KEYNOTE SPEECH

SENATOR BOB DOLE

AMERICAN HOSPITAL ASSOCIATION

ANNUAL MEETING, JANUARY 30, 1984

INTERNATIONAL BALL ROOM

WASHINGTON HILTON

WASHINGTON, D.C.

THE REVOLUTION IN THE HEALTH CARE INDUSTRY THAT WE HAVE SEEN SINCE THE PASSAGE OF MEDICARE AND MEDICAID WILL NO DOUBT PALE IN COMPARISON TO WHAT THE NEXT FIVE TO TEN YEARS WILL BRING.

WHILE THOSE REACHING AGE 65 IN THE FUTURE ARE LIKELY TO BE HEALTHIER, THE INCREASE IN THE TOTAL NUMBER OF OLDER PERSONS WILL NO DOUBT CAUSE A SERIOUS STRAIN ON THE HEALTH CARE DELIVERY SYSTEM. THE NUMBER OF PERSONS OVER AGE 65 IS EXPECTED TO INCREASE 40% BY THE YEAR 2000 AND ANOTHER 60 PERCENT BY 2025. THE POPULATION OF THOSE 85 AND OLDER IS PROJECTED TO GROW EVEN FASTER, WITH A STARTLING 91% INCREASE BY THE YEAR 2000.

IN THE HEALTH CARE FIELD, AS YOU WELL KNOW, THE IMPLICATIONS OF THIS GROWTH IN THIS POPULATION ARE ENORMOUS FOR THE SYSTEM AS A WHOLE AND FOR MEDICARE IN PARTICULAR.

IN THE NEXT WEEKS AND MONTHS AHEAD WE ARE GOING TO BEGIN TO GRAPPLE AGAIN WITH THE PRESSURES THAT FACE THE SYSTEM. THOSE RELATED TO THE AGING OF THE POPULATION AND THOSE RELATING TO THE COSTS AND UTILIZATION OF THE SYSTEM. YOUR CONTINUED INVOLVEMENT AND COOPERATION WILL BE VITAL TO ALL OUR EFFORTS.

THE HEALTH CARE DELIVERY SYSTEM IS ONE WE ARE STILL STRUGGLING TO UNDERSTAND. MY OFFICE IS INUNDATED ON A DAILY BASIS WITH ARTICLES AND STUDIES BY MANY MORE EXPERT THAN I-- WHO RAISE QUESTION AFTER QUESTION ABOUT THE DIRECTION WE ARE TAKING AND OUR LONG RANGE GOALS.

IF PRESSED TO ANSWER QUESTIONS ON WHAT I THINK WE THE GOVERNMENT OUGHT TO DO ABOUT HEALTH CARE COSTS AND THE CONTINUING FOCUS ON ILLNESS CARE, I COULD ONLY RESPOND THAT WE MUST CONTINUE TO SUPPORT THOSE WHO NEED OUR ASSISTANCE; THE POOR, THE ELDERLY AND THE DISABLED, AND MAINTAIN A SYSTEM THAT PROVIDES THE HIGHEST QUALITY CARE IN THE WORLD. IN DOING SO, WE MUST ALSO BE SURE THAT WE SPEND THE TAXPAYERS' MONEY IN A MOST EFFECTIVE MANNER, AND CREATE AN ENVIRONMENT WHERE PRIVATE CITIZENS AND BUSINESSES ARE ENCOURAGED TO DO THE SAME.

ALL OF THIS IS OF COURSE, IS A TALL ORDER.

ISSUES OF CONTINUING CONCERN

BUDGET DOWNPAYMENT

I HOPE YOU ARE AS PLEASED WITH PRESIDENT REAGAN'S MESSAGE TO THE NATION AS I WAS. HE DESERVES FULL CREDIT FOR TAKING THE LEAD ON THE DEFICIT ISSUE: HE'S OUT FRONT AND LEADING THE CHARGE. I WILL WORK TO SEE THAT HE GETS THE KIND OF COOPERATION FROM CONGRESS NEEDED TO GET THE JOB DONE.

