how best to care for the most vulnerable people in our society.

November is National Adoption Month, and I believe that our Nation must embrace, on a year-round basis, our less fortunate youths despite the shortcomings that life has dealt them. Under the leadership of Barbara Holtan, Tressler has soared in matching these youngsters, who otherwise may have languished in foster care with loving families and providing them with a home.

It is with regret that the business of the House has precluded me from attending the celebration of Tressler's silver anniversary on this day, November 9th. Nonetheless, my best wishes do go out to them.

On the 25th anniversary of the founding of Tressler Adoption Services, the community in south central Pennsylvania graciously thanks you and commends you on your years of good service. May many more productive years lie ahead.

## AMERICA DOESN'T LOVE ALL ITS CHILDREN

### HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

*Sunday, November 9, 1997*

Mr. STARK. Mr. Speaker, ''should the child of a poor American family have the same chance of avoiding preventable illness or of being cured from a given illness as does the child of a rich American family?''

That is the question.

That is the question brilliantly posed in the following essay by Uwe Reinhardt from the Journal of the American Medical Association's November 5 issue.

It is a profoundly moral and religious question.

America's answer to the question is, I am sad to say, no. Unlike other advanced industrial societies, America is saying no to millions of its children and their parents. In many ways, we really are not a nation or a society. We say we are, but we are practicing the social Darwinism of every man, woman, and child for himself.

We do not love all our children.

[From the Journal of the American Medical Association, Nov. 5, 1997]

WANTED: A CLEARLY ARTICULATED SOCIAL ETHIC FOR AMERICAN HEALTH CARE

(By Uwe Reinhardt)

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

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

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

But these straits have never been smooth for the uninsured, notwithstanding the soothing mantra cited earlier. Empirical research must have convinced policymakers long ago that our nation rations health care, health status, and life-years by ability to pay. It is known that other socioeconomic factors (such as income, family status, location, and so on) being equal, uninsured Americans receive, on average, ony about 50% of the health services received by equally situated insured Americans.[2] This appears to be true even for the subgroup of adults whose health status is poor or only fair.[3] Studies have shown that uninsured Americans relying on the emergency departments of heavily crowded public hospitals experience very long waits before being seen by a physician, sometimes so long that they leave because they are too sick to wait any longer.[4–6] Studies have found that after careful statistical control for a host of socioeconomic and medical factors, uninsured Americans tend to die in hospitals from the same illness at up to triple the rate that is observed for equally situated insured Americans[7] and that, over the long run, uninsured Americans tend to die at an earlier age than do similarly situated insured Americans.[8] Indeed, before the managed care industry cut the fees paid physicians sufficiently to make fees paid by Medicaid look relatively attractive to physicians and hospitals, even patients insured by that program found it difficult to find access to timely care. In one study, in which research assistants approached private medical practices pretending to be Medicaid patients in need of care, 63% of them were denied access because the fees paid by Medicaid were then still paltry relative to the much higher fees from commercial insurers.[9]

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

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

In his book, Epstein frames the debate over the right to health care as a choice between the ''maximization of social wealth'' as a national objective and the ''maximization of utility,'' by which he means human happiness. ''Under wealth maximization,'' he writes, ''individual preferences count only if they are backed by dollars. Preferences, however genuine, that are unmediated by wealth just do not count.''[10] One implication of resource allocation with the objective of wealth maximization is that a physician visit to the healthy infant of a rich family is viewed as a more valuable activity than is a physician visit to the sick child of a poor family.[13] If one does not accept that relative valuation, then one does not favor wealth maximization as the binding social objective.

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

One need not share Epstein's social ethic to agree with him that, over the long run, a nation that allocates resources generously to the unproductive frail, whether rich or poor, is likely to register a relatively slower growth of material wealth than does a nation that is more parsimonious vis-à-vis the

frail.[10] Nor does one need to share his social ethic to admire him for his courage to expose his conviction so boldly for open debate. Deep down, many members of this nation's policymaking elite, including many pundits who inspire that elite, and certainly a working majority of the Congress, share Epstein's view, although only rarely do they have the temerity to reveal their social ethnic to public scrutiny. Although this school of thought may not hold a numerical majority in American society, they appear to hold powerful sway over the political process as it operates in this country.[14] In any event, they have for decades been able to preserve a status quo that keeps millions of American families uninsured, among them about 10 million children.

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

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

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

FOOTNOTES

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## SALUTE TO REPRESENTATIVE STEPHEN CHEN

### HON. DONALD M. PAYNE

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

*Sunday, November 9, 1997*

Mr. PAYNE. Mr. Speaker, I rise today to welcome Taiwan's new representative, Dr. Stephen Chen, to Washington. Prior to his present assignment, Dr. Chen was deputy secretary-general in the office of the President, Taiwan.

Representative Chen is a career diplomat, having served his country in nearly every corner of the world. Fluent in English, Chinese, Portuguese, and Spanish, Chen is a master communicator. He will certainly bring to the Hill his vast knowledge of foreign policy issues affecting his country and ours.

At a time of our country seeking better relations with the People's Republic of China, it is indeed a privilege to have someone like Representative Chen representing the Republic of China, a free democratic and sovereign country, which deserves a much strong presence in the world.

## HONORING RADX TECHNOLOGY IN THE FIGHT AGAINST BREAST CANCER

### HON. KEN BENTSEN

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

*Sunday, November 9, 1997*

Mr. BENTSEN. Mr. Speaker, I rise to recognize the tremendous contribution RADX Technology of Houston has made in the battle against breast cancer.

In October, we celebrated Breast Cancer Awareness Month, which included highlighting efforts by medical providers, community organizations, and businesses to ensure that all women have access to the breast cancer screening and treatment they need. It is particularly gratifying to acknowledge the efforts of the management and employees of RADX Technology, whose generosity is helping achieve this goal and save lives.

RADX has donated a new, more cost-effective mammography screening system to The Rose Diagnostic Clinic, which will help The Rose tremendously in its life-saving mission of providing affordable and accessible breast cancer screening to all women regardless of their ability to pay. This new machine, the mammoscope, has great potential to save lives because it will reduce the time between screening and diagnosis.

The Rose, a non-profit organization under the leadership of founder Dr. Dixie Melillo and executive director Dorothy Weston, operates three neighborhood clinics in the Houston area. Since it was founded in 1986, The Rose has performed more than 72,000 procedures, with 6,030 women receiving services free through The Rose Sponsorship Program for medically underserved women.

The Rose is always seeking to expand the reach and quality of its services, and it depends on the generosity of paying patients and community and business contributors to do so. RADX, which builds viewing systems for general radiography and mammography films, has helped meet a crucial need with a donation of the mammoscope, an $18,000 device. Kathryn Earle, RADX purchasing manager, proposed the project after reading about The Rose and recognizing they would need to be able to read multiple mammograms efficiently to continue to increase their patient load. Using the mammoscope, The Rose will be able to increase the productivity of radiologists for both screening and diagnosis.

This project was a hands-on team effort of virtually all 60 RADX employees from management team members to warehouse works. The mammography viewing system was built