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news from

Senator DANIEL K. INOUYE

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I very much appreciate this opportunity to share with you my views on the evolving nature of our nation's health delivery system. Although it is difficult to predict with any certainty the exact specifics of what will occur, there are a number of trends which clearly suggest what we might expect. For example, I believe that the eventual enactment of a National Health Program is a certainty. When this will occur, and the specifics of such a program, are still unclear. However, like the enactment of Medicare only twenty years ago, I have no doubt that this will come to pass. My only hope is that prior to its enactment our nation's hospitals and health professionals will actively assist in shaping this eventual program, rather than continuing to take the position of adamant opposition, like the AMA did with Medicare and like the Trial Lawyers are currently doing on the issue of professional liability/medical malpractice.

Without question the driving force today in the health care arena is the specter of ever-escalating costs. The most recent statistics available indicate that last year, as a nation, we spent $387.4 billion, or 10.6% of our Gross National Product, on health. This is the highest amount in our history, although the actual rate of increase was the smallest in the past two decades. We are spending a higher proportion of our income on health care than any other country in the western industrialized world. Given the prospective payment approach to reimbursement of health care, with its DRGs (Diagnosis Related Groups) orientation, it has been suggested that we will soon be receiving devastating reports of "sick individuals" being discharged too early, with insufficient outreach and follow-up programs available to serve them. These are serious concerns, but realistically we will have to wait to see what transpires.

From my vantage point as a layperson, but one who has admittedly had a deep personal interest in health care all of my life, there are a number of concrete steps, which I fully expect we will soon be taking as a nation, to curtail health care costs. For example,

* I fully expect that we will see increased reliance upon the use of non-physician health care practitioners, such as nurse practitioners, nurse clinical specialists, certified nurse-midwives, or clinical psychologists. These alternative providers are just beginning to come into their own as a force within our nation's health delivery system and all reports which I have seen indicate that they provide high quality care. Further, the potential health care

savings are quite significant. Certified nurse-midwives, for example, have been shown to reduce the costs of delivery by nearly 40%. For two years the Department of Defense conducted a pilot program under which all categories of advanced nurse practitioners were authorized to bill autonomously under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) program. The results of this CHAMPUS pilot program, which were essentially the same found by the Office of Personnel Management under the Federal Employees Health Benefit program after a four year demonstration project, represent an unqualified endorsement of non-physician health care providers. Again, the overall quality of care was excellent. Not only did these new practitioners not increase the costs of delivering health care, as some economists had predicted, but generally their use is now viewed as representing a potentially very significant cost-containment tool.

* I also predict that mental health practitioners will be systematically incorporated into the general practice of health care. Earlier this session I hosted a special Congressional breakfast to receive a special report of a nationally recognized leader of psychology on his several decades of experience in dealing with patients who had a history of being chronically high utilizers of health care. He reported that over 60 percent of all physician visits today are by persons who have no physical illness, but rather are experiencing emotional distress. It has been his experience that, by providing quality short-term-oriented mental health care in a timely fashion, overall health care costs can be significantly reduced. For example, at the breakfast meeting he reported that his preliminary results from his Hawaii project suggest that, as a direct result of this type of mental health intervention, our own State's Medicaid program was experiencing a 37 percent overall reduction in medical utilization.

* I also expect that, as a nation, we will see increasing interest in funding programs that are "preventive" in nature. For years the Senate Appropriations Committee has received testimony stressing the importance of preventive health care. For example, the Surgeon General's Report Healthy People concluded that of the 10 leading causes of death in our nation, at least 7 could be substantially reduced if persons at risk would just focus on five basic problems: diet, smoking, lack of exercise, alcohol abuse, and the use of anti-hypertensive medication. Yet, we have been informed that, as a nation, we presently spend $1,400 per capita for "curative services", but less than 50 cents per capita on prevention.

During our recent deliberations on the Fiscal Year 1985 Supplemental Appropriations bill, I had $3 million included to begin funding a series of Prevention Centers which had been authorized during the closing hours of the 98th Congress. This was the first time that the Committee had

had an opportunity to fund this important initiative. Unfortunately, however, the House conferees were unwilling to go along with our Senate recommendations. Simply stated, although the concept sounded good to them, when it came to actually expending funds, prevention did not have sufficiently high priority. However, I am convinced that we must make this a priority. Accordingly, during our Senate deliberations on the Fiscal Year 1986 Appropriations Bill, $3 million was again included, at my request, to start this program. This time, I can see considerably more "grass-roots" support for my proposal. For example, I have been receiving letters of support from the Hawaii Heart Association and various other state affiliates. Hopefully, this time we will be more successful during our conference deliberations with the House of Representatives.

