REMARKS OF SENATOR BOB DOLE
NATIONAL PHARMACEUTICAL ALLIANCE
CAPITOL HILTON
MAY 22, 1978

IT IS A PLEASURE FOR ME TO BE HERE WITH YOU FOR THE ANNUAL MEETING OF THE NATIONAL PHARMACEUTICAL ALLIANCE. I AM PARTICULARLY PLEASED TO HAVE THE OPPORTUNITY TO TALK WITH YOU AT THIS TIME BECAUSE OF THE MANY, IMPORTANT HEALTH CARE ISSUES FACING US ALL.

HEALTH CARE COST CRISIS

THE EXTRAORDINARY RAPID RISE IN THE COST OF HEALTH CARE SERVICES IS INCREASING THE NEED FOR A RESPONSE. THE FEDERAL GOVERNMENT IS BEING ASKED TO ABSORB MORE OF THESE COSTS EACH DAY AND WE ARE STRETCHING OUR HEALTH CARE DOLLAR BEYOND REASON.

HEALTH CARE SPENDING HAS INCREASED OVER THE PAST DECADE AT AN ANNUAL RATE OF 12%, RISING FROM $42.1 BILLION IN FISCAL 1966 TO AN ESTIMATED $160 BILLION IN 1977. IN TWO RECENT SURVEYS THE MAJORITY OF THOSE QUESTIONED WHILE GENERALLY SATISFIED WITH THE PRESENT HEALTH CARE SYSTEM, INDICATED CONCERNS OVER COST. IT WOULD APPEAR THAT IF THERE IS A "HEALTH CARE CRISIS," IT IS NOT NECESSARILY THE SYSTEM AS MUCH AS THE COST OF THE PRODUCT.

THERE IS CONSIDERABLE PRESSURE FOR STRONGER FEDERAL ACTION TO CONTROL COSTS. BEFORE THIS IS DONE WE SHOULD EXAMINE THE PROBLEMS THAT ARE CAUSED BY THE FEDERAL AND STATE GOVERNMENT'S OWN PROGRAMS. THE DRUG INDUSTRY IS PARTICULARLY AWARE OF THE IMPACT OF FEDERAL REGULATIONS AND CONTROL.

FEDERAL REGULATIONS

THE COST OF OPERATING FEDERAL REGULATORY AGENCIES IS EXPECTED TO MORE THAN DOUBLE IN FISCAL YEARS 1974-79, RISING AT A FASTER RATE THAN THE FEDERAL BUDGET AS A WHOLE, THE POPULATION OF THE COUNTRY, OR THE GROSS NATIONAL PRODUCT. BUT THESE COSTS AS LARGE AS THEY ARE, DO NOT BEGIN TO REFLECT THE MORE CRITICAL COST OF COMPLIANCE. IT HAS BEEN ESTIMATED THAT FOR FISCAL YEAR 1979, THE SUM OF THE ADMINISTRATIVE COSTS OF FEDERAL REGULATION, PAID BY THE TAXPAYER, AND THE COMPLIANCE COSTS, GENERALLY PASSED ON TO THE CONSUMER, MAY TOP $100 BILLION.

DRUG REGULATIONS

IT HAS BEEN POINTED OUT, "GOVERNMENTS FACE A DILEMMA IN REGULATING PHARMACEUTICAL INNOVATION. IN OUR ANXIETY TO PROTECT THE GENERAL PUBLIC FROM THE EFFECTS OF BAD DRUGS, WE MAY HAVE A DETRIMENTAL EFFECT ON THE FLOW OF INNOVATIONS. THE REGULATORY CLIMATE IN THIS COUNTRY IN THE DRUG INDUSTRY HAS BEEN EVEN MORE RIGID SINCE THE PASSAGE OF THE 1962 KEFAUVER/HARRIS AMENDMENTS.

