August 23, 2007

HEALTH CARE QUALITY: Speech at the Dartmouth-Hitchcock Medical Center

Click here to read Hillary's vision for improving health care quality.

Thank you. Thank you all very much. Thank you Nancy for your introduction and for your leadership of this great medical center, and to Frank McDougall who has also helped very much in putting this event together. I also want to thank Dr. Susan Lynch for being here. Some of you know that Dr. Lynch did her residency at Dartmouth-Hitchcock and she's a pediatrician who works as a pediatric lipid specialist at the cholesterol treatment center at Concord Hospital in Concord.

It would be interesting to know just as historic fact when the first pediatric lipid specialist was certified because one thinks about cholesterol as a problem of us, the adult world. And now we know, as Dr. Lynch too well knows, with her advocacy on behalf of physical activity and trying to stem the tide of obesity among our children, how significant this is and I'm just absolutely delighted that she could be here today. It's also a pleasure being back here. I just had the opportunity to say hello to some of the physicians and nurses and staff members who run this great center. And a number of them reminded me that I was here in 1993, I actually met some of them before this occasion and I am thrilled to be back because I cannot imagine a more fitting place to talk about improving healthcare quality in America than at this institution which has helped to set the standard for excellence for more than 200 years.

As I travel across New Hampshire -- and certainly around our country -- I talk with people from all walks of life, it is really one of the great privileges of being in public life; I see the speaker here, and others who are involved in the day-to-day life of New Hampshire. You get to meet people you would have never otherwise met; you are invited into their lives, somewhat similar to what you do here, as you take care of them in very significant points of their life's journey. Well in the political arena we also have that privilege and no matter where I go, or with whom I talk -- whether it's a CEO or a small business owner or a doctor or a nurse or patient or a hospital administrator -- everyone tells me the same thing: "Our health care system isn't working and what can we do about it?" The costs are too high, the coverage too thin -- or in some cases non-existent -- the care not what it should be.

Now I have worked on health care, like Nancy said, for more years than I care to recount. Going back to 1979 and 80 in Arkansas, where I led an effort to try too bring more health care into rural areas, a problem we still have in Northern New Hampshire just as in Eastern Arkansas. And of course most memorably, during the eight years as First Lady.

Now despite the scars I carry from that, I also have learned some valuable lessons. And most importantly, that in order to answer any question about what we can do better to provide healthcare for all of our citizens in a cost effective quality driven way, we first have to establish a consensus in America. That this is a goal we intend to achieve together. We have to reach that consensus among providers, employers, employees, citizens, those who pay for, depend upon, and actually deliver healthcare

services. And this consensus has to be strong enough to persuade decision makers in Washington and to overcome entrenched opposition among the forces that oppose change for ideological and corporate reasons.

Now the good news is that I think we are finally reaching consensus. I see businesses, labor, government and other stakeholders increasingly investing in quality care because they realize that it's not only good for individuals and families that it's also goof or our economy. We've begun to agree that there is an economic as well as a moral imperative to reign in costs and to extend coverage to all Americans. There's a practical imperative to improve quality -- to promote wellness and prevent illness wherever possible. And these are the key components of my health care plan--lowering costs for everyone, improving quality for everyone, and providing coverage for everyone. I list them as three interlocking goals because I think we cannot do one without doing all of them.

A few months ago, I outlined my agenda to reduce health care costs and today, I want to talk about health care quality. And next month, I will announce my plan for universal coverage. My order here is deliberate. In order to forge a consensus on universal health care, we need to assure people they'll get the quality they expect at a price they can afford. And my recommendations to control costs and ensure quality lay the groundwork for insuring everyone.

Now, by all accounts, we should already have the highest quality health care in the world. Our doctors, nurses and other health care practitioners are among the best in the world. They have access to the most cutting-edge drugs, and treatments and medical technologies. And we spend more money per capita on health care, almost $5,700, than any country in the world.

But we are far from having the best care. We're ranked 23rd in infant mortality and 42nd in life expectancy. According to the 2006 survey by the Kaiser Family Foundation and the Agency for Healthcare Research and Quality, 51 percent of Americans were dissatisfied with the quality of our health care system. According to a RAND study, adults in the United States on average fail to receive about one half the medical care they need. More than one in ten patients may receive care that isn't recommended -- and may be potentially harmful. And the Institute of Medicine estimates that as many as 98,000 Americans are killed each year by preventable medical errors.