In addition to encouraging individuals to do the obvious, such as quit smoking, exercising, and eating healthy meals, I have recently been following reports on a number of innovative clinical efforts targeted towards individuals with specific deficiencies which might otherwise be overlooked under our usual way of doing things. For example, I received a fascinating report in which advances in genetics were credited with essentially saving a man's life. The patient involved was diagnosed as being anemic and the usual and customary treatment would have been to increase his intake of iron and other vitamins. However, when a small blood sample was taken, special genetic testing indicated that certain genes reacted negatively to any increase in iron. Further, it was felt that the reaction could be fatal. As a result, another clinical regimen was utilized. Had this testing not been done, the result could have been fatal.

Another example of the importance of targeting has to do with our basic demographics. As a nation, we are getting markedly older. Presently, 12% of our population is 65 years or older and by the year 2030 this is expected to reach 21.3%. In Hawaii, the elderly constitute 9% of our population, and this is the fastest growing segment, having increased 72% during the past decade. Yet, today, less than 0.001% of our nation's physicians and nurses have specialized training in geriatrics. We all know that the elderly are major users of health care. Nevertheless, to date, we have failed to develop the specialists necessary to provide the type of care required.

During our deliberations on the Fiscal Year 1985 and Fiscal Year 1986 Appropriations bills for the Department of Health and Human Services the Senate included $5 million which was specifically "earmarked" for geriatric training initiatives. Last year, the House of Representatives went along with our recommendation and, hopefully, they will also do likewise this year. These are very important funds and I understand that the various health professions schools at the University of Hawaii are exploring the possibility of

developing geriatric training programs with this support. As soon as the graduates from these new initiatives become assimilated into the leadership of our various health programs, we, as a nation, can expect that a new range of priorities and services will evolve.

* Another area of increasing concern is professional liability, or medical malpractice. I feel it is fair to say that we are once again on the verge of a "crisis". According to the New York Times, defensive medicine has been estimated to increase medical costs by as much as 30%. The American Medical Association (AMA) has estimated that defensive medicine adds $15 to $40 billion annually. The frequency of claims against physicians has been steadily increasing and the number of claims for 1983 are more than double that of the mid-1970s. The amount actually paid out has increased sevenfold between 1975 and 1984, with the most recent figure being $1.4 billion. The number of $1+ million settlements had increased tenfold over a four-year period of time. Since 1970, the malpractice premiums for all physicians increased by 434%. As all of us in Hawaii are aware, the physicians on Molokai recently stopped practicing obstetrics solely because of the proposed increase in their rates. The most current AMA projections are that one out of every five physicians will eventually be sued. Yet, it is not the incompetent who are sued. Experts have suggested that perhaps one-third of all suits simply may be unfounded. Seventy-five percent of all claims are closed with no indemnity and the defendant physicians prevail in 70% of all cases carried through to trial.

I hasten to point out that this is not merely of concern of physicians. I understand that within the psychological profession, for example, malpractice suits are considered to be of epidemic proportions. Certified nurse-midwives, who as a profession have a truly outstanding track record, are finding that there is simply no coverage available. This is in spite of the fact that since 1974 only 6% have been sued, in contrast to 60% of the obstetricians being sued at least once, and 20% sued three times or more. Of course, it is the patient who ultimately pays for the cost of malpractice insurance.

For the first time, the American Medical Association (AMA) not only expressed its formal support for federal involvement in the professional liability arena, but a specific bill was introduced, S. 1804, which was essentially drafted by the AMA. The bill was introduced this past Tuesday by Senator Orrin Hatch, Chairman of the Senate Labor and Human Resources Committee, which will have jurisdiction over the bill, and was cosponsored by myself and Senator Abdnor.

The essence of the AMA bill is actually quite similar to legislation which I had introduced earlier in the session, S. 175, the Health Care Protection Act of 1985. Both of these proposals would provide incentive grants to the various states to encourage them to adopt certain administrative and procedural reforms. Both bills would strengthen the disciplinary process for errant health care providers and would require risk-management programs. Both bills would set reasonable limits on

attorneys fees. The AMA bill would also set a limit of $250,000 on non-economic damages. My proposal would not set an absolute limit; however, I fully expect that, by giving real "teeth" to the recommendations of an interdisciplinary screening panel, we would essentially accomplish the same objective of ensuring reasonable reimbursment where appropriate. The AMA proposal calls for the expenditure of $224.9 million over a three year period of time; my proposal would cost the federal government $75 million over the same period of time.

