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REMARKS OF SENATOR BOB DOLE

AMERICAN HOSPITAL ASSOCIATION

WASHINGTON, D.C.

FEBRUARY 5, 1979

Let me begin by telling you how honored I am by your invitation to speak, and how much I welcome this opportunity to share with you some of my views about the role of you and your colleagues across the nation in providing the world's best health care. As many of you know, I nurture a certain suspicion about government when it intrudes into the private sector. I have seen too many regulations passed in the name of reform and efficiency, which instead have the ultimate effect of inefficiency and confusion. I have seen too many good intentions perverted by bureaucratic insensitivity. Indeed, the entire current inflation can be traced in large part to the zest for lawmaking and regulation writing of an over-active, intrusive federal government. And the health field is no exception to this sorry rule.

Let me give you one example of what I mean. In one agency alone--the Department of Health, Education and Welfare--the pages of relevant regulations have more than doubled in a decade. Many of these new regulations pertain to hospitals. And all this comes on top of a mountain of state and local regulations already in force. Perhaps the greatest single service the Congress could perform for your industry would be a thorough review of this tangle of regulation, with an eye toward elimination of duplication. This is one way we could provide you with assistance in your efforts to voluntarily hold down hospital costs.

HEALTH--A UNIQUE INDUSTRY

The year ahead will see considerable attention paid to two major initiatives in your field. I needn't remind you that the American people, prodded by certain individuals in the government, are urging both national health insurance of some form, and a still vague means of controlling the seemingly relentless rise in the cost of being sick in this country.

After those broad generalities, however, all is a blur. It's no secret that the D.C. in Washington, D.C. is sometimes said to stand for darkness and confusion. On the health issue, we have a great deal of both. And that is what I'd like to cut through today.

The health industry is unlike any other. It dispenses a product used infrequently by most of us. When we need that product, however, we want it immediately, and we want it to be perfect. In no area of American life do expectations run higher.

Yet conventional economic rules do not apply. Contrary to most fields, greater demand feeds upon itself. Supply and demand doesn't really work when you're dealing with human lives. Price is not usually a factor in deciding where to go or whom to seek help from. Yet factors such as geography and doctor preference, as impossible to regulate as human emotion itself, predominate.

Contradictions within the field are many. Health care is caught between the traditional desire for individual freedom and the equally strong desire for individual and group security. Providers such as yourselves are historically individualists of the entrepreneurial school, while government officials seek political solutions through general application of regulations.

In short, the only thing common to our hospitals and the professionals who run them is diversity. And one reason why I am personally wary of massive federal intrusion into the field is precisely this diversity. Any system of cost containment or health insurance must provide for flexibility in administration and permit change from generation to generation. I do not wish to saddle my children or grandchildren with systems too rigid to admit reform, nor too riddled by paperwork to maintain the historic tradition of individual choice and local oversight.

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COMPETITION VERSUS REGULATION

Thus arises the ultimate question relevant to both issues at hand: namely, what mix of competition and regulation is best in an economy of limited health resources? To put it another way, how can the public and private sectors share responsibility for designing and operating systems of cost-effective health care that are available to the greatest number of people?

That hospital costs are rising is beyond doubt. The average American now works a full month out of every year to pay his or her share of the national medical bill. Health care costs now form approximately 9% of the Gross National Product. But the costs of good health translate themselves into less obvious forms than the Federal ledger. A new car includes the cost of health insurance for auto workers. The same rule can be applied to hundreds of other products of modern industrial society.

Health care is a big business in 1979. You know that better than I. But you must also accept that rifts are developing within society over the cost of such care. Corporations are questioning the amount of their money put into health insurance plans. Unions are asking themselves if they do not bargain as effectively for health professionals as for their own members. And, of course, millions of ordinary citizens are willing to tell the nearest pollster that they consider the cost of good health in this country a national outrage. They probably do this en route to a lunch of empty calories and starch, having devoured a couple of soft drinks in the morning and prepared for an evening plopped before the television, potato chips and candy bars firmly clenched.

The problem would be a lot easier if the American people would take care of themselves. And health education must be made a primary responsibility of all those interested in promoting a nation of well people. We must never confuse the pursuit of happiness with Hostess Twinkies or Chef Boyardee.

Our experience with tobacco shows that government alone can have but little positive influence in such a field. But you, who have for yourselves a captive audience, can promote the basics of good health with far greater hopes for success. Your credibility as a pillar of community service is greater than government's. Your resources, both physical and intellectual, far outstrip government's.

I urge as strongly as I can that this potential for health teaching be maximized. Hospitals need no longer be perceived as illness factories, but as classrooms of health. Hospitals aren't just for sick people; they're to help well people stay that way.