Now in short, too often and in too may places, our health care system hurts us instead of helping us. It hurts doctors, who aren't rewarded for providing the best care -- and are often punished for it, financially at least. It hurts nurses, who are asked to work longer hours caring for more patients with fewer resources. And it hurts patients, who are forced to make complicated medical decisions without basic information about their conditions and options.

Now I'm hoping that we're getting to a point where the quality of our health care is not a partisan issue. Whether you're a Democrat or Republican, a liberal or a conservative, none of us wants to rush our child to an emergency room only to receive the wrong treatment. None of us wants to bring our spouse in for surgery only to see them next in the ICU with a preventable infection. None of us wants our loved one cared for by nurses who are juggling too many patients and too many medications with too little support.

And any of us could become seriously ill injured such that we won't have a second chance to get the right diagnosis and treatment. And when that day comes, why should we settle for less than the best?

But that is exactly what we're doing right now. When you buy a TV for your living room or a tire for your car, or a toy for your child, you want to know you're getting the best value -- and these days, especially with toys, the greatest safety. So you compare prices, you ask questions, you check the consumer reports and you rely on your government to establish and enforce basic guarantees of safety and reliability.

But too often, with the product we care most about --that can mean the difference between life and death, and between billions of dollars wasted and saved -- we don't

compare prices or quality we wind up stuck with something whether we think it's best for us or not.

And until recently, government at all levels did not use its enormous buying power to empower providers and patients to demand and deliver quality. We plod along with a twentieth century health care system, unable to take full advantage of 21st century medical advances, stuck in the same rut of fatalistic thinking that's defined our healthcare debate for more than a decade. If we try to cover everyone, the argument goes -- we'll lower quality. If we try to improve quality -- we'll break the bank. Our health care problems are too big, too deep, too complicated, the argument continues, for us to solve.

Well, I reject that and I think all of you here at this exemplary institution do as well. America is not a nation that settles. We don't wring our hands and make excuses. We roll up our sleeves. We invent. We innovate. We come up with solutions. And that's exactly what hospitals and nursing homes and providers across America have been doing with very little support. Many are improving the care they offer and lowering costs.

Take the example of Kaiser Permanente. Their management came together with 40 unions representing 90,000 healthcare workers and staff and formed a Labor Management Partnership. The Partnership works to solve problems, improve patient care and give everyone a seat at the table.

One example of their work involved a patient complaint that nurses often did their shift handover without input from the patient--so union nurses worked with management to come up with a solution: doing the handover in the patient's room, where the patient could join in the conversation. As a result, patients better understand their care, nurses spend more time with patients, and information is being shared more efficiently.

Since Kaiser's partnership began, costs have fallen, workplace injuries have fallen -- and patient satisfaction and employee retention have improved. And this is just one example of how, across America, workers and management can improve healthcare quality.

Or take the example of Ascension Health, America's largest non-profit hospital system. Back in 2002, they began a system-wide effort to improve their quality of care -- to meet best practices and provide better treatments. Today, their rate of certain hospital infections is 62 percent lower than the national average. Serious patient falls are 86 percent lower. Rates of bedsores are 93 percent lower.

But in the end, quality health care isn't just about savings or statistics. It's about something much more fundamental: the relationship between physicians and patients, between nurses and patients, between physicians, nurses and hospital administrators. That's what's at the heart of our quality, how we get along with one another, what our relationships are. The moment when someone in need seeks you out, they're scared and vulnerable, they want you to do what can get them better, but too often our healthcare system stands in the way, blocking that relationship, preventing physicians and nurses from doing what they would want to do. So therefore, we have to change the system.

Well, I'm here today because I believe it's time we had a health care system that lived up to the Hippocratic Oath. A system that empowers doctors, nurses and hospitals to give the best care. That empowers patients to make the best decisions. And that ensures that payers -- governments and private payers-- value, reward and promote the best results: longer, healthier lives, and money saved in lowering and unproductive and unnecessary hospital and nursing home costs.

That is what my Health Care Quality Plan tries to do. We have come to these recommendations in consultation with doctors, nurses and others across the country. We've developed a plan to raise standards, support health care providers, educate patients, realign the reimbursement systems to reward quality, recruit and retain more nurses, and address the health disparities that continue to plague our system.

I want to start by talking about how we ensure that our health care providers --

doctors, nurses and others -- provide the best possible care.

That starts with providing federal support for doctors' own quality certification standards.

