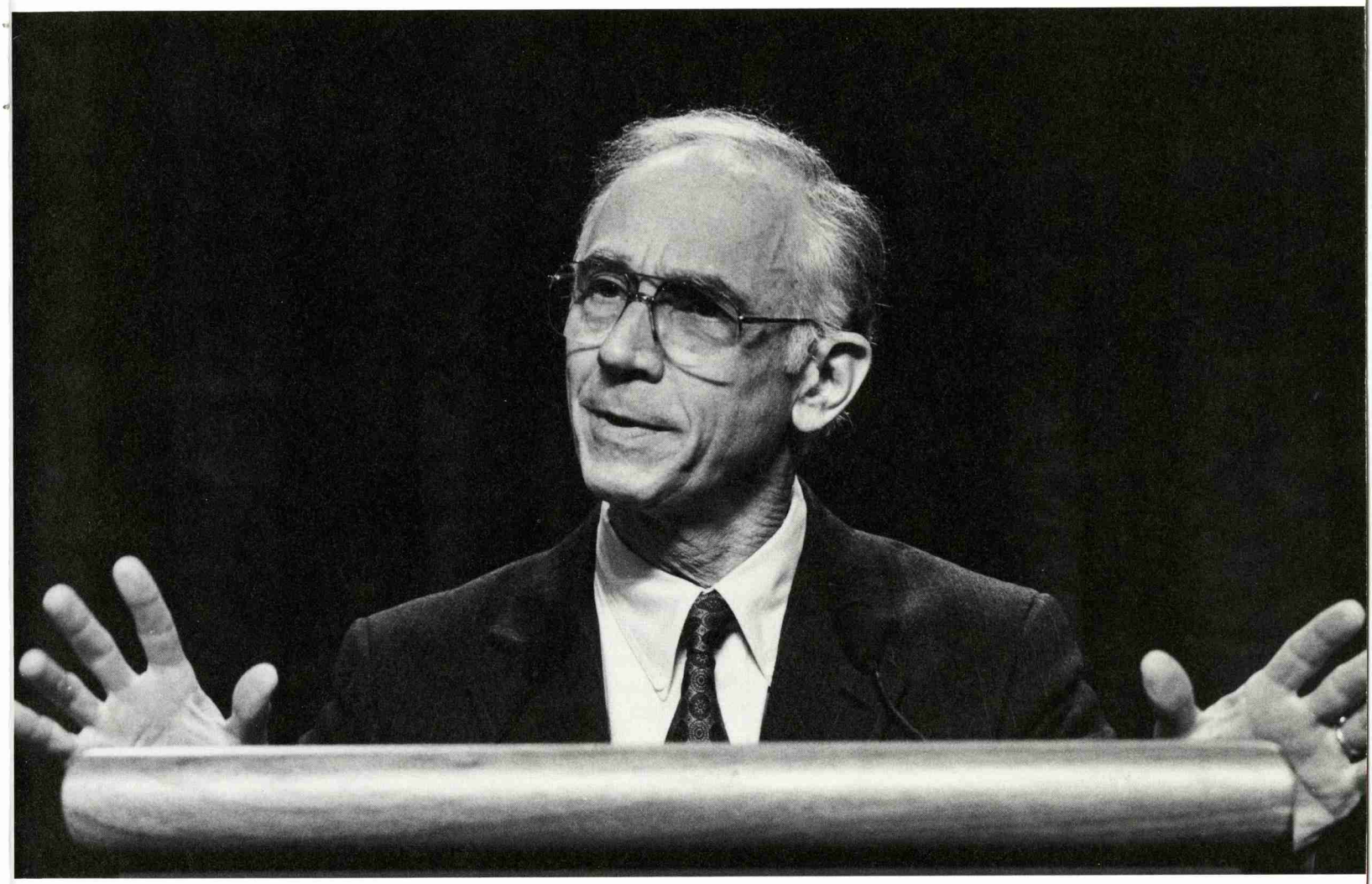
Second, it strongly opposes premium limits. "I don't think we know enough as a country to put health care on automatic pilot," he said. "There are better ways to constrain costs in health care than trying to decide years ahead of time what the proper amount should be."

Third, it opposes flat community rating, that is, setting one insurance premium rate for everyone in a given geographic area. Unless such a plan were phased in slowly, he said, "sticker price shock" would be too great, particularly for young people and companies that employ large numbers of young people.

Finally, the president's plan does not allow discounts for people making wise health decisions, he said. It does not, for example, allow discounts for nonsmokers or for families whose children receive recommended vaccinations.

