While fiscally the past decade has been a difficult one for almost all segments of our society, higher education—particularly public higher education—has endured painful budget reductions which continue to this day. Yet, President Pettigrew, through resourceful and courageous leadership, has successfully guided her campus through these very troubled times. And each spring, in a spectacular and very moving right of passage, SUNY Old Westbury holds a commencement ceremony unmatched on Long Island. Nearly 1,000 men and women of all ages, of remarkably different ethnic religious and racial backgrounds receive their diplomas from President Pettigrew. No where else on Long Island or in SUNY can one witness such a wonderful example of successfully bringing people from a broad spectrum of backgrounds together to learn from and with each other and, ultimately to succeed. Such wonderful diversity lies at the core of the success of the College at Old Westbury and President Pettigrew has played a major role in preserving the College at Old Westbury's very special and unique mission.

International education has been a longstanding interest of Dr. Pettigrew. She has traveled worldwide to participate in conferences and symposia which involve discussions about the expansion of international education programs on campuses throughout the world. Recently she led a delegation of public university presidents from throughout the United States to the People's Republic of China. The chancellor of the State University of New York has appointed her chair of a special Commission on Africa with primary focus on South Africa. She recently led a delegation of SUNY officials to South Africa to explore the possibility of exchange programs with South African universities.

Mr. Speaker, President L. Eudora Pettigrew is an extraordinary educator and dynamic leader who has contributed most significantly to the growth and development of the State University College at Old Westbury over the past decade. She is an educator extraordinaire and I am very pleased to publicly acknowledge her many works on behalf of the citizens of New York State. I call on my colleagues in the House of Representatives to join me in paying tribute to a dedicated educator and extraordinary humanitarian, Dr. L. Eudora Pettigrew.

RATIONING LIFE AND DEATH BY INCOME CLASS

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, July 9, 1996

Mr. STARK. Mr. Speaker, once again, Professor Uwe Reinhardt, cuts to the heart of the matter with his June 19, 1996, essay in the Journal of the American Medical Association entitled ''Economics.''

His short article is reprinted below. It is blunt. Americans have decided to ration health care by income class. The poor will die earlier than the rich. The poor will suffer more. Their children will be doomed to less healthy lives. That's the truth. We try to hide from that truth behind ideologies and high-flown talk of ''market-based'' health care systems. We pretend to be a Christian nation, but we violate all of Christ's teachings in our health care system, and hide our hypocrisy behind economic jargon about efficiency and competition and free markets.

For a conscience-challenging essay, read on:

ECONOMICS

(By Uwe E. Reinhardt, Ph.D., Princeton University)

Breakthroughs in the sciences often take the form of replacing 1 hitherto held hypothesis with another. In the social sciences, that process tends to be controversial, because hypotheses usually can be tested only on crude, nonexperimental data that tend to be compatible with numerous rival hypotheses (theories). More often than not, the individual social scientist's allegiance to this or that theory is dictated by that individual's personal predilections.[1] A ''breakthrough'' in the social sciences, therefore, may be nothing more than the triumph of 1 ideology over another.

During the past decade or so, economics experienced such a breakthrough. Certain theories favored by large segments of the profession, the ideology they embodied, and the felicitious jargon they inspired came to dominate the thrust of American health care policy. Goaded in good part by the writings, teaching, and punditry of economists, American politicians increasingly treated health care as just another private consumer good—certainly no different from food, clothes, and shelter—and physicians and hospitals as mere purveyors of that good. Hand in hand with that notion came the proposition that a free market can produce and distribute health care more ''efficiently'' than can any other imaginable arrangement. Hand in hand with that proposition, in turn, came the social ethic that the quantity and quality of health care received by individuals can properly vary with their ability to pay for that care.

It is imperative to hedge this assertion at the outset. First, by no means all American economists subscribe to this distributive ethic for health care. Second, by no means all American economists play politics thus in the guide of science. Many of them scrupulously apply scientific methods to identify the trade-offs that require moral choice on the part of policy-makers without packaging their own moral values into their analyses.