But people will go on ignoring the rules of nutrition. They will continue to fall prey to age old diseases, however vehement our warnings or hopeful our scientific research. As long as they do, you will retain an obligation of caring for them in a professional fashion, without the specter of imminent bankruptcy adding to their--or your--woes.

So we come back again to the chief question at hand. What kind of cost containment will preserve what is good about traditional health care?

COST CONTAINMENT: A RIGHT WAY AND A WRONG WAY

There is a right way and a wrong way to contain hospital costs. The wrong way is the cost containment formula proposed by the Carter Administration in the past. It isn't much of a formula; more an edict from on high. The President would slap an across the board limit on any and all hospitals, regardless of local or regional factors, oblivious to the hospital's unique record of accomplishment in the field. The problems with such an approach go beyond its arbitrary nature. For one thing, there is the possibility that a ceiling might turn into a floor. A cap may be ineffective; certainly its Administration poses enormous problems of enforcement. Finally, any cap penalizes hospitals with records of cost efficiency, and rewards those with less impressive records.

I am more attuned to the ideas put forward by you and your colleagues, ideas which seek to replace heavyhanded federal regulation with voluntary restraint. I have watched with interest as you've devised your own guidelines, meeting each target, the most recent one falling under 13 percent. This is encouraging to those of us who prefer private to public management of our hospitals.

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But the President, as stated in his recent budget and State of the Union address, continues to single your industry out for federal oversight. The battle over numbers will continue. The Administration will continue to undercut your own best efforts at cost cutting. But I will tell you in all honesty that those efforts must continue unabated. The pressure is on, and why not?

If you fail to meet the goals you have set, if the public and politicians perceive less than a genuine desire to reduce the financial pain of getting well, then support for the Carter cap will grow accordingly. You hold the power and bear the responsibility for avoiding such arbitrary measures.

And, while we're talking about putting business in order, we shouldn't overlook government's own. This year, I plan to re-introduce legislation with my colleague, Senator Herman Talmadge, that would do just that. Among other things, our bill would address the major problem of Medicare and Medicaid reimbursement provisions.

MEDICARE AND MEDICAID

As you know, typically, the American hospital relies upon Medicare and Medicaid for approximately 40 percent of its operating revenue. Given this economic fact of life, any revision in reimbursement formulas must be carefully thought out, with special precaution lest it create undesirable side effects. And this reflects once again on my opposition to the President's arbitrary cap on hospital costs.

Take, for instance, any arbitrary payment policy that overlooks the unique fiscal needs of diverse hospitals. Such a policy could cause chaos in the hospital sector of the capital, construction and medical equipment markets. Such a policy might eventually become the most important single factor in hospital administration, even more important than sound medical and management practices.

That's why our bill would link Medicare and Medicaid payment rates with the experience of similar hospitals. Not a single, nationwide standard, but a more realistic standard, would apply. Hospitals where costs substantially exceed those of comparable institutions would receive less than full cost reimbursement. Hospitals that are cost-efficient would have incentives to receive payments above and beyond actual costs.

Another provision of our bill would permit hospitals to be reimbursed for capital costs and increased operating expenses associated with closing down or converting under-utilized bed capacity or services. Such payments might not be possible under the Carter ceiling.

Our bill is not set in concrete. It is open to revision and will benefit from ideas which you and others in your profession may have. I invite you to join with me in this effort, a far better way to control costs and protect our health care systems than anything offered thus far by the Administration.

In the past, even the President has described his limit as temporary, to be replaced by something better, something he has yet to define. Imagine, if you can, switching every hospital in America from our current control mechanisms to a Carter cap for three to five years, and then to yet another, still undefined concept of control, whether it's the one contained in my bill or another.

NATIONAL HEALTH INSURANCE: WHEN AND HOW?

The idea of national health insurance is inescapably linked with the rise in health costs. The combination of new technologies, mounting labor and professional costs and the heightened expectations of the American public regarding the benefits of health care have resulted in a new clamor for some form of reliable and cost effective alternative to the present patchwork of programs. It is a fact that millions of Americans now have unmet medical needs. It is also a fact that existing prepayment plans suffer from gaps of coverage, gaps which, in the event of catastrophic illness, can destroy the financial security of even upper middle income families. Demographics point toward an aging society which will presumably require even more medical attention than in the past.

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Amidst all these and other signs of need are stacked some sobering realities.

First and foremost is the ability of the American people to support any costly new system of anything. Do not forget that by 1981, the person earning $30,000 a year will find himself paying $165 per month after taxes to support his membership in the Social Security system alone. Moreover, we have been warned by many experts that health care that appears to be "free" is in fact a dangerous psychological spur to further inflation.