He praised President and Mrs. Clinton for moving health care reform "from the back to the front burner" but criticized some of their tactics. "Blaming the insurance industry for the acknowledged problems that we have in this area is a little like blaming home builders for the existence of street people or blaming Winn-Dixie and Food Lion for the fact that some kids go to bed at night without enough food in their tummies."

Bill Gradison is president of the Health Insurance Association of America and a former Republican congressman from Ohio.



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— Bill Gradison, *president, Health Insurance Association of America*

Reform should proceed with caution

Lawrence Cutchin summed up his view of the health care reform debate succinctly: "To make an omelet, you have to crack an egg, but you don't do it with a sledgehammer."

Putting it in other words, he said the United States has developed a good core system of medical care that should be preserved while efforts continue to improve delivery and learn cost-efficiencies.

Cutchin reviewed nearly 100 years of U.S. medical history, including scientific advances, educational changes, and government programs. "It appears to me that until approximately 20 years ago, health care policy decisions in our country were driven by concern for quality, and then for access," he said. "In spite of the rhetoric to the contrary, most discussions and policy decisions today are driven by concerns for cost and cost containment."

He acknowledged, however, that costs cannot be ignored and suggested that President Clinton's proposal "promises more than we can afford." Furthermore, he said, the new bureaucracy created to administer the plan would impede innovations that respond to market pressure.

After noting several areas of agreement with the president's proposal, he outlined nine points he thought reform should address:

1. Universal access, at least as a goal. He said efforts to achieve universal access should include employer insurance plans, a health IRS, subsidies, and fairly priced basic benefits plans.
2. Insurance reform. This, he said, should eliminate limitations on pre-existing conditions, allow portability, implement community rating, cover preventive services, and offer premium discounts for healthy lifestyles.
3. Medical education and research. Reform must recognize the cost of medical education and support continued research, Cutchin said. It also should insist that teaching institutions

Insurance pools being set up for small companies in N.C.

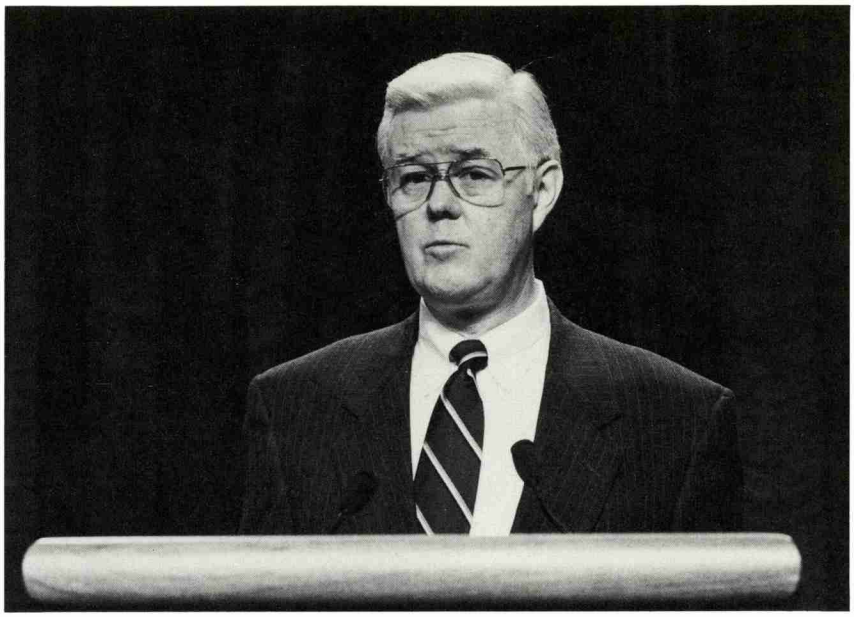
The North Carolina State Health Plan Purchasing Alliance Board has begun work on establishing a series of regional health insurance purchasing cooperatives, called alliances, for small business employers. The board was established by the 1993 General Assembly under the Small Employer Health Insurance Assistance Act. The legislature previously had passed the Small Group Reform Act of 1991, which set minimum benefits packages that health insurers were required to offer for small businesses desiring group policies.

The purchasing alliance board, which operates out of the lieutenant governor's office, expects to have some alliances in operation by summer 1994. The legislation sets January 1, 1995, as the deadline.

Joining an alliance will be voluntary for small businesses. Those who join must offer health insurance coverage to any employee who works more than 30 hours a week, and the employer must pay at least 50 percent of the cost of the lowest cost plan that the employer offers. The employer also must offer a choice of at least two plans through the alliance unless the employer pays more than 70 percent of the cost.