Scrupulous economists are mindful that the term ''efficiency'' has a quite technical meaning that severely limits its proper use in practical applications.[2,3] Every freshman in economics, for example, is or ought to be taught that the more efficient of 2 alternative policies is not necessarily more preferred, unless both policies achieve exactly the same outcome. To illustrate, a cost-minimizing (efficient) policy that succeeds in immunizing only, say, 80% of a target population is not necessarily superior to a more wasteful (inefficient) policy that succeeds in immunizing the entire population. Similarly, one cannot meaningfully compare 2 nation's health care systems in terms of their relative efficiency, if these 2 nations pursue different standards of equity across socioeconomic classes.

Srupulous economists know that virtually all benefit-cost analyses performed by economists are highly suspect if the benefits and costs in question do not accrue to the same persons.[4] The explanation is simple: If we measure benefits and costs in dollars, then a dollar of benefit (or cost) accruing to a poor person represents a quite different intensity of pleasure (or pain) than a dollar of benefit or cost accruing to a rich person. Following a dogma first proposed by the British economist Nicholas Kaldor,[5] economists have tried to escape this conundrum with the tenet that, if those who benefit from a social policy gain enough to be able to bribe the losers into accepting that policy, then that policy enhances social welfare even if the bribe never is paid. It is a preposterous sleight of hand.[4] Yet without it, many benefit-cost analyses sold by economists lose their legitimacy.

Economists ought to protest loudly the canard repeated with such distressing frequency during the health system reform debate of 1993 and 1994 that only a ''market approach'' to health care can avoid ''rationing.''[6] Every freshman knows that markets are just 1 of many methods of rationing goods and services. Markets do it by price and ability to pay.[7]

Finally, properly trained economists know that when person A derives satisfaction from knowing that individual B consumes a particular commodity (which tends to be true for much of health care), then the prices generated in free markets systematically underestimate the social value of such commodities.[8,9] That important insight is forgotten by economists who model health care simply as just another private consumption good[10] and who would blithely and quite illegitimately impute to, say, a physician visit by a baby from a low-income family a social value equal to the maximum price the baby's parents would be willing (and able) to pay for that visit.

In short, properly trained and scrupulously practicing economists appreciate that their ability to offer normative pronouncement on health policy is much more limited than seems widely supposed among policymakers. Normative economics seeks to prescribe what ''ought'' to be done. Because public health policy almost always redistributes economic privilege among members of society, such prescriptions almost always involve moral judgments best left to then political arena.

Economists are at their professional best when they offer purely positive, value-free analysis—for example, when they estimate empirically the responses of physicians, in terms of patients seen or hours worked, to ceilings on their fees or to increases in their malpractice premiums. Economists can also produce useful positive analyses by using their empirical estimates to simulate likely responses to proposed policies—for example, the imposition of a mandate on employers to provide their employees with health insurance.[11] Alas, even here ideology may creep in. During the health system reform debate of 1993 and 1994, for example, the opponents of such a mandate had no trouble finding respected economists who imputed to that mandate large losses in employment. These economists assumed that, over time, the cost of the mandate would be passed to employees through lower take-home pay, and that the supply of labor is highly sensitive to changes in take-home pay. On the other hand, policymakers who favored the employer mandate had no trouble finding equally respectable economists who assumed the supply of labor to be rather insensitive to take-home pay, in which case the mandate would lead to only a modest reduction in employment.[12]

As Victor Fuchs[13] has argued, the school of scrupulous economists did not carry the day during the health system reform debate of 1993 and 1994. That debate may have come across to the media and the laity as merely a giant exercise in accounting. In fact, it was the culmination of a decades-old battle over the proper distributive ethic for American health care. The issue can be crystalized in the following pointed question: To the extent that our health system can make it possible,

Footnotes at end of article.

should the child of, say, a waitress or a gas station attendant have the same chance of avoiding a given illness and, if afflicted by it, of surviving and fully recuperating from it as, say, the child of a corporate executive?

Evidently, the dominant decision makers in this nation have now concluded that our health system can properly offer the executive's child a higher probability of avoiding illness, or of surviving and fully recovering from a given illness, than it offers the child of a gas station attendant or waitress—that our health system can properly be tiered by income class.