Now, most doctors stay current on their own -- reading up on the latest advances, studying the latest techniques. But changes are coming so fast these days; many tell us they just can't keep up. Some might not even realize they're no longer using the latest protocols or the best systems. This may explain the dramatic variations in cost and quality from state to state, town to town -- even from hospital to hospital in the same town. Now some of these variations have been discovered and publicized right here at Dartmouth, the studies conducted by Jack Weinberg and his colleagues here have revolutionized how many people think about quality of care. They found that the quality of care for patients with terminal illnesses, just to pick one example, varied greatly. The percentage of patients who died as hospital inpatients instead of at home or in a hospice, range from 32 percent to more than 52 percent despite the fact that the overwhelming number of Americans would prefer not to die in a hospital.

Part of the solution to these disparities can be found in doctors' own voluntary Maintenance of Certification programs, so called MOC programs. They provide lifelong learning opportunities to help doctors stay up to date. They're generally run by the boards of the various specialties -- so cardiology runs the MOC for cardiologists, or the pediatrics runs the MOC for pediatricians, and so on.

Doctors who participate in certification programs have better outcomes. Heart attack patients treated by board certified doctors were 15 percent less likely to die than those treated by non-certified doctors. Doctors who scored higher on MOC examinations had better outcomes in treating patients with diabetes, and they were more likely to ensure that their patients received mammograms.

So as President, I want to lend the support of the federal government to MOC process to help our doctors stay on the top of their game. I will offer higher Medicare reimbursement rates to doctors who participate in qualified MOC programs. And to ensure that the MOCs are sufficiently rigorous -- I'll ask that the Secretary of HHS to invest $125 million to recognize and help fund the work of a public-private Quality Trust to certify the MOCs. This Trust will bring together people from across the health care system -- doctors, patients, nurses and others -- who will rigorously review MOCs to ensure they are up to the highest standards.

If you have any doubt about whether we need to do this, I'd refer you to an article from this week's New York Times indicating that just 7 percent of diabetics are getting all of the treatment they need -- often because their doctors are not versed in the latest developments. Now, imagine if instead, these doctors participated in certification programs that kept them up to date on nationally recognized standards for diabetic care. The most revealing conclusion in the very long article was that most doctors were vigilant about blood sugar, but not about blood pressure and cholesterol monitoring. Think of how many more lives could be saved and how much more money could be saved if they were.

I'll also support doctors by creating a Best Care Practices Institute, a public-private partnership to fund comparative effectiveness research and disseminate it across the country. Right now so much of the information on which drugs, devices, surgeries and treatments work best, either isn't researched, it isn't compared, it isn't published, and it isn't circulated. It takes years for an agreed upon treatment that a medical center like this one knows is the best practice to be disseminated across our country. So this Best Practices Institute will serve as a central national clearinghouse so no matter where you are, you and your doctor can access information on what the best treatments should be.

In addition to helping doctors provide the best care, I plan to finally implement medical malpractice reforms that work for doctors and patients alike. Many of the physicians that I meet say that high malpractice premiums force them to alter their practice-- and even consider leaving the profession altogether. I've also heard first hand from families who've experienced serious medical errors and have trouble getting the relief that they deserve. The current political stalemate on this issue

leaves both patients and physicians in the lurch.

Earlier before I came in I was speaking to the head of anesthesiology and I really give the anesthesiologists a lot of credit because for the last ten years they have moved toward standards of practice that have not only helped patients but dramatically lowered malpractice premiums and I believe there's a lot we can do within the specialties, following the example of anesthesiology, coming up with new approaches.

I've offered one solution based on a successful program at the University of Michigan Hospital system. It's called the National Medical Error Disclosure and Compensation Act. In the Congress you have to come up with acronyms so you search for days to try to name a piece of legislation with something that if you take the first letter it spells a word--so that is the MEDiC act for those of you who were wondering.

It's a novel approach to improving patient safety and the quality of care while protecting patients' rights, reducing medical errors and lowering malpractice costs. The bill that I have introduced based on the University of Michigan Hospital system would proved liability protections for physicians who disclose medical errors to patients and offer to enter into negotiations for fair compensation backed up by their hospital and their practice. At the University of Michigan, these policies have already resulted in greater patient trust and satisfaction, more patients being compensated for injuries, fewer malpractice suits, significantly reduced administrative costs, and between one and three million dollars in litigation cost savings.

But when I talk about supporting providers, I'm not just talking about doctors -- but about nurses as well. And that's the third step in my plan -- to immediately address our nursing shortage and to give nurses the training and educational and support that they need to provide the care patients deserve.