Those are the conflicting truths. We find ourselves walking a tightrope between demonstrated need and economic stringency. I'm not going to pretend to have all the answers. But I have given a great deal of thought to the questions that will have to be asked before any kind of national health insurance plan is formulated.

Let me list briefly the considerations that I think must be taken into account in designing and operating such a system:

1. Such a system should enlist the full support of a broad range of public and private interests. We've had enough fingerpointing in this country; enough of carrier pointing at providers, and vice versa, of everyone pointing at patients, and of government presuming to step in and point the largest finger of all.

2. Such a system should include provisions for realistic financing, recognizing that no single sector of society can afford to bear the entire burden.

3. Such a system must be evolutionary in scope. It would do well to acknowledge a finite amount of national resources, and stress responsible private competition as a meaningful alternative to government regulation.

4. Finally, any such system must recognize that gaps in existing plans ought to be filled in preference to any massive overhaul of the entire health care system. To suggest otherwise is to be dishonest with the American people.

What emerges from the Congress will be neither all public nor all private in nature. It will be neither wholly voluntary nor wholly involuntary, neither totally regulated nor purely competitive. But the fiscal facts of life strongly suggest to me, at least, that we cannot possibly afford a massive, cradle-to-grave system of health insurance, which might contain within its very universality seeds of its ultimate collapse.

Beyond that, I will listen carefully to my colleagues' words, and I will investigate carefully for myself. Our hospitals and the quality of our health care are resources too precious to be remade overnight. Prudence demands a thoughtful analysis of the alternatives.

THE PRIVATE RESPONSIBILITY

But, if a single principle unites our thinking, it is this: slogans, however appealing politically, do not assure adequate health coverage. Promises are cheaper than performance. It is inviting to attack visible symbols of inflation, and where the nation's hospitals contribute to less than efficient or cost-effective services they will not escape the brunt of such assaults. If you wish to avoid further regimentation from government, you must acknowledge your responsibility to control costs while maintaining the high level of care we've all grown accustomed to.

That is your special burden. It is your unique responsibility. But I, for one, am encouraged by the spirit of cooperation I've witnessed within groups such as this. I sense an awareness of the problem as more than bad public relations. The problem is staring us in the face, and it will not go away.

I pray that your efforts at cost containment succeed, because I believe in free enterprise as more than a ritualistic slogan. I believe it works, and works far better than all the well-intentioned efforts of a swollen or remote government. It is that ultimate principle that I will be trying to write into any legislation regarding containment or health insurance. I ask for your help.

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FEBRUARY 5, 1979

LET ME BEGIN BY TELLING YOU HOW HONORED I AM BY YOUR INVITATION TO SPEAK, AND HOW MUCH I WELCOME THIS OPPORTUNITY TO SHARE WITH YOU SOME OF MY VIEWS ABOUT THE ROLE OF YOU AND YOUR COLLEAGUES ACROSS THE NATION IN PROVIDING THE WORLD'S BEST HEALTH CARE. AS MANY OF YOU KNOW, I NURTURE A CERTAIN SUSPICION ABOUT GOVERNMENT WHEN IT INTRUDES INTO THE PRIVATE SECTOR. I HAVE SEEN TOO MANY REGULATIONS PASSED IN THE NAME OF REFORM AND EFFICIENCY, WHICH INSTEAD HAVE THE ULTIMATE EFFECT OF INEFFICIENCY AND CONFUSION. I HAVE SEEN TOO MANY GOOD INTENTIONS PERVERTED BY BUREAUCRATIC INSENSITIVITY. INDEED, THE ENTIRE CURRENT INFLATION CAN BE TRACED IN LARGE PART TO THE ZEST FOR LAWMAKING AND REGULATION WRITING OF AN OVERACTIVE, INTRUSIVE FEDERAL GOVERNMENT. AND THE HEALTH FIELD IS NO EXCEPTION TO THIS SORRY RULE.

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AFTER THOSE BROAD GENERALITIES, HOWEVER, ALL IS A BLUR. IT'S NO SECRET THAT THE D.C. IN WASHINGTON, D.C. IS SOMETIMES SAID TO STAND FOR DARKNESS AND CONFUSION. ON THE HEALTH ISSUE, WE HAVE A GREAT DEAL OF BOTH. AND THAT IS WHAT I'D LIKE TO CUT THROUGH TODAY.

THE HEALTH INDUSTRY IS UNLIKE ANY OTHER. IT DISPENSES A PRODUCT USED INFREQUENTLY BY MOST OF US. WHEN WE NEED THAT PRODUCT, HOWEVER, WE WANT IT IMMEDIATELY, AND WE WANT IT TO BE PERFECT. IN NO AREA OF AMERICAN LIFE DO EXPECTATIONS RUN HIGHER.