THE SAFETY AND WELL-BEING OF OUR CITIZENS MUST REMAIN UPPERMOST IN OUR MINDS WHEN WE EXAMINE THE REQUIREMENTS AND REGULATIONS THAT CONTROL THE DRUG INDUSTRY, OR ANY OTHER INDUSTRY. BUT TOO MUCH REGULATION, TOO MUCH UNNECESSARY INTERFERENCE, ARE AT TIMES HARMFUL IN THEMSELVES. THE BALANCE BETWEEN APPROPRIATE CAUTION AND OVER-REGULATION IS A FINE ONE, AND DIFFICULT TO DETERMINE. OUR PRESENT REGULATORY SYSTEM HAS BEEN OFFERED AS A MAJOR REASON THAT THIS COUNTRY LAGS BEHIND OTHERS IN THE DEVELOPMENT AND PRODUCTION OF NEW DRUGS.

IT NOW COSTS OVER $20 MILLION TO BRING THE AVERAGE NEW DRUG TO THE U.S. MARKET -- AN ASTOUNDING AMOUNT. IT IS NO WONDER THAT CONSIDERING THE AMOUNTS NECESSARY TO SATISFY GOVERNMENT REQUIREMENTS THAT FEWER DRUG PROJECTS CAN BE UNDERTAKEN.

IN A COUNTRY THAT THRIVES ON INNOVATION AND DISCOVERY, THIS IS A SAD COMMENTARY.

THE DRUG REGULATION REFORM ACT OF 1978, PRESENTLY BEING CONSIDERED BY THE HUMAN RESOURCE COMMITTEE, PRESENTS US WITH AN OPPORTUNITY TO EXAMINE THESE ISSUES CAREFULLY. IF ENACTED THE BILL WOULD BE THE FIRST MAJOR REVISION OF DRUG REGULATION LAW SINCE 1962 AND THE THIRD SINCE THE FIRST DRUG LAW WAS PASSED APPROXIMATELY 70 YEARS AGO.

THIS LEGISLATION IS NOT WITHIN THE JURISDICTION OF THE SENATE FINANCE HEALTH SUBCOMMITTEE, OF WHICH I AM THE RANKING REPUBLICAN MEMBER, BUT WE WILL BE WATCHING THE BILL AND TRUST YOU WILL SHARE YOUR COMMENTS AND SUGGESTIONS WITH US.

HOSPITAL REGULATIONS

IN ANOTHER AREA OF THE HEALTH CARE INDUSTRY, THE HOSPITAL, GOVERNMENT REGULATIONS HAVE PROVEN EQUALLY AS COSTLY. I THOUGHT YOU WOULD BE INTERESTED IN PORTIONS OF A LETTER THAT SENATORS TALMADGE, NUNN, AND I SENT TO THE COMPTROLLER GENERAL OF THE UNITED STATES.

"DUPLICATION IN HOSPITAL REGULATORY ACTIVITY AND DATA REPORTING REQUIREMENTS AND AUDITS ARE OF INCREASING CONCERN TO HOSPITALS AND ALL LEVELS OF GOVERNMENT, PARTICULARLY IN VIEW OF THE EFFORTS TO COME TO GRIPS WITH INCREASING HOSPITAL COSTS. IN ONE AGENCY ALONE -- THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE -- THE PAGES IN THE CODE OF FEDERAL REGULATIONS RELATING TO VARIOUS PROGRAMS ADMINISTERED BY THAT AGENCY HAVE MORE THAN DOUBLED SINCE 1969.

"THERE IS CERTAINLY LEGITIMATE NEED FOR CLEAR AND CONCISE REGULATIONS ISSUED IN A TIMELY MANNER TO ASSURE HEALTH AND SAFETY. HOWEVER, THERE IS ALSO A NEED TO ASSURE THAT DUPLICATIVE AND NON-ESSENTIAL REGULATORY AND ADMINISTRATIVE ACTIVITIES ARE CONSOLIDATED OR ELIMINATED.