That is purely a moral judgment. As such, it is not wrong. But it would have been appropriate, in a democracy, to debate this important question more explicitly than it was. Instead, the proponents of this distributional ethic cloaked their case in the jargon and normative theories willingly supplied, without proper warnings, by the economics profession. Thus, the new ethic was sold to the public by the argument that a ''market-based'' health system in which individuals are granted ''responsibility'' for their own health care (and their own health status!), and in which individual ''consumers'' are ''empowered'' to exercise ''free choice'' of the ''consumer good'' health care, would be more ''efficient'' (and hence ''better'') than any alternative system, and that it would obviate the need for ''rationing'' health care. But to tell an uninsured single mother of several possibly sickly children that she is henceforth empowered to exercise free choice in health care with her meager budget is not necessarily a form of liberation, nor is it efficient in any meaningful sense of that term. It is rationing by income class.

To have one's professional jargon, hypotheses, and embedded ideology dominate in this way may be a triumph of sorts. Readers will judge whether it was a genuine accomplishment.

FOOTNOTES

[1] Nelson R. *The Moon and the Ghetto.* New York, NY: WW Norton & Co Inc; 1977: lt 23.

[2] Bator FM. The simple economics of welfare maximization. *Am Econ Rev.* 1958; 72:351–379.

[3] Reinhardt UE. Reflections on the meaning of efficiency: can efficiency be separated from equity? *Yale Law Policy Rev.* 1992;10:302–315.

[4] Baumol WJ. *Economic Theory and Operations Analysis.* 4th ed. Englewood Cliffs, NJ: Prentice-Hall International Inc; 1977:chap 21.

[5] Kaldor N. Welfare propositions of economists and interpersonal comparisons of utility *Econ J.* September 1939:549–552.

[6] Reinhardt UE. Rationing in health care: what it is, and what it is not. In: Altman EH, Reinhardt UE, eds. *Strategic Choices for a Changing Health System.* Chicago, Ill: Health Administration Press; 1996.

[7] Rosen HS, Katz ML. *Microeconomics.* Homewood, Ill: Richard D Irwin Inc; 1991:15–16.

[8] Kearl JR. *Principles of Microeconomics.* Lexington, Mass: DC Heath & Co; 1993:chap 16, especially p 418.

[9] Friendman LS. *Microeconomic Policy Analysis.* New York, NY: McGraw-Hill International Book Co; 1984:64–70.

[10] Phelps CE. *Health Economics.* New York, NY: Harper Collins Publishers Inc; 1992:chap 4.

[11] Clinton W. *President Clinton's Health Care Reform Proposal and Health Security Act, as Presented to Congress on October 27, 1993.* Chicago, Ill: Commerce Clearing House Inc; 1993.

[12] Krueger AB, Reinhardt UE. The economics of employer versus individual mandates. *Health Aff (Millwood).* Spring 1994:34–53.

[13] Fuchs VR. Economics, values and health care reform. *An Econ Rev.* 1996;86:1–24.

TRIBUTE TO KABILI TAYARI

HON. DONALD M. PAYNE

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Tuesday, July 9, 1996

Mr. PAYNE of New Jersey. Mr. Speaker, on Thursday, July 11, Kabili Tayari is being honored for his lifelong commitment to justice. This event is being held at Jersey City State College in Jersey City, NJ.

Kabili Tayari is a true believer of empowerment. Malcolm X's statement, ''use any means necessary'' comes to mind as I think of Kabili. Although he is a man of many strategies, he has chosen education as his ''weapon'' of choice in fighting the injustices of our society.

In 1989, New Jersey's Governor appointed him to the Jersey City Board of Education. He has served the board in a number of capacities. He served as chairperson of the legislative committee from 1991 to 1996. He was vice president of the board from 1993 to 1995. On May 2, 1996, he was elected president of the Jersey City Board of Education.