YET CONVENTIONAL ECONOMIC RULES DO NOT APPLY. CONTRARY TO MOST FIELDS, GREATER DEMAND FEEDS UPON ITSELF. SUPPLY AND DEMAND DOESN'T REALLY WORK WHEN YOU'RE DEALING WITH HUMAN LIVES. PRICE IS NOT USUALLY A FACTOR IN DECIDING WHERE TO GO OR WHOM TO SEEK HELP FROM. YET FACTORS SUCH AS GEOGRAPHY AND DOCTOR PREFERENCE, AS IMPOSSIBLE TO REGULATE AS HUMAN EMOTION ITSELF, PREDOMINATE.

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CONTRADICTIONS WITHIN THE FIELD ARE MANY. HEALTH CARE IS CAUGHT BETWEEN THE TRADITIONAL DESIRE FOR INDIVIDUAL FREEDOM AND THE EQUALLY STRONG DESIRE FOR INDIVIDUAL AND GROUP SECURITY. PROVIDERS SUCH AS YOURSELVES ARE HISTORICALLY INDIVIDUALISTS OF THE ENTREPRENURIAL SCHOOL, WHILE GOVERNMENT OFFICIALS SEEK POLITICAL SOLUTIONS THROUGH GENERAL APPLICATION OF REGULATIONS.

IN SHORT, THE ONLY THING COMMON TO OUR HOSPITALS AND THE PROFESSIONALS WHO RUN THEM IS DIVERSITY. AND ONE REASON WHY I AM PERSONALLY WARY OF MASSIVE FEDERAL INTRUSION INTO THE FIELD IS PRECISELY THIS DIVERSITY. ANY SYSTEM OF COST CONTAINMENT OR HEALTH INSURANCE MUST PROVIDE FOR FLEXIBILITY IN ADMINISTRATION AND PERMIT CHANGE FROM GENERATION TO GENERATION. I DO NOT WISH TO SADDLE MY CHILDREN OR GRANDCHILDREN WITH SYSTEMS TOO RIGID TO ADMIT REFORM, NOR TOO RIDDLED BY PAPERWORK TO MAINTAIN THE HISTORIC TRADITION OF INDIVIDUAL CHOICE AND LOCAL OVERSIGHT.

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COMPETITION VERSUS REGULATION

THUS ARISES THE ULTIMATE QUESTION RELEVANT TO BOTH ISSUES AT HAND: NAMELY, WHAT MIX OF COMPETITION AND REGULATION IS BEST IN AN ECONOMY OF LIMITED HEALTH RESOURCES? TO PUT IT ANOTHER WAY, HOW CAN THE PUBLIC AND PRIVATE SECTORS SHARE RESPONSIBILITY FOR DESIGNING AND OPERATING SYSTEMS OF COST-EFFECTIVE HEALTH CARE THAT ARE AVAILABLE TO THE GREATEST NUMBER OF PEOPLE?

THAT HOSPITAL COSTS ARE RISING IS BEYOND DOUBT. THE AVERAGE AMERICAN NOW WORKS A FULL MONTH OUT OF EVERY YEAR TO PAY HIS OR HER SHARE OF THE NATIONAL MEDICAL BILL. HEALTH CARE COSTS NOW FORM APPROXIMATELY 9% OF THE GROSS NATIONAL PRODUCT. BUT THE COSTS OF GOOD HEALTH TRANSLATE THEMSELVES INTO LESS OBVIOUS FORMS THAN THE FEDERAL LEDGER. A NEW CAR INCLUDES THE COST OF HEALTH INSURANCE FOR AUTO WORKERS. THE SAME RULE CAN BE APPLIED TO HUNDREDS OF OTHER PRODUCTS OF MODERN INDUSTRIAL SOCIETY.

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HEALTH CARE IS A BIG BUSINESS IN 1979. YOU KNOW THAT BETTER THAN I. BUT YOU MUST ALSO ACCEPT THAT RIFTS ARE DEVELOPING WITHIN SOCIETY OVER THE COST OF SUCH CARE. CORPORATIONS ARE QUESTIONING THE AMOUNT OF THEIR MONEY PUT INTO HEALTH INSURANCE PLANS. UNIONS ARE ASKING THEMSELVES IF THEY DO NOT BARGAIN AS EFFECTIVELY FOR HEALTH PROFESSIONALS AS FOR THEIR OWN MEMBERS. AND, OF COURSE, MILLIONS OF ORDINARY CITIZENS ARE WILLING TO TELL THE NEAREST POLLSTER THAT THEY CONSIDER THE COST OF GOOD HEALTH IN THIS COUNTRY A NATIONAL OUTRAGE. THEY PROBABLY DO THIS EN ROUTE TO A LUNCH OF EMPTY CALORIES AND STARCH, HAVING DEVOURED A COUPLE OF SOFT DRINKS IN THE MORNING AND PREPARED FOR AN EVENING PLOPPED BEFORE THE TELEVISION, POTATO CHIPS AND CANDY BARS FIRMLY CLENCHED.