"....WE WOULD APPRECIATE YOUR REVIEW AND EVALUATION OF ALL REQUIREMENTS APPLICABLE TO HOSPITALS WHICH DEAL WITH LICENSURE, CERTIFICATION, DATA REQUESTS, NON-STANDARD CLAIMS FORMS, HEALTH AND SAFETY REQUIREMENTS FOR PATIENTS AND EMPLOYEES, AND ASSOCIATED MATTERS WITH A VIEW TOWARDS LEGISLATIVE AND/OR ADMINISTRATIVE RECOMMENDATIONS TO ELIMINATE OR CONSOLIDATE ACTIVITIES AND REQUIREMENTS AND TO ESTABLISH PROCEDURES TO ASSURE THAT REQUIREMENTS ARE ESSENTIAL AND COST EFFECTIVE.

"NOTHING IN OUR REQUEST SHOULD BE INTERPRETED TO UNDERCUT IN ANY WAY APPROPRIATE HEALTH AND SAFETY OR OTHER REQUIREMENTS. WE ARE CONVINCED, HOWEVER, THAT A MORE RATIONAL AND COMMON SENSE APPROACH IS NEEDED."

WE ARE HOPEFUL THAT THIS INQUIRY WILL RESULT IN MAKING THE SYSTEM A MORE REASONABLE AND RESPONSIBLE ONE. THE STUDY REQUESTED ON JANUARY 24 MAY TAKE SOME TIME TO BE COMPLETED, HOWEVER, WE HOPE THAT SOME PRELIMINARY DATA WILL BE COMING SHORTLY.

AND, IF THIS INQUIRY PROVES AS PRODUCTIVE AND CONSTRUCTIVE AS WE HOPE, IT MAY WELL PROVE A PRECEDENT FOR REQUIRING REVIEW OF REGULATORY ACTIVITY IN AREAS OTHER THAN HOSPITAL REGULATION.

CATASTROPHIC HEALTH INSURANCE

ANOTHER AREA THAT I BELIEVE SHOULD BE ADDRESSED IS PROTECTION FOR INDIVIDUALS FROM THE EXTRAORDINARY EXPENSES INCURRED FORM AN EXTENDED OR PARTICULARLY SERIOUS ILLNESS. THIS IS A HEALTH INSURANCE NEED THAT PRIVATE INSURERS HAVE BEEN SLOW TO RESPOND TO.

LAST THURSDAY, I JOINED WITH SENATORS LONG, RIBICOFF AND TALMADGE, IN INTRODUCING THE CATASTROPHIC HEALTH INSURANCE AND MEDICAL ASSISTANCE REFORM ACT OF 1978.

I BELIEVE OUR PROPOSAL IS A FISCALLY RESPONSIBLE WAY OF ATTACKING SOME OF THE MOST IMPORTANT PROBLEMS IN THE AMERICAN HEALTH CARE SYSTEM.

FIRST, THE BILL WOULD PROTECT OUR CITIZENS AGAINST THE DEVASTATING FINANCIAL IMPACT OF CATASTROPHIC ILLNESS OR ACCIDENT. SECOND, THE BILL WOULD REPLACE THE PERENNIALLY TROUBLED MEDICAID PROGRAM WITH A UNIFORM, NATIONAL PROGRAM OF MEDICAL BENEFITS FOR LOW-INCOME PERSONS. FINALLY, THIS PROPOSAL PROVIDES FOR A VOLUNTARY FEDERAL CERTIFICATION PROGRAM FOR BASIC PRIVATE HEALTH INSURANCE TO ENCOURAGE PRIVATE INSURERS TO MAKE SUCH BASIC COVERAGE AVAILABLE IN ALL AREAS OF THE COUNTRY TO SUPPLEMENT THE CATASTROPHIC PROGRAM.