Although Kabili has served the citizens of Jersey City through its board of education, he has also shared his talents with other organizations. They include the Association for Retarded Children, the New Jersey State Conference of NAACP Branches, the Hudson County College Education Opportunity Fund, the Essex County College Education Opportunity Fund, the New Jersey Martin Luther King Commemorative Commission, the Region II National Title I/Chapter 1 Parents Organization, the Parents Council of the Jersey City a.k.a. Citywide Parents Council, and the Jersey City State College; his alma mater. He has held leadership roles in each of these groups that work for the empowerment of our citizens.

Mr. Speaker, I am sure my colleagues will want to join me as I congratulate and thank Kabili Tayari for his dedication and commitment to making life better for so many.

THE NEW YORK EYE SURGERY CENTER

HON. ELIOT L. ENGEL

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, July 9, 1996

Mr. ENGEL. Mr. Speaker, the New York Eye Surgery Center is celebrating its 10th anniversary of state-of-the-art medical care in the Bronx. I want to congratulate the center for the medical service it has given to the area over that decade. I also want to congratulate the center for its annual gift of a day of free cataract surgery for those unable to afford the procedure. Last year 20 free surgeries were performed and more are expected to be performed this year. The center also has a day of free eye screenings for glaucoma, cataracts, and diabetes and this year May 17 is the day for free eye care as part of Mission Cataract USA '96. The screenings are free to anyone from the community regardless of need. This state-of-the-art care is also state-of-the-heart care and I congratulate the New York Eye Surgery Center for the great and good work it is doing.

TRIBUTE TO JIM PRUTZMAN

HON. J. DENNIS HASTERT

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, July 9, 1996

Mr. HASTERT. Mr. Speaker, I rise today to honor an outstanding citizen of Illinois' 14th Congressional District, Mr. Jim Prutzman of West Chicago.

A Navy veteran of World War II, Jim Prutzman has been a successful businessman in his hometown and has served his community as a past-commander of American Legion Post No. 300 and as a past president of the West Chicago Chamber of Commerce. While these activities alone are worthy of honor, though, I rise today to honor Jim for his decades of work with the West Chicago Fire Department.

Jim Prutzman began his work with the West Chicago Fire Protection District in 1959, as a paid on-call firefighter. In 1971, Jim was appointed to the fire district's board of trustees and elected treasurer. Shortly after his appointment, the West Chicago fire district hired its first full-time firefighters in 1972, which also resulted in the formation of the municipal ambulance service. Jim Prutzman was elected president of the fire district board in 1981, serving in that capacity for the next 14 years, and retired from his duty with the fire district just a few short weeks ago.

In his 37 years with the West Chicago Fire Protection District, the department has grown from a few paid on-call firemen to today's 3 fire stations, 22 full-time employees, 14 on-call firefighters, and 9 paramedics. Jim has been actively involved in that growth, and the people of West Chicago are better protected today because of his efforts.

Mr. Speaker, I ask you and my colleagues to join me in honoring this dedicated man, for his commitment and service to the West Chicago community. I join the citizens of West Chicago in congratulating Jim on his well-deserved retirement from the fire protection district, and wish him all the best for the future.

INTRODUCTION OF LEGISLATION REGARDING THE COUNTRY OF ORIGIN RULES

HON. ENI F.H. FALEOMAVAEGA

OF AMERICAN SAMOA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, July 9, 1996

Mr. FALEOMAVAEGA. Mr. Speaker, I rise today to introduce legislation which would retain the country of origin rules in effect on June 30, 1996 for apparel items produced in American Samoa. This legislation is limited in scope, and it will have a limited impact on U.S. trade. It is, however, critical to the economic development of American Samoa.

Mr. Speaker, the American Samoa Government has been pursuing outside investment opportunities for many years. Recently, a garment manufacturing company has begun production in American Samoa—the first significant new outside industry to invest in the territory since the 1960's. The new industry provides jobs for our people, tax revenues for the local government, and secondary revenue for a variety of private sector businesses.

The industry is small by U.S. standards, it employs fewer than 500 local people at this time, but it represents diversification for our economy, and its presence lessens our dependence on the Federal Government. The plant is running smoothly and is ahead of schedule with respect to production levels.

Because this is a new industry for American Samoa, it requires a significant amount of