THE PROBLEM WOULD BE A LOT EASIER IF THE AMERICAN PEOPLE WOULD TAKE CARE OF THEMSELVES. AND HEALTH EDUCATION MUST BE MADE A PRIMARY RESPONSIBILITY OF ALL THOSE INTERESTED IN PROMOTING A NATION OF WELL PEOPLE. WE MUST NEVER CONFUSE THE PURSUIT OF HAPPINESS WITH HOSTESS TWINKIES OR CHEF BOYARDEE.

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OUR EXPERIENCE WITH TOBACCO SHOWS THAT GOVERNMENT ALONE CAN HAVE BUT LITTLE POSITIVE INFLUENCE IN SUCH A FIELD. BUT YOU, WHO HAVE FOR YOURSELVES A CAPTIVE AUDIENCE, CAN PROMOTE THE BASICS OF GOOD HEALTH WITH FAR GREATER HOPES FOR SUCCESS. YOUR CREDIBILITY AS A PILLAR OF COMMUNITY SERVICE IS GREATER THAN GOVERNMENT'S. YOUR RESOURCES, BOTH PHYSICAL AND INTELLECTUAL, FAR OUTSTRIP GOVERNMENT'S.

I URGE AS STRONGLY AS I CAN THAT THIS POTENTIAL FOR HEALTH TEACHING BE MAXIMIZED. HOSPITALS NEED NO LONGER BE PERCEIVED AS ILLNESS FACTORIES, BUT AS CLASSROOMS OF HEALTH. HOSPITALS AREN'T JUST FOR SICK PEOPLE; THEY'RE TO HELP WELL PEOPLE STAY THAT WAY.

BUT PEOPLE WILL GO ON IGNORING THE RULES OF NUTRITION. THEY WILL CONTINUE TO FALL PREY TO AGE OLD DISEASES, HOWEVER VEHEMENT OUR WARNINGS OR HOPEFUL OUR SCIENTIFIC RESEARCH. AS LONG AS THEY DO, YOU WILL RETAIN AN OBLIGATION OF CARING FOR THEM IN A PROFESSIONAL FASHION, WITHOUT THE SPECTER OF IMMINENT BANKRUPTCY ADDING TO THEIR--OR YOUR--WOES.

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SO WE COME BACK AGAIN TO THE CHIEF QUESTION AT HAND. WHAT KIND OF COST CONTAINMENT WILL PRESERVE WHAT IS GOOD ABOUT TRADITIONAL HEALTH CARE?

COST CONTAINMENT: A RIGHT WAY AND A WRONG WAY

THERE IS A RIGHT WAY AND A WRONG WAY TO CONTAIN HOSPITAL COSTS. THE WRONG WAY IS THE COST CONTAINMENT FORMULA PROPOSED BY THE CARTER ADMINISTRATION IN THE PAST. IT ISN'T MUCH OF A FORMULA; MORE AN EDICT FROM ON HIGH. THE PRESIDENT WOULD SLAP AN ACROSS THE BOARD LIMIT ON ANY AND ALL HOSPITALS, REGARDLESS OF LOCAL OR REGIONAL FACTORS, OBLIVIOUS TO THE HOSPITAL'S UNIQUE RECORD OF ACCOMPLISHMENT IN THE FIELD. THE PROBLEMS WITH SUCH AN APPROACH GO BEYOND ITS ARBITRARY NATURE. FOR ONE THING, THERE IS THE POSSIBILITY THAT A CEILING MIGHT TURN INTO A FLOOR. A CAP MAY BE INEFFECTIVE; CERTAINLY ITS ADMINISTRATION POSES ENORMOUS PROBLEMS OF ENFORCEMENT. FINALLY, ANY CAP PENALIZES HOSPITALS WITH RECORDS OF COST EFFICIENCY, AND REWARDS THOSE WITH LESS IMPRESSIVE RECORDS.

