NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES

WASHINGTON, D.C.

MARCH 4, 1980

IT'S A GREAT PLEASURE FOR ME TO BE WITH ALL OF YOU TODAY. I HAVE FOND MEMORIES OF SPEAKING ABOUT HOSPICES BEFORE MANY OF YOU A COUPLE OF YEARS BACK, AND I CONSIDER MY EFFORTS ON BEHALF OF OUR MUTUAL INTERESTS TO BE AMONG THE MOST SATISFYING OF MY PUBLIC LIFE.

AS RANKING REPUBLICAN ON THE FINANCE COMMITTEE, I'VE COME TO SEE THE CRITICAL NATURE OF HEALTH ISSUES IN THIS RICHEST OF ALL COUNTRIES, AND TO UNDERSTAND BETTER THAN EVER BEFORE THE INTIMATE AND FRAGILE LINKS BETWEEN A HEALTHY POPULATION AND A HEALTHY ECONOMY.

A NATION THAT CLAIMS TO CARE ABOUT EQUAL OPPORTUNITY FOR ALL ITS CITIZENS CANNOT NEGLECT THEIR ACCESS TO EXCELLENT HEALTH CARE. YET A NATION IN THE GRIPS OF DOUBLE-DIGIT INFLATION AND A PEOPLE GROPING TO CLIMB OUT FROM UNDER A MOUNTAIN OF GOVERNMENT DICTATION AND INTRUSION MUST NOT SHY AWAY FROM ASKING HARD QUESTIONS ABOUT THE FINANCIAL AND STRUCTURAL PRATICALITY OF ANY UNIVERSAL HEALTH INSURANCE PROGRAM.

SO, BEFORE I GET INTO HOME HEALTH ISSUES THEMSELVES, LET ME TAKE A FEW MINUTES TO EXPLAIN MY VIEW OF THE NATIONAL HEALTH INSURANCE ISSUE. LET ME ALSO TRY AND GIVE YOU AN IDEA OF WHERE WE ARE IN THE CONGRESSIONAL DEBATE OVER HEALTH INSURANCE, AND WHERE WE MAY BE GOING.

FOR MY OWN PART, I ANTICIPATE NO FINAL ACTION THIS YEAR. BUT I DO SEE A GROWING NEED FOR AMERICANS TO HAVE ACCESS TO A PROGRAM OF CATASTROPHIC INSURANCE. WE LIVE IN A RICH NATION, WHERE MILLIONS OF POOR AND MIDDLE INCOME PEOPLE FACE THE PARADOX OF ECONOMIC DISASTER IN THE EVENT OF LONG-TERM CATASTROPHIC ILLNESS. EACH YEAR, ROUGHLY SEVEN MILLION AMERICAN FAMILIES PAY 15% OR MORE OF THEIR INCOME ON HEALTH COSTS. AND THIS AT A TIME WHEN INFLATION IS PRESSING MILLIONS MORE AGAINST THE ECONOMIC WALL.

NOW, LET'S ADMIT THAT A PROBLEM EXISTS. HOW DO WE BEST SOLVE IT? DO WE FILL IN EXISTING GAPS, PREFECTING A BASICALLY SOUND SYSTEM - OR DO WE TEAR DOWN WHAT WE HAVE AND START ANEW?

THE CARTER ADMINISTRATION SAYS IT WILL APPROACH THE NATIONAL HEALTH ISSUE INCREMENTALLY. BUT IF YOU KNOW ANYTHING ABOUT WASHINGTON, D.C., YOU KNOW THAT "INCREMENTAL" HAS A WAY OF TURNING ALMOST OVERNIGHT INTO A FULL-SCALE FEDERAL TAKEOVER. THE CARTER PLAN HAS BEEN TO SEEK COVERAGE FOR CATASTROPHIC CASES, PLUS FULL COVERAGE FOR PREG-NANT WOMEN AND CHILDREN.

THEN THERE IS SENATOR KENNEDY, WHOSE OWN PRESIDENTIAL CAMPAIGN HAS ALREADY CONFIRMED THOSE WHO BELIEVE THAT NOSTALIGIA ISN'T WHAT IT USED TO BE. HIS IS THE COMPREHENSIVE CRADLE-TO-GRAVE APPROACH. WITH NATIONAL AND REGIONAL CONTROLS ON SPENDING. AND VERY LIKELY A RATIONING OF HEALTH CARE BY GOVERNMENT.