The nursing shortage has become a nursing crisis. And that means it's a crisis for everyone, because nurses are critical to delivering and improving quality. Our nurses are truly the eyes and ears --and in many ways, the heart and soul -- of our health care system. And when we've got fewer nurses, working longer hours, serving more patients -- the result can be worse outcomes. We currently face a shortfall of 118,000 nurses. If we don't take action now, by the year 2020, the estimate is that we will be short as many as one million nurses. In addition to the shortage, nurses are aging. On average a nurse is over 45 in America. So we need a comprehensive solution.

According to the American Association of Colleges of Nursing, in 2005, American nursing programs turned away nearly 32,000 qualified bachelor and masters degree applicants. They just didn't have the slots. So when I'm President, I will provide funding to nursing schools to allow them to admit and train more nurses and to recruit and retain more faculty. And I'll give first priority to schools with a record of sending graduates to serve in underserved areas -- from rural communities, to inner-cities, to low-income neighborhoods.

I'll also work to recruit more nurses to the profession in the first place -- reaching out to communities of color that are traditionally underrepresented, providing scholarships and loan forgiveness so we can have a more diverse, culturally competent nursing workforce.

But we know that the problem isn't just recruiting -- it's retaining nurses. Roughly 50 percent of new nurses leave their jobs within the first year -- all too often because they're not getting the support they need to do their jobs. I will address that by funding innovative mentoring and residency programs with a proven track record of helping to keep nurses in the profession.

Programs like the RN Residency program that was launched five years ago at Children's Hospital Los Angeles. This 22-week program provides new nursing school graduates with a comprehensive clinical experience to prepare them for careers in acute care environments. Prior to this program, turnover for new graduates during their first year was 36 percent. Graduates of the RN Residency program have a first-year turnover rate of just 11 percent, and a 24 month turnover rate that has dropped from 56 to 22 percent. Given that it costs roughly $50,000 to replace each nurse -- and thousands more to pay temporary nurses to fill in -- you can see the kinds of

savings that Children's is experiencing.

I also want to do more to empower advanced practice nurses. We're going to have to change the practice, acts, and protocols that govern what nurses can do-- nurse practitioners, nurse midwives, physician's assistants, advanced practice professionals. Because it's clear that we will not be able to reach our goals for preventive care if we don't have better utilization of nurses.

We need to empower patients. And that means giving them the information they need to make the right choices. Today even the savviest, best informed patients struggle to choose providers and treatment options and it is easy to feel helpless and overwhelmed about these decisions.

Now some people will tell you the best way to provide consumer choice is to give everyone a Health Savings Account -- and leave them to find the least expensive, most effective providers on their own. If they're in good health, chances are that they'll be able to navigate this. But if they get seriously ill, or have an accident that is serious, well I don't think that there's much hope there.

The idea is that we have to really empower patients -- not shift costs on to them under the guise of so called "consumer-driven" care. So when I talk about informed consumer choice, I mean no one should have to guess their way through this maze.

That's why we need a comprehensive, patient-friendly quality database. With the click of a mouse, patients should be able to see which hospitals have the best care, the best specialists, the lowest infection rates, the most efficient discharge policies, the shortest emergency room waiting times, and more.

And that is exactly what you're doing here at Dartmouth-Hitchcock, publishing comprehensive public reports on everything from the quality of your cancer treatments and pneumonia care to your infection prevention rates. I'm so impressed by what you've done here and the difference that it is making that I have teamed up with Senator Judd Gregg and introduced bipartisan legislation to create this kind of system on a national scale using Medicare claims data to make risk-adjusted quality reports publicly available.

I also empower patients by making sure that the information that they get is understandable. The Center for Shared Decision Making here at Dartmouth Hitchcock is another perfect example. This center approaches medical decisions as collaboration between patients and doctors. Doctors take the time to talk with patients, discuss their concerns and their goals -- and then help them reach the outcomes they desire. And once again the results speak for themselves. 98 percent of patients report they understood their treatment choices. 96 percent said they realized which treatment risks and benefits mattered most to them as they made their decisions.

We cannot do this however if we don't invest in electronic medical records. I've already proposed this as legislation, a bipartisan piece of legislation that I have worked on for four and a half years, passed the Senate last year, it died in the house. But we're back with bipartisan legislation again.

It is essential that we begin to do this. Institutions like this have electronic medical records as do other of our medical centers and fine hospitals around the country but we're not creating a seamless system. We're not creating one where if you're a patient here and you're visiting family in Florida or if you're on a business trip to LA, your record can be easily transmitted. And while Amazon.com knows exactly which books you've bought and what music you like -- an emergency room doctor may have no way of knowing what medications you're taking, what you're allergic to -- or even what your blood type is.