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I AM MORE ATTUNED TO THE IDEAS PUT FORWARD BY YOU AND YOUR COLLEAGUES, IDEAS WHICH SEEK TO REPLACE HEAVYHANDED FEDERAL REGULATION WITH VOLUNTARY RESTRAINT. I HAVE WATCHED WITH INTEREST AS YOU'VE DEVISED YOUR OWN GUIDELINES, MEETING EACH TARGET, THE MOST RECENT ONE FALLING UNDER 13 PERCENT. THIS IS ENCOURAGING TO THOSE OF US WHO PREFER PRIVATE TO PUBLIC MANAGEMENT OF OUR HOSPITALS.

BUT THE PRESIDENT, AS STATED IN HIS RECENT BUDGET AND STATE OF THE UNION ADDRESS, CONTINUES TO SINGLE YOUR INDUSTRY OUT FOR FEDERAL OVERSIGHT. THE BATTLE OVER NUMBERS WILL CONTINUE. THE ADMINISTRATION WILL CONTINUE TO UNDERCUT YOUR OWN BEST EFFORTS AT COST CUTTING. BUT I WILL TELL YOU IN ALL HONESTY THAT THOSE EFFORTS MUST CONTINUE UNABATED. THE PRESSURE IS ON, AND WHY NOT?

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IF YOU FAIL TO MEET THE GOALS YOU HAVE SET, IF THE PUBLIC AND POLITICIANS PERCEIVE LESS THAN A GENUINE DESIRE TO REDUCE THE FINANCIAL PAIN OF GETTING WELL, THEN SUPPORT FOR THE CARTER CAP WILL GROW ACCORDINGLY. YOU HOLD THE POWER AND BEAR THE RESPONSIBILITY FOR AVOIDING SUCH ARBITRARY MEASURES.

AND, WHILE WE'RE TALKING ABOUT PUTTING BUSINESS IN ORDER, WE SHOULDN'T OVERLOOK GOVERNMENT'S OWN. THIS YEAR, I PLAN TO RE-INTRODUCE LEGISLATION WITH MY COLLEAGUE, SENATOR HERMAN TALMADGE, THAT WOULD DO JUST THAT. AMONG OTHER THINGS, OUR BILL WOULD ADDRESS THE MAJOR PROBLEM OF MEDICARE AND MEDICAID REIMBURSEMENT PROVISIONS.

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MEDICARE AND MEDICAID

AS YOU KNOW, TYPICALLY, THE AMERICAN HOSPITAL RELIES UPON MEDICARE AND MEDICAID FOR APPROXIMATELY 40 PERCENT OF ITS OPERATING REVENUE. GIVEN THIS ECONOMIC FACT OF LIFE, ANY REVISION IN REIMBURSEMENT FORMULAS MUST BE CAREFULLY THOUGHT OUT, WITH SPECIAL PRECAUTION LEST IT CREATE UNDESIRABLE SIDE EFFECTS. AND THIS REFLECTS ONCE AGAIN ON MY OPPOSITION TO THE PRESIDENT'S ARBITRARY CAP ON HOSPITAL COSTS.

TAKE, FOR INSTANCE, ANY ARBITRARY PAYMENT POLICY THAT OVERLOOKS THE UNIQUE FISCAL NEEDS OF DIVERSE HOSPITALS. SUCH A POLICY COULD CAUSE CHAOS IN THE HOSPITAL SECTOR OF THE CAPITAL, CONSTRUCTION AND MEDICAL EQUIPMENT MARKETS. SUCH A POLICY MIGHT EVENTUALLY BECOME THE MOST IMPORTANT SINGLE FACTOR IN HOSPITAL ADMINISTRATION, EVEN MORE IMPORTANT THAN SOUND MEDICAL AND MANAGEMENT PRACTICES.

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THAT'S WHY OUR BILL WOULD LINK MEDICARE AND MEDICAID PAYMENT RATES WITH THE EXPERIENCE OF SIMILAR HOSPITALS. NOT A SINGLE, NATIONWIDE STANDARD, BUT A MORE REALISTIC STANDARD, WOULD APPLY. HOSPITALS WHERE COSTS SUBSTANTIALLY EXCEED THOSE OF COMPARABLE INSTITUTIONS WOULD RECEIVE LESS THAN FULL COST REIMBURSEMENT. HOSPITALS THAT ARE COST-EFFICIENT WOULD HAVE INCENTIVES TO RECEIVE PAYMENTS ABOVE AND BEYOND ACTUAL COSTS.

ANOTHER PROVISION OF OUR BILL WOULD PERMIT HOSPITALS TO BE REIMBURSED FOR CAPITAL COSTS AND INCREASED OPERATING EXPENSES ASSOCIATED WITH CLOSING DOWN OR CONVERTING UNDER-UTILIZED BED CAPACITY OR SERVICES. SUCH PAYMENTS MIGHT NOT BE POSSIBLE UNDER THE CARTER CEILING.