TITLE I OF THE BILL, WHICH CREATES THE CATASTROPHIC INSURANCE PROGRAM, IS A PARTICULARLY IMPORTANT STEP TO CONSIDER AT THIS TIME. CATASTROPHIC ILLNESS AND ACCIDENTS CAN STRIKE ANYONE AT ANY TIME, AND THE FEAR OF THE DISABLING OR EVEN FATAL ILLNESS OR INJURY SHOULD NOT ALWAYS BE ACCOMPANIED BY THE FEAR OF THE CRIPPLING FINANCIAL BURDEN OF THE COST OF TREATMENT.

THE CONGRESSIONAL BUDGET OFFICE, IN A 1977 REPORT, OUTLINED THE INADEQUACY OF THE THREE MAJOR SOURCES OF ASSISTANCE IN MEETING THE COST OF HEALTH CARE: PRIVATE INSURANCE, PUBLIC PROGRAMS, AND TAX SUBSIDIES. THESE SOURCES DO SIGNIFICANTLY REDUCE THE PERCENTAGE OF MEDICAL EXPENSES THAT ARE PAID DIRECTLY BY THE CONSUMER AND THUS THE INCIDENCE OF COSTS THAT ARE CATASTROPHIC TO THE PERSON INVOLVED. THE PROBLEMS THAT REMAIN, HOWEVER, ARE CRUCIAL. FOR INSTANCE, COVERAGE IS UNEVEN. AN ESTIMATED 18 MILLION PERSONS, ACCORDING TO CBO, ARE TOTALLY WITHOUT PROTECTION UNDER EITHER PRIVATE INSURANCE OR PUBLIC PROGRAMS. CERTAIN SERVICES ARE EXCLUDED FROM COVERAGE BY MANY PUBLIC AND PRIVATE INSURANCE PLANS OR ARE INSURED INADEQUATELY. SOME INSURANCE PLANS DO NOT ADEQUATELY COVER HIGH EXPENSES. THE CBO ESTIMATES THAT 37 MILLION PERSONS ARE COVERED UNDER INSURANCE PLANS THAT DO NOT ADEQUATELY COVER HIGH EXPENSES OR LONG HOSPITAL STAYS. FINALLY, TAX SUBSIDIES, WHICH ARE FAIRLY EFFECTIVE IN MITIGATING THE IMPACT OF HIGH OUT-OF-POCKET EXPENSES OF MIDDLE-INCOME FAMILIES WHEN INSURANCE IS INADEQUATE, PROVIDE ONLY MARGINAL ASSISTANCE TO LOWER-INCOME FAMILIES.

CBO ESTIMATES FOR 1978 SHOW 18 MILLION PERSONS WHO ARE UNINSURED, 19 MILLION PERSONS IN FAMILIES WITH INCOMES OF LESS THAN $10,000 WHO HOLD ONLY INDIVIDUAL PRIVATE POLICIES, 26 MILLION AGED AND DISABLED PERSONS ON MEDICARE, AND 37.5 MILLION PERSONS WITH BASIC HOSPITAL INSURANCE WITH NO MAJOR MEDICAL COVERAGE - ALL LESS THAN ADEQUATE PROTECTION AGAINST CATASTROPHIC COSTS.

EVERY FAMILY IN THIS COUNTRY NEEDS AND DESERVES PROTECTION AGAINST THE COSTS OF CATASTROPHIC ILLNESS AND I SEE THIS BILL AS THE BEST APPROACH AT THE PRESENT TIME TO PROVIDE IT.

THE TITLE II PROGRAM, WHICH WOULD REPLACE MEDICAID WITH AN ENTIRELY NEW BASIC HEALTH BENEFITS PROGRAM FOR LOW-INCOME INDIVIDUALS AND FAMILIES, WOULD HELP TO CORRECT SOME OF THE INEQUITIES OF THAT PROGRAM, SUCH AS THE STATE-BY-STATE VARIATIONS IN ELIGIBILITY AND BENEFITS. THE NEED FOR REFORM IN THIS PROGRAM HAS BEEN EVIDENT FOR SOME TIME.