The legislature dictates that premiums will be set using adjusted community ratings, which are based on demographic factors such as age, gender, and geographic location. The community rates will be phased in over three years for employers currently offering insurance.

The 1993 General Assembly also established the State Health Planning Commission, which is charged with planning a statewide, universal access health care program. Operating out of the governor's office, the commission has organized 13 advisory committees on various aspects of health care. It is to present its plan by April 1995.



address the shortage of primary care providers and cost-effective medical care.

4. Malpractice reform, including a reasonable ceiling on non-economic damages.
5. Voluntary employer purchasing alliances.
6. Relief for physicians from anti-trust restrictions "that prevent cooperative approaches to holding down costs."
7. Inclusiveness. All federal, state, and local government employees and retirees should be included in any reform, he said.
8. Choice. Reform must allow fee-for-service plans to compete on an even playing field, he said.
9. Incentives to assure adequate supply of primary care providers.

Dr. Lawrence M. Cutchin is first vice president of the North Carolina Medical Society and president, chief executive officer, and medical director of Carolina Doctors Care, Inc., and Health Care Savings, Inc.

What medicine can learn from agriculture

Ellis Cowling, NCSU professor of forest resources, served Emerging Issues Forum panelists some food for thought during a question-and-answer session.

"Where are the health economists?" he asked. Cowling pointed out that in the United States there are approximately 4,000 agricultural economists and the nation has the lowest food prices in the developed world. On the other hand, he said, there are only 500 health economists and U.S. health care costs exceed those of all other nations. He suggested that health care, like agriculture, might benefit from the closer scrutiny of the cost-effectiveness of delivery systems, research, technology transfer, and other areas by trained economists.

The forum panelists could only nod their agreement. Cowling drew his figures from an essay he had just written with two colleagues from Duke University, John Sigmon, associate dean of the School of Environment, and Charles E. Putman, M.D., executive vice president for administration. The essay is titled "Maximizing Quality and Value-Returns from Public Investments in Science: Lessons from Medicine and Agriculture and Implications for the Environmental Sciences." Cowling said they hope to publish the essay soon.

Democracy's fate may hang on the health care debate

David Broder sees a lot at stake in the health care debate. It is an issue on which widespread concern comes head to head with widespread cynicism about Congress's ability to function effectively on the public's behalf.

"Health care is a huge and important test, not just of the health care system but of the political and governmental system," Broder said.

He cited a survey showing that eight out of ten people think the health care system is in crisis and six out of ten think government can do something about it. But with so many players and constituencies involved — including 1,100 interest groups — it will be difficult to fashion a coherent policy out of the current debate, he said. It is made more difficult by the complexity of the issues. People want to understand how the various plans could affect them, Broder said, but even the experts have difficulty explaining their own proposals.

"I have yet to hear any of them who can walk people through their own proposal, even in the barest outline, in less than a half hour's time, " he said.