PRESIDENT REAGAN KNOWS THAT THERE IS A BIG JOB YET TO BE DONE, AND WE IN THE SENATE FINANCE COMMITTEE AND A BIPARTISAN MAJORITY IN CONGRESS ARE READY TO GO TO WORK ON THE DEFICITS -- CLEARLY, WE ARE ON THE OFFENSIVE.

THE PRESIDENT HAS UNDERSCORED HIS RESOLVE TO DO SOMETHING ABOUT THE DEFICIT AND HIS INITIATIVE IS THE FIRST STEP TOWARDS MEANINGFUL DEFICIT REDUCTION. IN 1982 A BIPARTISAN WORKING GROUP REPRESENTING CONGRESS AND THE ADMINISTRATION PAVED THE WAY FOR MAJOR DEFICIT REDUCTIONS. PRESIDENT REAGAN BELIEVES AS I DO THAT THIS APPROACH CAN WORK AGAIN.

THE DOWNPAYMENT TOWARD CUTTING THE DEFICIT SUGGESTED BY THE PRESIDENT WILL BUILD MOMENTUM FOR FURTHER DEFICIT REDUCTIONS, LOWER INTEREST RATES, A MORE STABLE RECOVERY, AND A MORE SECURE FUTURE FOR ALL AMERICANS.

PRESIDENT REAGAN'S INITIATIVE GIVES US HOPE THAT 1984 CAN BE A YEAR OF PROMISE, NOT PARTISANSHIP. OF COURSE, IN LOOKING AT BUDGET OPTIONS WE WILL AGAIN BE FORCED TO LOOK AT ALL PROGRAMS, INCLUDING THE MEDICARE PROGRAM AND THE MEDICAID PROGRAM. WE WILL ALSO LOOK AT DEFENSE SPENDING, THE AGRICULTURE PROGRAMS AND EVERY OTHER ASPECT OF OUR GOVERNMENT.

Costs of Care

It would be unfair to you to suggest that our concerns with the continued escalation in the cost of care disappeared with the enactment of prospective payment. Certainly that was an enormous step, one we should be proud of--though cautiously--until all the necessary adjustments are made. But it was for many, just the first step down a long road.

In 1982 health expenditures in the U.S. totaled $322.4 billion, an average of $1,365 per person, comprising 10.5 percent of the GNP. Medical prices continued to soar despite the marked decrease in the rate of price inflation for the general economy.

Now I know you are not to blame for the whole problem--and in helping us craft the prospective payment system, helped to find some of the solution. But there are many other aspects of the system yet to be addressed.

In solving the medicare crisis I believe that we need to consider all possible options. These include Democratic proposals, the recommendations of the Advisory Council on Social Security, and recommendations from other sources. We should not limit our options, nor should we allow ourselves to think of the various options as mutually exclusive. The solution we may adopt will very likely reflect variations of several different options,

EACH THOUGHT BY SOMEONE, AT SOME TIME, TO BE A SOLUTION IN ITS OWN RIGHT.

ON FEBRUARY 21, 1984, THE FINANCE COMMITTEE WILL HOLD A HEARING DURING WHICH THE SOCIAL SECURITY ADVISORY COUNCIL WILL PRESENT TO THE COMMITTEE THEIR RECOMMENDATIONS REGARDING MEDICARE. THIS HEARING WILL PROVIDE US THE OPPORTUNITY TO BEGIN TO EXAMINE ALL THE OPTIONS IN EARNEST.

IT WILL NOT BE TOO LONG BEFORE WE SEE THE INTRODUCTION OF A MAJOR DEMOCRATIC EFFORT DIRECTED AT CONTROLLING HEALTH CARE COSTS AND RESTORING SOLVENCY TO THE MEDICARE TRUST FUND. AS I UNDERSTAND IT, THAT LEGISLATION WILL FRANCHISE THE STATES TO DEVISE ALL-PAYOR SYSTEMS. GENERALLY SUCH SYSTEMS REQUIRE THAT GOVERNMENT PROGRAMS; WHETHER MEDICARE OR MEDICAID, AND PRIVATE INSURERS, WHETHER BLUE CROSS OR AETNA; ALL PAY THE SAME PRICE FOR HEALTH CARE SERVICES.