THE TITLE III PROVISIONS FOR CERTIFICATION OF PRIVATE BASIC HEALTH INSURANCE PLANS WILL FACILITATE THE OFFERING OF SUCH PLANS THROUGH INSURANCE POOLS AND ENCOURAGE STATES TO FACILITATE THE OFFERING OF SUCH PLANS. UNDER THIS PROVISION, IT WILL BE POSSIBLE FOR ANY PERSON NOT ELIGIBLE FOR COVERAGE UNDER THE TITLE II MEDICAL ASSISTANCE PROGRAM TO GET A GOOD, GOVERNMENT-CERTIFIED INSURANCE POLICY AT A REASONABLE PRICE. INSURERS WHO CHOOSE TO HAVE THEIR POLICIES CERTIFIED CAN USE THEIR CERTIFICATION IN THEIR ADVERTISING.

ALL IN ALL, I BELIEVE THIS BILL IS A REALISTIC APPROACH TO DEALING WITH SOME OF OUR MOST PRESSING HEALTH NEEDS AND AT A COST WE CAN AFFORD. THERE IS A GREAT TEMPTATION TO DO MORE WITH A NATIONAL HEALTH PLAN, TO ATTEMPT TO PROVIDE ALL TYPES OF HEALTH CARE TO NEARLY EVERYONE, BUT THE POTENTIAL FOR BANKRUPTCY AND THE CHANCES OF ERROR ARE TOO GREAT FOR SUCH AN EXPANSIVE APPROACH.

WHILE RECOGNIZING THAT OUR PROPOSAL MAY NOT ADDRESS ALL THE HEALTH PROBLEMS OF THE CITIZENS IN THIS COUNTRY, IT IS A BEGINNING UPON WHICH FUTURE DISCUSSIONS CAN BE BASED. I TRUST THE BILL WILL BENEFIT FROM ADDITIONAL DISCUSSIONS AND CONSTRUCTIVE EFFORTS IN THE MONTHS AHEAD.

HOWEVER, EFFORTS TO CONTROL COSTS MUST TAKE PRECEDENCE OVER THIS AND MANY OTHER SUBJECTS. UNCONTROLLED, INFLATIONARY INCREASES IN NATIONAL HEALTH EXPENDITURES WILL REMOVE FROM OUR ECONOMY CAPITAL RESOURCES WHICH COULD OTHERWISE BE SPENT ON SUCH PROPOSALS.

MEDICARE AND MEDICAID REFORM

INCREASING ATTENTION IS BEING GIVEN TO COST CONTROL EFFORTS BY THE FINANCE HEALTH SUBCOMMITTEE IN ADDITION TO OTHER COMMITTEES ON BOTH THE HOUSE AND SENATE SIDES.

THERE IS NO QUESTION IN MY MIND THAT MEDICARE AND MEDICAID HAVE CONTRIBUTED TO THE HEALTH COST PROBLEM.

THESE PROGRAMS WILL COST FEDERAL AND STATE TAXPAYERS MORE THAN $47 BILLION THIS FISCAL YEAR -- SOME $9 BILLION MORE THAN LAST YEAR.

THAT'S A LOT OF MONEY.

I, TOGETHER WITH SENATOR HERMAN TALMADGE, AM A PRINCIPAL SPONSOR OF S. 1470, A BILL THAT WOULD DEAL WITH A NUMBER OF THESE MEDICARE AND MEDICAID ADMINISTRATIVE AND REIMBURSEMENT PROBLEMS.

THE HOSPITAL REIMBURSEMENT PROVISIONS OF THE BILL MAKE WHAT ARE PERHAPS THE MOST IMPORTANT CHANGES.

AS YOU KNOW, THE TYPICAL HOSPITAL RECEIVES AROUND 40 PERCENT OF ITS OPERATING REVENUE FROM MEDICARE AND MEDICAID. IT GOES WITHOUT SAYING THAT THESE PROGRAMS EXERT CONSIDERABLE INFLUENCE IN THE HOSPITAL MARKETPLACE.