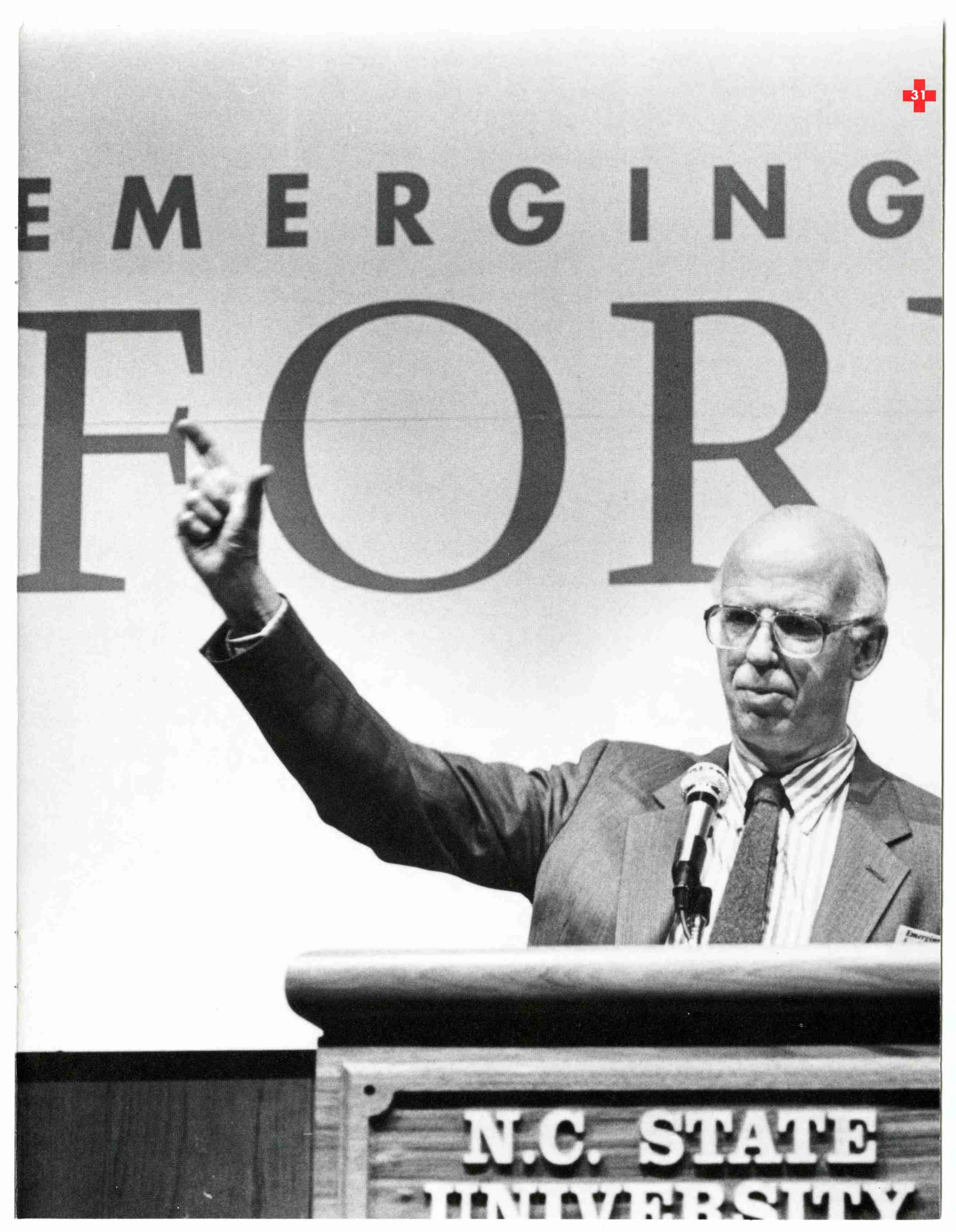
To broaden public participation and understanding, some groups are pulling together community forums to give ordinary citizens an opportunity to share their experiences and test ideas. Broder witnessed one such forum. He said it was exciting to see "the engagement people feel once they are brought into this kind of a process, where they are actually offered the opportunity and the challenge of thinking through these hard questions for themselves."

Meanwhile, factions in the debate are mobilizing the way they would any other political fight, with big-time consultants and "war room" strategies, and public confidence in its representatives has hit an all-time low. A recent Washington Post poll showed that only 29 percent of the public approves of the job Congress is doing, he said. Fewer said they could believe what people in Washington say all or most of the time. That is where the concern and cynicism come head to head.

"Any change in this system is going to be difficult," Broder said. "Large-scale change will be traumatic.... The public in this country had better feel that this is something they have chosen for themselves, not something that's been handed to them by somebody else.

"The public's voice has to be heard on this issue or more than health care will be damaged in this country. The whole concept of representative government will be damaged."

David S. Broder is a political columnist for the Washington Post and a winner of the Pulitzer Prize for distinguished commentary.


EMERGING
FOR
N.C. STATE

WHERE THEY PRACTICE

Physicians who complete their residencies at Area Health Education Centers or at East Carolina University are more likely than others to establish practices in North Carolina, including small towns. Bowman Gray School of Medicine joins those two programs for high proportion of residents adding to the state's supply of primary care physicians.

Information for the following charts was supplied by the Area Health Education Centers Program.

Historical Trends in the Retention of North Carolina Medical School Graduates 1965–1988

Percent of Graduates Initially Practicing in N.C. by the Year of Graduation

Medical School	1965–69*	1970–74**	1975–79**	1980–84**	1985–88**
Bowman Gray	20%	37%	41%	40%	33%
Duke	22%	20%	27%	27%	29%
ECU	N/A	N/A	N/A	52%	54%
UNC-CH	40%	50%	50%	51%	47%
State Total	30%	34%	40%	43%	41%

*Source: Medical School Alumni, AMA 1975
**Source: Alumni Office, NC Medical Schools

Notes: ECU enrolled its first class in 1977

Initial Practice Location of Residents & Fellows Who Attended Medical School in North Carolina 1977–1991