NOT HAVING SEEN THE PROPOSAL I DON'T FEEL THAT I CAN COMMENT ON IT IN DETAIL, HOWEVER, IT DOESN'T MAKE SENSE TO ME TO DEBATE THE PROPOSAL AS AN ALTERNATIVE TO ALL OTHER SOLUTIONS. INSTEAD, WE SHOULD RECOGNIZE THAT DEVISING A SOLUTION TO THE MEDICARE SOLVENCY PROBLEM REQUIRES SOMETHING OTHER THAN BI-POLAR THINKING. NO ONE SOLUTION WILL BE PERFECT. THIS NEWEST EFFORT WILL BRING TO OUR ATTENTION YET ANOTHER OPTION WHICH DESERVES OUR CONSIDERATION. AN OPTION WHICH, TO A LIMITED EXTENT, ALREADY EXISTS IN CURRENT LAW.

You may recall that in the 1983 Social Security Amendments the Congress not only authorized State hospital cost control systems but required the Secretary to approve requests for such State systems if certain conditions are met. We continue to learn from the existing state hospital cost control systems, and are likely to learn more as additional options are tried, but I'm not sure we're ready to hand over total control to the States.

Physician Reimbursment

Throughout our discussions on prospective payment we heard the continuing cry that we were leaving out the most critical element of the picture--the physician--the one who admits, orders, and discharges.

In response to that, many claimed 1983 would be the year of the physician. In many ways it was--but 1984, 1985 and 1986 will see even more activity.

In 1983 we directed staff to begin the data collection necessary to enable us to examine our current reimbursement methodologies. In October a document was published containing such information.

In the fall of the year both the House and Senate considered some limited changes in the context of the budget legislation -- these changes were not designed to resolve the underlying

PROBLEMS. THEY WERE DESIGNED VERY HONESTLY, TO HELP REDUCE OUR EXPENDITURES, WHILE WE SORTED OUT THE BIGGER QUESTIONS.

THE NEXT STEP, I BELIEVE, IS TO SIT DOWN WITH THE PRINCIPALS AND DEFINE THE PROBLEMS AND OUTLINE THE ALTERNATIVES.

TO THIS END, I WILL BE ASKING REPRESENTATIVES FROM MEDICAL SPECIALITY GROUPS, CONSUMER GROUPS, THE INSTITUTE OF MEDICINE, THE BUSINESS COMMUNITY AND THE INSURANCE INDUSTRY AND OTHERS, TO SIT DOWN WITH US IN A SERIES OF INFORMAL MEETINGS TO HAMMER OUT THESE ISSUES. IT IS ONLY IN THIS FASHION THAT I BELIEVE WE CAN RESOLVE THE VERY DIFFICULT ISSUES BEFORE US.

OVER THE LAST YEAR I HAVE SENSED TREMENDOUS INTEREST AMONG MANY PHYSICIAN GROUPS IN HELPING US--THIS WILL PROVIDE THEM AN OPPORTUNITY TO DO SO.

LONG-TERM CARE SERVICES

EACH DAY IT IS BECOMING MORE APPARENT THAT WE MUST BEGIN SHIFTING OUR FOCUS FROM THE ACUTE HEALTH CARE MARKET TO THE LONG-TERM CARE HEALTH MARKET. CHANGING DEMOGRAPHICS HAVE MADE LONG-TERM CARE SPENDING THE FASTEST GROWING SEGMENT OF THE U.S. HEALTH CARE INDUSTRY. AVERAGE ANNUAL INCREASES IN OUR NATIONAL EXPENDITURES FOR NURSING HOME CARE, FOR EXAMPLE, CONSISTENTLY EXCEED THE AVERAGE FOR ALL OTHER EXPENDITURES, INCLUDING HOSPITAL CARE.