SENATOR KENNEDY AND HIS ALLIES INSISTED THEN, AND STILL DO, THAT THE INCREMENTAL APPROACH IS UNACCEPTABLE. THEY WOULD RATHER HAVE NO CATASTROPHIC INSURANCE COVERAGE THAN PERMIT ENACTMENT OF LEGIS-LATION WHICH DOES NOT PROVIDE FOR FURTHER BROAD EXPANSION OF COVER-AGE IN YEARS TO COME.

THIS ISN'T SURPRISING. THE FACT IS, A CATASTROPHIC HEALTH INSURANCE PROGRAM MIGHT SOLVE SO MUCH OF THE REAL PROBLEM AS TO ELIMINATE THE APPEAL OF THEIR EXPENSIVE AND BUREAUCRATIC PROGRAM. SO THEY WANT ENACTMENT OF A "PACKAGE" DEAL NOW WHICH WILL AUTOMATICALLY EXPAND HEALTH CARE BUREAUCRACY AND CONTROLS IN YEARS TO COME, WHETHER OR NOT THE INTERVENING EXPERIENCE INDICATES THIS TO BE NECESSARY, DESIRABLE OR AFFORDABLE.

FORTUNATELY, THE REST OF THE CONGRESS IS MUCH MORE CAUTIOUS. A YEAR AGO THIS MONTH, I INTRODUCED 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.

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 OR 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.

UNLIKE SOME OF MY COLLEAGUES, I BELIEVE THAT FIXING A SET DOLLAR AMOUNT IN 1980 TO MEASURE CATASTROPHIC MAY NOT BE TRULY REPRESENTATIVE OF THE SITUATION IN 1981 OR 1982 OR FURTHER IN THE FUTURE.

THE BILL THAT EMERGES FROM FINANCE WILL MOST LIKELY BE A CONSENSUS BUILT ON PROVISIONS CONTAINED IN A NUMBER OF BILLS. I BELIEVE OUR FINAL ANSWERS WILL BE LIMITED - BUT REASONABLE CONSIDERING THE CURRENT STATE OF THE ECONOMY, AND THE ACTUAL NEED WHICH EXISTS.

BY CONTRAST, SENATOR KENNEDY'S HEALTH INSURANCE PLAN CREATES ANOTHER NEW, HIGHLY COMPLEX FEDERAL AND STATE BUREAUCRACY--ONE THAT IS NEEDLESS FOR THE INDUSTRY TODAY. HIS LEGISLATION GIVES THE ILLUSION OF MAINTAINING THE PRIVATE INSURANCE INDUSTRY--BUT IN REALITY GUTS THEIR CURRENT RESPONSIBILITIES, MAKING THEM MERE INTERMEDIARIES. IT SEEMS TO BE ADDRESSED LARGELY TO POTENTIAL CONSTITUENCIES WITHIN THE DEMOCRATIC PARTY.

COOPERATION AND CONSENSUS

AND WHAT ABOUT THE MEDICAL PROFESSION ITSELF?

IN SHAPING A POSITION GENERALLY AGAINST MORE GOVERNMENT MEDICINE AND THE TYPE OF GRAND DESIGN ENVISIONED BY SENATOR KENNEDY AND OTHERS, IT IS IMPERATIVE THAT PHYSICIANS DEMONSTRATE AN UNDERSTANDING AND ACCEPTANCE OF THE FACT THAT SOMETHING MAY HAPPEN ON THIS ISSUE WHETHER WE LIKE IT OR NOT.

IN THAT REGARD, I FIND IT VERY GRATIFYING THAT MANY MEDICAL GROUPS HAVE EMBRACED THE CONCEPT OF LIMITED CATASTROPHIC HEALTH INSURANCE AND IMPROVEMENTS IN MEDICARE AS A WAY OF ADDRESSING THE UNMET NEEDS OF OUR PRESENT SYSTEM.

HOME HEALTH CARE: PROBLEMS AND POTENTIAL

NOW LET ME TURN TO YOUR OWN FIELD. THE HOPE OF STAYING AT HOME IS BEING OFFERED TO OUR ELDERLY CITIZENS BY INCREASING NUMBERS OF PEOPLE, BOTH POLITICIANS AND PROVIDERS.

WE HOLD OUT THIS HOPE TO SAVE COSTS, AND TO PROVIDE DIGNITY AND INDEPENDENCE IN CARING FOR OUR CITIZENS.