Residency Site	Total # of Residents & Fellows	# Remaining in N.C. to Practice	% Retention	Of Those Remaining in N.C., % in Towns under 10,000
AHECs	271	208	77%	25%
Bowman Gray	404	254	63%	16%
Duke	136	94	69%	06%
ECU	147	119	81%	26%
UNC-CH	537	346	64%	11%
State Total	1495	1021	68%	16%

Initial Practice Location of Residents & Fellows Who Attended Medical School Out-of-State 1977–1991

Residency Site	Total # of Residents & Fellows	# Remaining in N.C. to Practice	% Retention	Of Those Remaining in N.C., % in Towns under 10,000
AHECs	635	272	43%	22%
Bowman Gray	902	315	35%	09%
Duke	1685	694	41%	04%
ECU	165	60	36%	18%
UNC-CH	1388	474	34%	05%
State Total	4775	1815	38%	08%

*These tables do not include information for 239 persons for whom medical school is unknown.

Initial Practice Location of Primary Care Physicians* Who Completed Residency or Fellowship Training in North Carolina 1977–1991

Residency Site	Total # of Residents & Fellows	# Remaining in N.C. to Practice	% Retention	Of Those Remaining in N.C., % in Towns under 10,000
AHECs	668	392	59%	25%
Bowman Gray	545	255	47%	19%
Duke	588	275	47%	05%
ECU	176	102	58%	36%
UNC-CH	676	272	40%	07%
State Total	2653	1296	49%	17%

*Includes ob/gyn, family practice, internal medicine, and pediatric residents and fellows

Initial Practice Location of Non-Primary Care Physicians* Who Completed Residency or Fellowship Training in North Carolina 1977–1991

Residency Site	Total # of Residents & Fellows	# Remaining in N.C. to Practice	% Retention	Of Those Remaining in N.C., % in Towns under 10,000
AHECs	232	86	37%	17%
Bowman Gray	741	311	42%	07%
Duke	1292	513	40%	04%
ECU	123	71	58%	07%
UNC-CH	1249	548	44%	08%
State Total	3637	1529	42%	07%

*These tables do not include information for 219 persons for whom specialty is unknown.

Thursday Morning February 10, 1994

10:00 AM

Larry K. Monteith
Chancellor, North Carolina State University

Charles H. Carlton
Faculty Senate Chair, NCSU

Christopher S. Jones
Student Body President, NCSU

The Honorable James B. Hunt, Jr.
Governor, State of North Carolina & Chairman, Emerging Issues Forum

Decisions for Health

Christopher J. Conover
Associate in Research, Center for Health Policy Research & Education, Duke University

Speaking for Consumers

Judith G. Waxman
Director of Government Affairs, Families USA

Barbara K. Garland
Associate Professor & Health Program Coordinator, Cooperative Extension Service, NCSU

Thursday Afternoon February 10, 1994

1:00 PM

Ronald H. Levine, MD
State Health Director, North Carolina Department of Environment, Health & Natural Resources

An Ounce of Prevention

M. Joycelyn Elders, MD
United States Surgeon General

The Challenge to States

The Honorable Lawton Chiles
Governor, State of Florida

3:00 PM

America's Health: Adjusting Expectations

Richard D. Lamm
Director, Center for Public Policy & Contemporary Issues, former governor, State of Colorado

4:30 PM

C. Dixon Spangler, Jr.
President, The University of North Carolina

The Clinton Health Care Reform Plan

Hillary Rodham Clinton
First Lady of the United States

Friday Morning February 11, 1994

8:45 AM

Jerry L. Whitten
Dean, College of Physical & Mathematical Sciences, NCSU

The Science of Health

David W. Barry, MD
Vice President, Research, Development & Medical Affairs, Burroughs Wellcome Company

Maxwell R. Thurman
General, US Army (Retired), Executive-in-Residence, NCSU

Breakthroughs in Technology

Paul F. Gorman
General, US Army (Retired), Visiting Professor, University of Virginia

The Business of Health

Lanty L. Smith
Chairman & CEO, Precision Fabrics Group, Inc.

10:30 AM

Health Security: Quality, Cost & Access

David M. Lawrence, MD
Chairman & Chief Executive Officer, Kaiser Foundation Health Plans, Inc.

Bill Gradison
President, Health Insurance Association of America

Lawrence Cutchin, MD
First Vice-President, North Carolina Medical Society

Friday Afternoon February 11, 1994

12:30 PM

Whose Voices Are Heard?

David S. Broder
Columnist, Washington Post

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Chancellor, North Carolina State University

Governor James B. Hunt, Jr.
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