AND THE SITUATION WILL ONLY GET WORSE. BETWEEN NOW AND THE TURN OF THE CENTURY, THE MOST VULNERABLE POPULATION FOR LONG-TERM CARE, THOSE OVER 85 YEARS OF AGE, WILL GROW AT A RATE MORE THAN TWO AND HALF TIMES THAT OF THE TOTAL POPULATION. THESE PROJECTIONS LED TO ESTIMATES THAT 2.5 TO 3 MILLION MORE NURSING HOME BEDS WILL BE NEEDED IN 1990 IF CURRENT USE PATTERNS ARE MAINTAINED.

THE FINANCING OF LONG-TERM CARE THUS HAS BECOME A MAJOR CONCERN FOR CITIZENS AND PUBLIC OFFICIALS ALIKE. BUT TWO QUESTIONS REMAIN TO BE ANSWERED - WHO SHALL PAY FOR THESE SERVICES AND FOR WHAT SERVICES SHALL WE PAY.

TODAY, RESPONSIBILITY FOR LONG-TERM CARE SERVICES IS SHARED ALMOST EQUALLY BY THE PUBLIC AND PRIVATE SECTORS. PUBLIC RESPONSIBILITY RESTS MAINLY WITH THE MEDICAID PROGRAM WHICH PAYS ABOUT 56 PERCENT OF OUR NATION'S NURSING HOME BILL. BUT THE REMAINDER OF THIS BILL, OVER $11 BILLION, COMES DIRECTLY FROM THE POCKETS OF PATIENTS AND THEIR FAMILIES. PRIVATE INSURANCE PLAYS ALMOST NO ROLE IN THE FINANCING OF LONG-TERM CARE, NOR DOES MEDICARE, WHICH HAS ONLY LIMITED PROVISIONS FOR POST-HOSPITAL SKILLED NURSING OR REHABILITATIVE CARE. SLOWING THE GROWTH OF LONG-TERM CARE EXPENDITURES (PERHAPS THROUGH A PROSPECTIVE PAYMENT SYSTEM) AND AGREEING ON THE MIX OF PUBLIC AND PRIVATE FISCAL RESPONSIBILITY IN THIS AREA ARE ISSUES THAT WILL REQUIRE FURTHER DISCUSSION.

So too, the issue of service mix. Most long-term care services now are being provided in costly institutions. Less than one-quarter of our public long-term care expenditures pay for services delivered within the home or community. A redirection of this funding pattern is long overdue. On February 27th, the Finance Health Subcommittee has scheduled a hearing on the Community Living Amendments. This proposal would shift the medicaid funding from large institutions caring for the mentally and physically handicapped to small community-based facilities. Needless to say this is a very controversial subject, but one that deserves our attention.

Two years ago, Congress acted to allow states significantly greater flexibility in the development of home and community-based long-term care services. The response from the states has been enthusiastic. Creative and cost-effective programs are springing up from Maine to California and everywhere in-between.

Private sector experimentation also is evident. There are those who believe contrary to the conventional wisdom, that the risk of long-term disability in old age is an insurable one. Future generations of older persons may be both more interested in and financially able to purchase private long-term care insurance. This potentially new market is being tested now in a number of places.

It is my view that hospitals can not keep themselves aloof from this new health care market. As more hospitals become vertically integrated, long-term care will become part of their package of services. Hence, reimbursement and financing decisions will affect them directly. Additionally, it is often the hospital discharge planner that arranges for nursing home placement or other needed long-term care services after hospitalization, thus making hospital personnel important gate-keepers and traffic managers in the long-term-care system.

The expansion of long-term care services is inevitable although many questions remain unanswered regarding the financing and delivery of these services. The role of the hospitals in this health service sector is inevitable even though that role is not yet clear.

OVERSIGHT ON PROSPECTIVE PAYMENT

Perhaps of more immediate concern to you is the implementation of the prospective payment system. Certainly one of the most talked about issues is the treatment of capital costs.