While we can surely expect Senate hearings and possibly even legislative action on these bills during this session of Congress, of even more immediate concern is the fact that, during our recent Senate deliberations on the Fiscal Year 1986 Appropriations bill for the Department of Health and Human Services, $1 million was included, at my request, so that the department can begin to aggressively develop legislative and administrative remedies, including the possibility of serving as a reinsurer if that becomes appropriate. We do not know how the House conferees will respond to our proposal; however, it is clearly a first step, and one that we must take.

I am very concerned that the constant high cost of health care may bring the specter of socialized medicine closer to reality than any of us would want. If my mail is any barometer of public feeling, there is a growing perception among the public that professionals of all disciplines have lost touch with their patients and clients. "Blood sucking ambulance chasers", "profit motive physicians", these are not my words, but they are what I am hearing with increasing frequency. Oftentimes in the political process, perception may be more important than reality. Phrases such as these unfortunately can form the basis for the politicalization of health care. The Congress of the United States, like any other legislative body, reflects to some degree the various attitudes of the constituents of the members. Reaction may be slow in developing, but history has shown that when reaction becomes irresistible, the results may be considerably less than desired. As I noted earlier, several years ago the Congress enacted the Prospective Payment approach to Medicare which relies upon a series of 467 Diagnosis Related Groups, or DRGs. In essence, the plan was to put the provider, or the institution, at financial risk for services rendered. Presently, this approach only directly affects Medicare inpatient services, and some institutions, such as rehabilitation hospitals and psychiatric hospitals, are excluded from the program. During the past year there has been a significant reduction in the rate of hospital expenditures. So at first blush, the program seems to be working, although a number of health policy experts have suggested that it has been the easy cases that have responded so far.

It does not take too much insight to suggest that, if major problems do not evolve in the near future, the Congress will give serious consideration to expanding the DRG system to Medicare outpatient services. Two other federal programs, the Veterans Administration and the Department of Defense CHAMPUS program, are already actively exploring ways to utilize the DRG system with their providers and beneficiaries. From the federal level we can also see efforts by several Medicaid directors to utilize the DRG approach with their programs. I would not be at all surprised if various private sector third-party payers ultimately followed suit. I personally feel that this apparent rush to adopt the DRG system is unfortunate. In my judgment, it does not really take into account the

extent to which providing health care is an art, and not an exact science. It puts an unfortunate check on the development of innovative approaches to delivering care. However, as I indicated, we must control health care costs.

To be perfectly candid, I would not be at all surprised if, in the reasonably near future, we abandoned the specifics of the DRG approach and instead give greater consideration to purchasing health care on a capitated basis. For example, I can see the day in the near future when the federal government, our state government, and private employers would negotiate a contract with an institution such as Straub to provide all care required by its employees for a preset fixed price. What I am describing is essentially an HMO approach. The price would be based on previous histories of utilization and quality assurance would be addressed through peer review procedures. There are ways through the political process to ensure that no one "falls between the cracks". There are ways, again through the political process, to share the burden associated with heavy utilizers in an equitable manner. There are ways to ensure that the interests of all parties involved -- the institution, the practitioner, and the consumer -- are protected. The key to such an approach is to ensure that health care is purchased <u>through</u> an institution such as Straub, which has demonstrated through its track record that it can provide quality care and that it can provide a comprehensive range of care.

It is quite evident to me as a politician that, unfortunately, adverse public reaction is steadily developing to our present health delivery system. It is no longer clear to the public-at-large that, if and when they or their loved ones need health care, it will be readily available. This perception is most unfortunate and we must deal with it immediately. I think it is imperative that we put our heads together to come up with solutions. The underlying problem is not solely that of the physician, nor of the hospital; it is a problem for all of us, both as professionals and as concerned citizens. If not addressed, this could strike at the very heart of our democratic society. We must find a reasonable solution in a timely manner. I have no doubt that while we are seeking reasonable solutions, the health care industry will be in considerable turmoil. This is truly unfortunate, but I know of no alternative. Hopefully, by working together, we will be able to serve society.

STRAUB ADDRESS

D-R-A-F-T

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which all categories of advanced nurse practitioners were authorized to bill autonomously under (Spell out) the CHAMPUS program. The results of this CHAMPUS pilot program which were essentially the same found by the Office of Personnel Management under the Federal Employees Health Benefit program after a four year demonstration project, represent an unqualified endorsement of non-physician health care providers. Again, the overall quality of care was excellent. Not only did these new practitioners not increase the costs of delivering health care, as some economists had predicted, but generally their use is now viewed as

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To be perfectly candid, I would not be at all surprised if, in the reasonably near future, we abandon the specifics of the DRG approach and instead give greater consideration to purchasing health care on a capitated basis. For example, I can see the day in the near future when the

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