Electronic medical records will change that. They'll ensure that patients can have secure, confidential access to their medical history wherever and whenever they need it. This will save, according to a RAND study, approximately 77 billion dollars a year. And it will also save lives.

The VA is a great example of a healthcare system that has dramatically improved the quality of patient care. The American Consumer Satisfaction Index Survey shows that

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VA patients were significantly more satisfied with both inpatient and outpatient care than patients in the private medical system. The New England Journal of Medicine found that VA healthcare ranked higher than Medicare in 12 out of 13 measurements of quality and the VA system achieves better rates of quality care for diabetics than commercial managed care organizations.

Now what made this success possible? Well, in part the use of information technology. During the Clinton Administration, a transition to a paperless system was accelerated and today the VA maintains electronic health records in 1,300 facilities for over 5 million veterans. And this enables someone to go from VA hospital to VA hospital and have that record be seamlessly delivered wherever it is needed.

The VA medical records system supports the use of advanced technology including mobile devices, wireless interfaces, and a barcode medication administration system in which patients are given a bar-coded ID tag. Nurses scan this tag when providing medications allowing them to confirm that the right person receives the right medicine at the right time. So the VA is doing it, there's no reason we can't do it across our healthcare system,

And through my coverage recommendations which I will be making next month, I want to come up with ideas to incentives patients and potential patients which includes all of us to make better decisions about our own health. Information alone about behaviors like smoking or obesity does not automatically result in change. We need both a renewed public health effort that I think should be lead by the president, stressing better health outcomes and financial benefits to motivate such changes through the way we pay for public and private insurance.

I want to emphasize that when I talk about empowering patients -- I mean all patients -- from all backgrounds and all walks of life. We are far from that goal now. Our health care system unfortunately is still plagued with racial, ethnic, socioeconomic and gender disparities at every level. And my goal is to eliminate those disparities once and for all.

Right now, African American infant mortality rates are more than double those for whites. More than one-fifth of American Indians do not have a reliable source of health care, as compared to 15 percent of whites. Asian-Americans are less likely to receive critical screening tests like mammograms and pap smears. Hispanics living with diabetes are almost 20 percent less likely to receive recommended diabetes treatments. And women are more likely than men to be hospitalized for high blood pressure -- a manageable chronic condition.

Minority populations aren't just sicker -- they also get lower-quality care. According to the annual National Healthcare Disparities Report released by HHS, African Americans and Hispanics received worse care than whites on more than 70 percent of the criteria used to measure quality.

This is simply unacceptable in our country. The quality of your care should have nothing to do with your ethnicity, skin color, or gender. And when I'm President, I will see to it that it doesn't. I will start by directing the Department of Health and Human Services to collect detailed, up-to-date information on healthcare disparities, so we actually can know the full extent of the .

I'll also invest in developing culturally competent health care for minority population. That means ensuring health care providers have access to the language skills they need to communicate with their patients -- and that patient information is appropriately translated into the many languages that a hospital often has to deal with.

Finally, I want to discuss the role of payers -- insurance companies and state and federal governments -- in providing quality health care.

I want to start with our reimbursement system. We have to completely re-haul this system. We need a system that actually encourages -- instead of discourages -- quality care. Right now, the incentives in our reimbursement system are upside-down and backwards. They often punish doctors are trying to do the right thing -- like spend time with their patients, trying to prevent, not just treat illness. Doing what's

best for patients is sometimes bad for business.

Hospitals are paid for each episode of care, each hospitalization. Doctors are paid for each office visit, each procedure. People aren't paid to coordinate patients' treatments to ensure they get the best quality care. So let's say you are a diabetic with high blood pressure. Your doctor won't be reimbursed for hiring a nutritionist to track your weight and help you understand what you can and can't eat. Your hospital won't be reimbursed for hiring a nurse assistant to ensure you have regular appointments to get your feet and eyes checked. Or to make sure your blood pressure doctor and your diabetes doctor communicate with each other about your care. And healthcare providers who wish to work in teams to coordinate services and treat patients holistically receive lower reimbursements than if they all worked separately.

So we wind up treating patients like walking collections of symptoms and diseases -- each to be treated discretely. But that is not how illness works, that's not how the body or the mind works. For example, if you are a diabetic with high blood pressure, your high blood pressure obviously affects your diabetes, and vice versa. So there's incredible value to coordinating care and in having doctors, nurses, social workers, nutritionists and other professionals working together as a team.