Capital Costs

A great deal of time and effort is currently going into proposing methods for dealing with capital-related costs under the Medicare program. I can understand why. Although, the capital cost pass-through we adopted with prospective payment will not expire until October 1, 1986; that date is not far off in terms of the lead time needed to plan and undertake capital projects. We welcome these efforts. They will provide us with a number of options which will have been exposed to some scrutiny by the financial community, provider organizations, and other interested parties. But I must add a note of caution. It should not be assumed that the incorporation of capital into the prospective payment system limits our options to a so-called prospective payment rate capital "add-on". An add-on, or capital factor, is a possibility. But it should be no more than just that, one of a number of options to be considered.

I recognize that the capital cost issue should be resolved as soon as possible, but I must also tell you something you probably already know. Legislation to finally resolve the issue is unlikely this year. That does not mean we will ignore the issue. Instead, we will use our time to consider the current proposals and the Secretary's report on methods to deal with capital costs when it becomes available later this year. I would hope that all our efforts will allow us to adopt appropriate legislation early in 1985.

URBAN--RURAL

ONE OF THE MOST DIFFICULT DECISIONS THAT HAD TO BE MADE WHEN WE DRAFTED THE PROSPECTIVE PAYMENT LEGISLATION WAS WHETHER OR NOT TO REQUIRE SEPARATE URBAN/RURAL RATES. THE DECISION TO DO SO WAS BASED ON A CONCERN THAT INSTITUTIONS BE GIVEN A FURTHER OPPORTUNITY TO MAKE A RELATIVELY SMOOTH TRANSITION TO REGIONAL AND THEN NATIONAL RATES.

HOWEVER, WITH EVERY SOLUTION THERE COMES ANOTHER PROBLEM. I HAVE HEARD A GREAT DEAL ABOUT THE DIFFICULTIES OF HOSPITALS CLASSIFIED AS RURAL WHO ARE VERY CLOSE TO URBAN AREAS THANKS TO THE EFFORTS OF THE MEMBERS OF THE KANSAS HOSPTIAL ASSOCIATION. MY OFFICE HAS ALSO BEEN ALERTED TO THE DIFFICULTIES OF HOSPITALS WHO, BECAUSE OF THE WAY CENSUS AREAS ARE CONSTRUCTED, END UP IN SEPARATE REGIONS, WITH SEPARATE RATES--THOUGH ACTUALLY LOCATED IN THE SAME AREA. I UNDERSTAND THE HOSPITALS AROUND CINCINNATI ARE FACED WITH THIS PROBLEM.

WE KNEW THAT PROBLEMS WOULD ARISE AS THE SYSTEM WAS IMPLEMENTED, BUT WE ALSO AGREED TO SOLVE THEM AS WE WENT ALONG. MY OFFICE WILL CERTAINLY DO ALL THAT IT CAN TO ASSIST YOU IN FINDING A RESOLUTION TO THESE ISSUES, AND ANY OTHERS, INCLUDING THE WAGE INDEX. IT IS IN ALL OF OUR BEST INTERESTS TO MAKE THIS NEW SYSTEM WORK.

CONCLUSION

THE YEAR AHEAD WILL ADDRESS THE DEFICIT AND HOPEFULLY MAKE THAT DOWNPAYMENT ON THE FUTURE.

WE WILL ALSO HAVE AMPLE OPPORTUNITY FOR OVERSIGHT AND FACT FINDING.

AS I SAID AT THE OUTSET OF MY REMARKS, YOUR PAST COOPERATION AND INPUT HAS BEEN OF TREMENDOUS ASSISTANCE TO US. TOUGH TIMES ARE STILL AHEAD, AND WE WOULD LIKE TO AGAIN WORK WITH YOU AND NOT AGAINST YOU IN SEEKING OUT ANSWERS TO THE QUESTIONS BEFORE US.

WHILE WE HAVE HAD OUR DIFFERENCES IN THE PAST, I NEVERTHELESS BELIEVE WE HAVE THE SAME GOALS IN MIND: A STRONG, HEALTHY ECONOMY AND A STRONG, HEALTHY PEOPLE. YOUR COMMITTMENT TO QUALITY CARE HELPS TO MAKE THESE GOALS A REALITY.