OUR BILL IS NOT SET IN CONCRETE. IT IS OPEN TO REVISION AND WILL BENEFIT FROM IDEAS WHICH YOU AND OTHERS IN YOUR PROFESSION MAY HAVE. I INVITE YOU TO JOIN WITH ME IN THIS EFFORT, A FAR BETTER WAY TO CONTROL COSTS AND PROTECT OUR HEALTH CARE SYSTEMS THAN ANYTHING OFFERED THUS FAR BY THE ADMINISTRATION.

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IN THE PAST, EVEN THE PRESIDENT HAS DESCRIBED HIS LIMIT AS TEMPORARY, TO BE REPLACED BY SOMETHING BETTER, SOMETHING HE HAS YET TO DEFINE. IMAGINE, IF YOU CAN, SWITCHING EVERY HOSPITAL IN AMERICA FROM OUR CURRENT CONTROL MECHANISMS TO A CARTER CAP FOR THREE TO FIVE YEARS, AND THEN TO YET ANOTHER, STILL UNDEFINED CONCEPT OF CONTROL, WHETHER IT'S THE ONE CONTAINED IN MY BILL OR ANOTHER.

NATIONAL HEALTH INSURANCE: WHEN AND HOW?

THE IDEA OF NATIONAL HEALTH INSURANCE IS INESCAPABLY LINKED WITH THE RISE IN HEALTH COSTS. THE COMBINATION OF NEW TECHNOLOGIES, MOUNTING LABOR AND PROFESSIONAL COSTS AND THE HEIGHTENED EXPECTATIONS OF THE AMERICAN PUBLIC REGARDING THE BENEFITS OF HEALTH CARE HAVE RESULTED IN A NEW CLAMOR FOR SOME FORM OF RELIABLE AND COST EFFECTIVE ALTERNATIVE TO THE PRESENT PATCHWORK OF PROGRAMS. IT IS A FACT THAT MILLIONS OF AMERICANS NOW HAVE UNMET MEDICAL NEEDS. IT IS ALSO A FACT THAT EXISTING PREPAYMENT PLANS SUFFER FROM GAPS OF COVERAGE, GAPS WHICH, IN THE EVENT OF CATASTROPHIC ILLNESS, CAN DESTROY THE FINANCIAL SECURITY OF EVEN UPPER MIDDLE INCOME FAMILIES. DEMOGRAPHICS POINT TOWARD AN AGING SOCIETY WHICH WILL PRESUMABLY REQUIRE EVEN MORE MEDICAL ATTENTION THAN IN THE PAST.

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AMIDST ALL THESE AND OTHER SIGNS OF NEED ARE STACKED SOME SOBERING REALITIES.

FIRST AND FOREMOST IS THE ABILITY OF THE AMERICAN PEOPLE TO SUPPORT ANY COSTLY NEW SYSTEM OF ANYTHING. DO NOT FORGET THAT BY 1981, THE PERSON EARNING $30,000 A YEAR WILL FIND HIMSELF PAYING $165 PER MONTH AFTER TAXES TO SUPPORT HIS MEMBERSHIP IN THE SOCIAL SECURITY SYSTEM ALONE. MOREOVER, WE HAVE BEEN WARNED BY MANY EXPERTS THAT HEALTH CARE THAT APPEARS TO BE "FREE" IS IN FACT A DANGEROUS PSYCHOLOGICAL SPUR TO FURTHER INFLATION.

THOSE ARE THE CONFLICTING TRUTHS. WE FIND OURSELVES WALKING A TIGHTROPE BETWEEN DEMONSTRATED NEED AND ECONOMIC STRINGENCY. I'M NOT GOING TO PRETEND TO HAVE ALL THE ANSWERS. BUT I HAVE GIVEN A GREAT DEAL OF THOUGHT TO THE QUESTIONS THAT WILL HAVE TO BE ASKED BEFORE ANY KIND OF NATIONAL HEALTH INSURANCE PLAN IS FORMULATED.

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LET ME LIST BRIEFLY THE CONSIDERATIONS THAT I THINK MUST BE TAKEN INTO ACCOUNT IN DESIGNING AND OPERATING SUCH A SYSTEM:

1. SUCH A SYSTEM SHOULD ENLIST THE FULL SUPPORT OF A BROAD RANGE OF PUBLIC AND PRIVATE INTERESTS. WE'VE HAD ENOUGH FINGERPOINTING IN THIS COUNTRY; ENOUGH OF CARRIER POINTING AT PROVIDERS, AND VICE VERSA, OF EVERYONE POINTING AT PATIENTS, AND OF GOVERNMENT PRESUMING TO STEP IN AND POINT THE LARGEST FINGER OF ALL.