FOR TOO LONG, CARE IN THIS COUNTRY HAS BEEN FOCUSED ON INSTITUTIONS. NO DOUBT, WE AS A NATION HAVE BENEFITED FROM THIS "INSTITUTIONAL BIAS" AS WE HAVE SEEN AN INCREASINGLY HEALTHY POPULATION -- BUT I BELIEVE THE TIME HAS COME TO REEVALUATE THIS NARROW FOCUS. THERE ARE PROMISING SIGNS ... IT HAS BEEN OBSERVED THAT TWO OR THREE TIMES AS MANY AGED IN THIS COUNTRY ARE BED FAST AND HOME-BOUND AS ARE IN INSTITUTIONS, MAKING THE FAMILY AND NOT THE INSTITUTION THE MAJOR "PROVIDER" FOR THESE ELDERLY.

THE ROLE OF THE FAMILY, BOTH ACTUAL AND POTENTIAL, IN PROVIDING CARE FOR ITS SICK OR AGED RELATIVES, HAS ONLY RECENTLY BEGUN TO BE CONSIDERED IN THE FORMULATION OF PUBLIC POLICY. WE MUST LOOK CAREFULLY AT WHAT THEY NEED TO ENABLE THEM TO CARE FOR THESE ELDERLY. BUT WE MUST ALSO BEWARE OF TOO MUCH DEPENDENCE ON THE FAMILY UNIT AS THE SOLUTION TO OUR PROBLEMS.

SOME GERONTOLOGISTS HAVE WARNED THAT THE NUMBER OF SINGLE, WIDOWED AND DIVORCED ELDERLY MEN AND WOMEN WITHOUT FAMILIES COULD PRESENT MORE IMPORTANT PROBLEMS THAN THE INCREASING PROPORTION OF THE OVER 75 POPULATION. THE STABILIZATION IN GENERAL POPULATION GROWTH WILL MEAN A REDUCTION IN THE NUMBER OF DESCENDANTS AND THUS A DECREASE IN THE POTENTIAL SOCIAL, PSYCHOLOGICAL AND ECONOMIC SUPPORT AFFORDED BY CHILDREN OF THE ILL AGED.

SO, WE MUST SEEK OUT MULTIPLE SOLUTIONS TO FIT THESE MULTIPLE SITUATIONS. HOME BASED HEALTH SERVICES DO OFFER TO MANY INDIVIDUALS THE OPPORTUNITY TO REMAIN IN SURROUNDINGS MOST SUPPORTIVE OF THEIR PHYSICAL AND MENTAL WELL BEING.

CONGRESS ORIGINALLY INCLUDED HOME CARE BENEFITS IN THE SOCIAL SECURITY AMENDMENTS OF 1965; AND WHILE UTILIZATION OF THESE SERVICES HAS INCREASED SINCE THAT TIME, SO HAVE THE PROBLEMS, PROBLEMS FOUND IN MANY AREAS.

QUESTIONS AND ANSWERS

CONGRESSIONAL HEARINGS IN 1976 AND 1977 RAISED NUMEROUS QUESTIONS ABOUT THE REASONABLENESS OF HOME HEALTH AGENCY COSTS. OTHER QUESTIONS HAVE BEEN RAISED ABOUT THE RESTRICTIVE NATURE OF THE HOMEBOUND REQUIREMENT. SOME HAVE CLAIMED THAT THERE IS NO COORDINATED HOME HEALTH POLICY IN THIS COUNTRY. OTHERS HAVE NOTED OUR FAILURE TO USE THESE SERVICES TO THEIR FULLEST EXTENT.

ALL OF THESE, AND OTHER ISSUES, MUST BE ADDRESSED. BUT IT IS, OF LITTLE USE TO POINT OUT THE PROBLEMS, WITHOUT THEN SEEKING OUT ANSWERS.

WHILE RECOGNIZING THE FISCAL DIFFICULTIES FACING THE MEDICARE PROGRAM, I NONETHELESS BELIEVE THAT WE MUST EXAMINE NUMEROUS OPTIONS, AND DEBATE THEM ON THEIR MERITS. LET ME RETURN TO THE DOLE-DANFORTH-DOMENICI PLAN FOR CATASTROPHIC HEALTH INSURANCE AND MEDICARE AMENDMENTS. THIS LEGISLATION CONTAINS A NUMBER OF PROVISIONS DEALING WITH HOME HEALTH CARE WHICH WOULD DELETE ALL LIMITS ON THE NUMBER OF DAYS, LIBERALIZE THE HOMEBOUND REQUIREMENT, AND ADD OCCUPATIONAL THERAPY AS A PRIMARY SERVICE. SENATORS DOMENICI AND PACKWOOD HAVE ALSO INTRODUCED S. 489, THE HOME HEALTH CARE AMENDMENTS OF 1979, WHICH CONTAINS A NUMBER OF ADDITIONAL SUGGESTIONS.