GIVEN THIS ECONOMIC FACT OF LIFE, ANY SHIFT IN REIMBURSEMENT POLICY MUST BE CAREFULLY THOUGHT OUT LEST THE POLICY CREATE UNDESIRABLE SIDE EFFECTS.

FOR EXAMPLE, AN ARBITRARY PAYMENT POLICY THAT FAILS TO TAKE ACCOUNT OF LEGITIMATE DIFFERENCES BETWEEN HOSPITALS AND THEIR UNIQUE FISCAL NEEDS COULD BECOME A MORE IMPORTANT FACTOR IN RUNNING A HOSPITAL THAN SOUND MEDICAL AND MANAGEMENT PRACTICES.

IT COULD ALSO CAUSE CHAOS IN THE HOSPITAL SECTOR OF THE CAPITAL, CONSTRUCTION AND MEDICAL EQUIPMENT MARKETS.

THESE ARE BUT A FEW OF THE MANY RISKS THAT MUST BE CONSIDERED IN DECIDING ON A HOSPITAL REIMBURSEMENT POLICY. S. 1470 SEEKS TO TAKE ACCOUNT OF DIFFERENCES BETWEEN HOSPITALS' FINANCIAL NEEDS BY RELATING THEIR PAYMENT RATES UNDER MEDICARE AND MEDICAID TO THE COSTS EXPERIENCES BY SIMILAR HOSPITALS.

HOSPITALS WHOSE COSTS SUBSTANTIALLY EXCEEDS THOSE OF COMPARABLE INSTITUTIONS WOULD RECEIVE LESS THAN FULL-COST REIMBURSEMENT. THIS IS IN SHARP CONTRAST TO FLAT CEILINGS, PERCENTAGE LIMITATIONS OR STRAIGHT-OUT PRICE CONTROLS, WHICH APPLY IN THE SAME MANNER TO THE ENTIRE SPECTRUM OF HOSPITALS.

S. 1470 ALSO PROVIDES AN OPPORTUNITY FOR HOSPITALS THAT ARE EFFICIENT -- AS COMPARED TO LIKE HOSPITALS -- TO EARN INCENTIVE PAYMENTS ABOVE THEIR COSTS.

YOU ARE PERHAPS FAMILIAR WITH THE ADMINISTRATION'S APPROACH TO THE MODERATION OF HOSPITAL COSTS. THEY PROPOSE A LIMIT -- INITIALLY 9 PERCENT -- ON THE AMOUNT BY WHICH A HOSPITAL'S REVENUE CAN INCREASE FROM YEAR TO YEAR.

I HAVE STRONG RESERVATIONS ABOUT THE WISDOM OF AN OVERALL CAP ON HOSPITAL REVENUES. FIRST, THAT CAP MAY BECOME A FLOOR. SECOND, WITH ALL THE EXCEPTIONS, THE CAP MAY BE INEFFECTIVE AS A CEILING. AND, THIRD, A CAP BY ITS VERY NATURE IS ARBITRARY AND TENDS TO PENALIZE THOSE WHO HAVE BEEN EFFICIENT IN THE PAST AND REWARD THOSE WHO HAVE BEEN INEFFICIENT. IT IS LIKE PUTTING ALL HOSPITALS ON A CRASH DIET BECAUSE SOME ARE, AS SECRETARY CALIFANO WOULD PUT IT, "OBESE."

YOU ARE ALSO NO DOUBT FAMILIAR WITH THE VOLUNTARY COST CONTAINMENT PROGRAM THAT HAS BEEN PROPOSED BY THE AMERICAN HOSPITAL ASSOCIATION, THE FEDERATION OF AMERICAN HOSPITALS AND THE AMERICAN MEDICAL ASSOCIATION. THIS APPROACH TO COST CONTAINMENT WOULD CALL FOR VOLUNTARY EFFORTS TO CURTAIL INCREASES IN HOSPITAL EXPENDITURES.