2. SUCH A SYSTEM SHOULD INCLUDE PROVISIONS FOR REALISTIC FINANCING, RECOGNIZING THAT NO SINGLE SECTOR OF SOCIETY CAN AFFORD TO BEAR THE ENTIRE BURDEN.

3. SUCH A SYSTEM MUST BE EVOLUTIONARY IN SCOPE. IT WOULD DO WELL TO ACKNOWLEDGE A FINITE AMOUNT OF NATIONAL RESOURCES, AND STRESS RESPONSIBLE PRIVATE COMPETITION AS A MEANINGFUL ALTERNATIVE TO GOVERNMENT REGULATION.

4. FINALLY, ANY SUCH SYSTEM MUST RECOGNIZE THAT GAPS IN EXISTING PLANS OUGHT TO BE FILLED IN PREFERENCE TO ANY MASSIVE OVERHAUL OF THE ENTIRE HEALTH CARE SYSTEM. TO SUGGEST OTHERWISE IS TO BE DISHONEST WITH THE AMERICAN PEOPLE.

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WHAT EMERGES FROM THE CONGRESS WILL BE NEITHER ALL PUBLIC NOR ALL PRIVATE IN NATURE. IT WILL BE NEITHER WHOLLY VOLUNTARY NOR WHOLLY INVOLUNTARY, NEITHER TOTALLY REGULATED NOR PURELY COMPETITIVE. BUT THE FISCAL FACTS OF LIFE STRONGLY SUGGEST TO ME, AT LEAST, THAT WE CANNOT POSSIBLY AFFORD A MASSIVE, CRADLE-TO-GRAVE SYSTEM OF HEALTH INSURANCE, WHICH MIGHT CONTAIN WITHIN ITS VERY UNIVERSALITY SEEDS OF ITS ULTIMATE COLLAPSE.

BEYOND THAT, I WILL LISTEN CAREFULLY TO MY COLLEAGUES' WORDS, AND I WILL INVESTIGATE CAREFULLY FOR MYSELF. OUR HOSPITALS AND THE QUALITY OF OUR HEALTH CARE ARE RESOURCES TOO PRECIOUS TO BE REMADE OVERNIGHT. PRUDENCE DEMANDS A THOUGHTFUL ANALYSIS OF THE ALTERNATIVES.

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THE PRIVATE RESPONSIBILITY

BUT, IF A SINGLE PRINCIPLE UNITES OUR THINKING, IT IS THIS: SLOGANS, HOWEVER APPEALING POLITICALLY, DO NOT ASSURE ADEQUATE HEALTH COVERAGE. PROMISES ARE CHEAPER THAN PERFORMANCE. IT IS INVITING TO ATTACK VISIBLE SYMBOLS OF INFLATION, AND WHERE THE NATIONS' HOSPITALS CONTRIBUTE TO LESS THAN EFFICIENT OR COST-EFFECTIVE SERVICES THEY WILL NOT ESCAPE THE BRUNT OF SUCH ASSAULTS. IF YOU WISH TO AVOID FURTHER REGIMENTATION FROM GOVERNMENT, YOU MUST ACKNOWLEDGE YOUR RESPONSIBILITY TO CONTROL COSTS WHILE MAINTAINING THE HIGH LEVEL OF CARE WE'VE ALL GROWN ACCUSTOMED TO.

THAT IS YOUR SPECIAL BURDEN. IT IS YOUR UNIQUE RESPONSIBILITY. BUT I, FOR ONE, AM ENCOURAGED BY THE SPIRIT OF CO-OPERATION I'VE WITNESSED WITHIN GROUPS SUCH AS THIS. I SENSE AN AWARENESS OF THE PROBLEM AS MORE THAN BAD PUBLIC RELATIONS. THE PROBLEM IS STARING US IN THE FACE, AND IT WILL NOT GO AWAY.

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I PRAY THAT YOUR EFFORTS AT COST CONTAINMENT SUCCEED, BECAUSE I BELIEVE IN FREE ENTERPRISE AS MORE THAN A RITUALISTIC SLOGAN. I BELIEVE IT WORKS, AND WORKS FAR BETTER THAN ALL THE WELL-INTENTIONED EFFORTS OF A SWOLLEN OR REMOTE GOVERNMENT. IT IS THAT ULTIMATE PRINCIPLE THAT I WILL BE TRYING TO WRITE INTO ANY LEGISLATION REGARDING CONTAINMENT OR HEALTH INSURANCE. I ASK FOR YOUR HELP.