I BELIEVE OUR BILLS ADDRESS SOME OF THE PROBLEMS THAT EXIST -- CERTAINLY NOT ALL. FOR INSTANCE, WE MUST LOOK AT NOT ONLY HEALTH SERVICES, BUT ALSO THOSE THINGS CONSIDERED TO BE SOCIAL SERVICES --WHICH ARE ALSO NECESSARY TO KEEP PEOPLE AT HOME. FOR EXAMPLE MEALS, HOMEMAKER SERVICES, PERHAPS EVEN ACTUAL HOUSING ARRANGEMENTS.

ALTERNATIVE CARE FOR TERMINALLY ILL

ONE AREA THAT I HOPE RECEIVES PARTICULAR ATTENTION IS THE USE OF HOME CARE SERVICES BY THE TERMINALLY ILL. THE FOCUS OF OUR HEALTH CARE DELIVERY SYSTEM, EVEN HOME CARE, HAS HISTORICALLY BEEN DIRECTED TOWARD CARING AND CURING. CENTRAL TO THIS IS THE QUESTION OF WHAT KIND OF CARE IS MORE APPROPRIATE FOR THE TERMINALLY ILL?

AS SOCIETY HAS MOVED FROM THE EXTENDED FAMILY OF OLD TO THE SMALLER, NON-EXTENDED FAMILY OF TODAY, THE SUPPORT SYSTEMS NECESSARY TO CARE FOR A TERMINALLY ILL FAMILY MEMBER HAVE BECOME LESS AVAILABLE.

NOT SURPRISINGLY, THERE IS A DESIRE ON THE PART OF MANY TO LOOK TO HOME CARE AS A VIABLE ALTERNATIVE.

IN A SOUTH-CENTRAL CONNECTICUT SURVEY OF DEATHS FROM CANCER, BETWEEN 1969 AND 1971, 67% OF THE PATIENTS EXPRESSED A DESIRE TO DIE AT HOME. 20% ACTUALLY DID DIE AT HOME. HOWEVER, IN ORDER FOR HOME CARE TO AGAIN BECOME A REALITY WE MUST DETERMINE THE TYPE OF SUPPORT SYSTEMS THE FAMILY AND THE INDIVIDUAL NEED.

WE MUST ALSO CONTINUE TO SEEK OUT OTHER MODELS OF CARE, FOR WHILE THERE IS GENERAL CONSENSUS THAT FOR THE INDIVIDUAL WITH APPROPRIATE SUPPORT SYSTEMS, FINANCIAL MEANS, ETC., THE BEST PLACE TO DIE MAY BE AT HOME, THERE MAY BE CIRCUMSTANCES WHERE THIS IS NOT APPROPRIATE.

WHAT APPEARS TO BE EMERGING IS A SENSITIVITY TOWARD THE DYING INDIVIDUAL AND AN APPRECIATION FOR THE ROLE OF THE FAMILY AND THE HOME IN CARING FOR THESE PEOPLE. GOVERNMENT CAN AND SHOULD SUPPORT THIS MOVEMENT, AND AFFORD EACH INDIVIDUAL THE OPTIMUM OPPORTUNITY TO MAKE HIS OR HER OWN DECISIONS.

HOWEVER, WE NEED TO EXAMINE NOT ONLY THE NEEDS OF THE ELDERLY WHO ARE ILL, BUT ALSO THOSE WHO ARE HEALTHY AND NEED ASSISTANCE TO STAY THAT WAY.

AT THE CURRENT MOMENT, MY STAFF ARE WORKING WITH SENATOR PACKWOOD'S STAFF AND OTHERS TO PREPARE AND PROPOSE DESIGNED TO COORDINATE THE FINANCING AND DELIVERY OF MANY OF THE HOME BASED SOURCES THAT I HAVE MENTIONED. YOUR INPUT IS ENCOURAGED AND SOUGHT IN DESIGNING THIS NEW PROGRAM.

YOU WILL OF COURSE CONTINUE TO BE VITAL TO THE SUCCESS OF THIS EMERGING MOOD. TOGETHER, WE CAN TURN POTENTIAL INTO REALITY - AND MAKE AMERICA A PLACE WHERE TRADITIONAL SENSITIVITY AND RESPECT FOR THE INDIVIDUAL IS NOT CONFINED TO THE YOUNG, THE VIGOROUS, THE RICH. EVERY MAN AND WOMAN HAS A RIGHT TO LIVE-AND TO DIE-IN A WAY THAT REALIZES HIS OR HER OWN DIGNITY. AND NOT ONE OF US CAN REST UNTIL THIS RIGHT IS RECOGNIZED FOR ALL AMERICANS.