I BELIEVE THIS EFFORT SHOULD BE GIVEN EVERY OPPORTUNITY TO SUCCEED. THE BEST COST CONTAINMENT EFFORT WILL BE THE ONE WHICH REQUIRES THE LEAST AMOUNT OF GOVERNMENT INTERFERENCE, AND ENCOURAGES INDIVIDUAL RESPONSIBILITY AND ACCOUNTABILITY. BUT, ADDITIONALLY, I BELIEVE THE FEDERAL PAYMENT PROGRAMS SHOULD PUT THEIR OWN HOUSE IN ORDER BY ADOPTING THE REIMBURSEMENT REFORMS IN THE TALMADGE/DOLE BILL, S. 1470.

I MYSELF HAVE SEVERAL FURTHER CONCERNS IN THE PROVISION OF HEALTH CARE AND AM IN THE PROCESS OF DEVELOPING SEVERAL LEGISLATIVE INITIATIVES WHICH I HOPE TO PRESENT IN THE NEAR FUTURE.

PREVENTIVE HEALTH CARE

FIRST, I THINK WE CAN DO MORE IN THE AREA OF PREVENTIVE HEALTH CARE. THERE ARE MANY THINGS THE PEOPLE OF THIS COUNTRY COULD DO AND SHOULD BE ENCOURAGED AND TAUGHT TO DO TO ENHANCE THEIR OWN GOOD HEALTH AND FORESTALL THE NEED FOR MORE EXPENSIVE UTILIZATION OF THE HEALTH CARE SYSTEM. WE CAN LEARN TO TAKE BETTER CARE OF OURSELVES SO THAT WE DON'T NEED TO GO TO THE DOCTOR OR THE HOSPITAL FOR CARE. BUT WE NEED TO PROVIDE INCENTIVES TO INDIVIDUALS AND TO INDUSTRY TO PROMOTE THESE ACTIVITIES IN ADDITION TO PROVIDING FUNDS FOR STATE PROJECTS AND PROGRAMS.

CARE FOR TERMINALLY ILL

THE SECOND AREA OF CONCERN I AM WORKING ON IS THE CARE OF THE TERMINALLY ILL, SPECIFICALLY THE HOSPICE MOVEMENT. I HAVE BEEN VERY IMPRESSED WITH WHAT I HAVE READ AND HEARD ABOUT THE SUCCESS OF HOSPICES IN DEALING WITH THE SPECIAL PROBLEMS AND NEEDS OF THOSE WHO ARE DYING AND THE PROBLEMS OF THEIR FAMILIES. I AM ENCOURAGED WITH THE POSSIBILITIES OF AN EXPANSION OF THE HOSPICE MOVEMENT IN THIS COUNTRY.

OF COURSE, CRITICAL TO ANY DISCUSSIONS ABOUT THE CARE OF THE TERMINALLY ILL ARE THE INNOVATIVE USER OF DRUGS TO LESSEN THE DISCOMFORT OF THOSE WHO ARE DYING, WHILE ALLOWING THEM TO PARTICIPATE AS FULLY AS POSSIBLE IN ACTIVITIES AROUND THEM.

WE WILL BE COUNTING HEAVILY ON YOUR INDUSTRY TO ASSIST IN NEW METHODS AND NEW DRUGS IF NECESSARY FOR THESE PURPOSES.

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CONCLUSION

IN CONCLUSION, I WOULD LIKE TO THANK YOU FOR ALLOWING ME TO BE WITH YOU, AND AGAIN STRESS THE NEED FOR BOTH INDUSTRY AND THE GOVERNMENT TO WORK TOGETHER TO ADDRESS THE PROBLEMS THAT FACE US. I BELIEVE IT IS ONLY THROUGH THIS METHOD THAT WE WILL BE ABLE TO TRULY DEVELOP RATIONAL AND EQUITABLE SOLUTIONS.

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