That's exactly how it's done at the Mayo Clinic, one of the most respected health care institutions in America, actually probably in the world. Under their integrated healthcare system, primary care physicians work together with specialists to develop a comprehensive approach to treat each patient. The result is better care, lower costs, and fewer hospitalizations and doctor visits. The result is better care, lower costs, and fewer hospitalizations and doctor visits. In fact, if hospitalizations and doctor visits across America mirrored the numbers at Mayo, for certain conditions, inpatient Medicare spending would decrease 20 percent, Medicare costs for doctor visits would decrease 35 percent. That's billions of dollars in savings. But at the same time physicians salaries are above the national average. So when I'm President, I'll support federal reimbursements for precisely this kind of team approach to medicine. We know it saves money -- and saves lives.

I'll also ensure that the federal reimbursement system rewards care based on how effective it is. Today, we often do just the opposite. In a Pennsylvania government survey of the state's 60 hospitals performing heart bypass surgery, the best-paid hospital received nearly $100,000, on average for the operation, while the least-paid got less than $20,000. But at both hospitals, patients had comparable lengths of stay and death rates. And among the 20 hospitals serving metropolitan Philadelphia, two of the highest paid actually had higher-than-expected death rates. Now, we know we have to adjust for risk, and we know that very often the most difficult cases end up at the hospitals that have the greatest capacity. But I think we could do a better job in actually figuring out what we should be paying for -- work that has also been pioneered here at Dartmouth-Hitchcock.

With the right incentives, we can make a difference. Take the example of the Marshfield Clinic, in Wisconsin, where doctors are paid based on the quality of care they provide for common diseases like diabetes and heart disease. They could earn up to 80 percent of the Medicare savings that result from their good treatment. Preliminary results revealed a 50 percent increase in electronically documented foot exams for diabetes -- and a 29 percent decrease in hospitalization.

Another excellent example of incentivizing good care with smart reimbursement policies is the Bush Administration's recent decision to refuse Medicare payments for preventable infections, injuries and errors sustained during hospital stays. A sponge accidentally left inside a patient during surgery, a broken arm sustained when a patient is improperly handled. They're known as "never events," because they never should have happened. It's not often that I offer praise for the Bush Administration, but it is well deserved for this decision.

Now Michigan has had great success with systematic efforts to reduce infection rates in intensive care units. Hospitals in that state have reduced blood stream infections related to catheters, as reported in the New England Journal of Medicine. The hospitals did not use expensive new technology, but followed well-established

infection control practices, like covering doctors and patients with sterile gowns and sheets when catheters were inserted.

So, As President, I won't just sustain these good policies at the federal and the state level -- I'll take it one step further. I'll insist that any insurance company wishing to provide coverage through the Federal Employees Health Benefits Program, which is all of them, has to also refuse to cover these costs. And I'll encourage private plans to follow suit. I believe we could not only save billions of dollars but thousands of lives over time.

Finally, ensuring that our reimbursement system rewards quality care also means ending insurance company discrimination against people with pre-existing conditions. Right now, insurance companies have free reign to cherry pick the healthiest patients and shut out everyone who seems like a "bad risk." In fact, they spend $50 billion a year on elaborate underwriting calculations and schemes to figure out how not to cover people or that not to pay you for what you do once you've delivered the service. As President, I'll put an end to that. I believe we should examine the patchwork nature of regulation of the insurance system. And I believe we have to end insurance discrimination.

Now, will all of this be easy? We just elect a new president? Will it just happen? Of course not. But let's remember, we're gathered today at the school that introduced the stethoscope to the American Medical School curriculum, took the first clinical X-Ray, established the first ICU. The institution that has always been pushing the boundaries, and looking toward that next horizon. Oliver Wendell Holmes, who served as a professor in this school back in the 19th century, put it best when he said, "I find the great thing in this world is not so much where we stand, as in what direction we are moving."

We may have a long road ahead of us, but I believe we're finally moving in the right direction. That we can empower patients to make the right decisions for themselves. We can empower doctors and nurses to deliver the best care that they want to, and are often prevented from doing so. We can have the highest quality health care system in the world and we can do it in a cost-effective manner. That's the direction that I'm headed in. And I'm proud to be at this institution, which has pioneered so many of the changes that benefit us today, and I hope that you'll all join me on this journey to better quality healthcare.

Thank you all very much.