REMARKS OF SENATOR BOB DOLE

NEW MEXICO MEDICAL ASSOCIATION PAC

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Let me begin this morning by telling you how honored I am by your invitation. I'm reminded of Emerson's maxim "the first wealth is health." If you, like me, feel that health and the American economy are inseparable, then you will also agree that both have come to operate within boundaries set by government. A government that is insensitive to or ignorant of the finer points of either can do irreparable damage to both. And that is one reason I welcome a meeting such as this; an opportunity for some intellectual cross-pollination, as it were, and the chance to share with you some of my ideas about the state of the economy and its relationship with the health profession.

SOME PRESCRIPTIONS FOR A SICK ECONOMY

It is no longer unfashionable for politicians to venture out from Washington and criticize the excesses of government. Indeed, it threatens to become downright trendy. Unfortunately, what with all sorts of big spenders bending over backwards to sound like born-again tax cutters, it can become confusing. Perhaps you should ask yourself--who is talking about spending cuts, and who is doing something about them? Who pays verbal tributes to tax reduction, and who tries to get them enacted into law? Most important, who is riding a politically popular issue, and who is looking ahead to the philosophical and economic implications of a seemingly unlimited federal spending apparatus?

The health care industry knows all about government excess. Singled out by President Carter in his recent State of the Union Address, attacked by him as a major cause of inflation, you might be forgiven a certain distrust of administration policy toward the health sector. I share your distrust.

More specifically, your industry has come under the same incessant rush to regulate that has marked the growth of modern government since the New Deal. Private lives have a disturbing tendency these days to become public property, at least so long as federal regulators have their way.

And we all wind up paying the bill. Over 90 agencies, and more than 100,000 government employees now have as their sole function telling other Americans what government forbids them from doing. The bill for all this, according to the Office of Management and Budget, exceeds a hundred billion dollars--enough to buy a year's supply of groceries for each and every family in America.

It's about time that the Congress recognize its responsibility in the regulatory field. I've suggested a new Hoover Commission, ideally chaired by my former running mate and good friend, Gerald Ford, to examine the top-heavy regulatory structure with an idea toward its reduction and possible replacement. In your own field, I anticipate the release this summer of a current study of hospital regulation by the General Accounting Office, and I am hopeful that the hearings which follow can lead to some rational revisions. It goes without saying that I would welcome suggestions and constructive criticisms from you, the acknowledged experts. We also intend to review the proposed system for hospital uniform reporting. Serious complaints have been made by hospitals across the country that the system, as proposed, will require unreasonable amounts of additional data.

## A VIABLE WAY TO REDUCE GOVERNMENT

That government has grown like topsy in recent years is beyond dispute. A half century ago, government at all levels spent just 11 percent of the Gross National Product. Last year, that figure stood at 38 percent. Federal spending alone has reached 22 percent of the GNP, and with it, a national debt has accrued that is fast approaching a trillion dollars.

Budget deficits are not just some abstract outrage to be denounced over rubbery chicken and cold peas. They have become a real and present danger to the very underpinnings of the American economy. Such deficits are the largest single factor in rampant inflation--inflation which, I needn't remind you, rose last month at an annual rate of 12 percent. By running persistent deficits, government cheapens the dollar. More money chases the same number of goods, and inflation is an inevitable result.

In addition, government borrowing to cover deficit spending forces an increase in the money supply, thus fueling still further inflation. Dollars become scarcer for private investment, the economy assumes sluggish proportions, and all largely because of government's supposed good intentions in addressing social and other problems.

It is a painful case of irony, in which the only logical prescription must be an end to the federal money machine.

## COST CONTAINMENT: A RIGHT WAY AND A WRONG WAY

Nowhere does government tread on thinner ice than in attempting to regulate the economy of health in America. Your industry is unlike any other; conventional economic rules rarely apply. You dispense a product used infrequently by most of us. When we need that product, however, we need it immediately, and we want it to be perfect.

Moreover, supply and demand can hardly apply to the saving of human lives. Greater demand only feeds upon itself, and any attempt by government to mandate either cost containment or national health insurance flies in the face of this unique character and the rich diversity of American hospitals and health professionals.

The Carter Administration has once again submitted a cost containment proposal which will bear more than a passing resemblance to last year's 9 percent cap rejected by the Congress as unworkable. The problems with such an approach seem obvious to me. For one thing, a ceiling might become a floor, or at the least pose daunting problems of enforcement. Moreover, such a cap, mandatory and across the board, penalizes hospitals with records of cost efficiency, while rewarding their less accomplished colleagues. The Administration has already recognized many of its mistakes and is rapidly redrafting to accommodate those who have raised objections. Whatever changes are made, I am still far more attuned to voluntary restraint. I note the successes of the American Hospital Association in meeting cost control targets of 13 percent, as well as your own effort, to reduce the growth in physician fees. These are encouraging signs to those of us who prefer private to public management of our nation's hospitals, and health care system.

I don't have to remind you that the public and politicians are watching what you do. If they perceive anything less than a genuine desire to reduce the financial pain of getting well, then support for the Carter cap will grow accordingly. This, in spite of the unrealistic promises being made in an effort to line up support for the program. The President's budgetmakers assume a savings of $1.7 billion through cost control--2 and 1/2 times what they claimed last year, and one more in a series of dreamlike assumptions which pervade the Carter White House.

If you, like me, believe in free enterprise as more than a ritualistic slogan, then you will join with me in seeking private alternatives to public regulation. Quality health care demands it. Common sense insists upon it.

## NATIONAL HEALTH INSURANCE: WHEN AND HOW?

The idea of national health insurance is inexplicably 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 health needs. It is also a fact that the existing health insurance programs sometimes suffer from gaps in 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 health care than in the past.

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 which appears to be "free" is, in fact, a dangerous psychological spur to further inflation.

These are the conflicting truths. We find ourselves walking a tightrope between demonstrated need and economic stringency. We all know that there are gaps in the system, but at a time when the need for fiscal constraint weighs so heavily on our minds, problems that need to be addressed must be carefully examined and priorities carefully set. I believe the most glaring of concerns in the health care system is the fear of financial ruin due to catastrophic illness. The fear of economic disaster is shared by all, regardless of socio-economic level, race or age. To correct this major deficiency in our system could be the greatest step possible toward meeting the needs of the health care system in the face of fiscal constraint.

A catastrophic health insurance plan could entail anything from substantial system reform to a more moderate approach dealing with gaps in the present system.

Because I do have faith in the ability of the private system as it stands to eventually remedy many of the flaws that exist, I have opted for the latter.

On March 26, 1979, I joined with Senators Danforth and Domenici in introducing S. 748, the Catastrophic Health Insurance and Medicare amendments of 1979.

The bill contains three key parts: First, it would expand the range of benefits for those now covered by Medicare and provide them with broader coverage.

Second, the large majority of those employed will be assured of the availability of adequate private insurance protection against catastrophic costs.

And third, those who are part of the residual marketplace and not already covered, may choose to have the federal government serve as a facilitator and in some instances, a financial backup in contracting with the private insurance companies for catastrophic coverage.

This plan is designed primarily for low-income families not covered by Medicaid; however all except those covered by Medicare and Medicaid would be eligible for participation.

The state Medicaid programs would also be required to provide catastrophic coverage for their recipients.

Our bill will provide a means for all Americans to protect themselves and their families from financial bankruptcy due to catastrophic illness expenses.

There is an emphasis on the use of the private sector. There will be the possibility of some cost-sharing arrangements between the employer and the employee for this coverage, and if an employer experiences a financial hardship in providing catastrophic coverage to employees, we will provide a limited subsidy.

Unlike some of my colleagues, I do not believe that we should force individuals to participate in a plan. Rather, individuals, to the extent possible, should be given the opportunity to choose where and how they obtain catastrophic health insurance. Unlike some of my colleagues, I do not believe that the measure of catastrophic should be limited to a fixed dollar amount of number of days in the hospital. In some instances, it should also be directly related to the percentage of income extended for health care services. I also, unlike some of my colleagues, believe that fixing a set dollar amount in 1979 to measure catastrophic may not be truly representative of the situation in 1980 or 1981 or 1982 or in the future.

## COOPERATION AND CONSENSUS

As I am sure you are aware, hearings on catastrophic health insurance were held in the Senate Finance Committee on March 27 and 28. What I have outlined in broad form this morning represents one Senator's contribution to what promises to be a protracted debate over national health insurance. I look forward to working closely with you in perfecting the imperfect, and honing the broad outlines of catastrophic health insurance into a viable alternative to the impossibly expensive cradle-to-grave approach favored by Senator Kennedy, among others.

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. Here, as elsewhere, what we do is bounded by the shape of the American economy. In health care, as in economic planning, the guiding principles should be individual freedom and practical results.

A consensus is waiting to be formed. I ask you to take the lead in forming that consensus, in guaranteeing that we preserve the best traditions of health care in America. I pledge my support, and my fullest cooperation.

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