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Senator Daniel K. Inouye Papers
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news from

Senator DANIEL K. INOUYE

topic: Speech by Senator Daniel K. Inouye, College of Health Sciences and Social Welfare, University of Hawaii, Honolulu, Hawaii

date:

release date: July 2, 1974, 10:30 a.m.

At the present time there is a growing consensus in the Congress that every American citizen is entitled to ready access to the highest quality health care. Yet, snow-balling medical costs and inefficient use of our health resources have removed this hope from ready attainment. This is especially distressing in light of the fact that we are, in material terms, the richest nation on the map of the globe.

Statistics clearly illustrate the relative ineffectiveness of medical care in this country when compared to other countries. We rank 17th in infant mortality, according to a United Nations study; 13th in life expectancy for females; and 30th in life expectancy for males. A baby born in Hong Kong has a better chance of survival than does a baby born in a typical American big city. The "health" gap that exists between America and the other nations of the world is not closing either. Our relative ratings are worse in 1974 than they were in 1954. Translated into more human measurements, these numbers indicate that if our American infant death rate had been proportioned to that of Sweden, 50,000 fewer babies would have died last year. These startling facts exist in spite of the trend toward directing more and more of our economic resources on health services.

As Americans, we spend 56 per cent more on medical services today than we did five years ago, and three times as much as we did in 1960. In 1950, our total medical expenditures accounted for 4.6 per cent of the Gross National Product; yet, in calendar year 1973, this figure rose to an astronomical $94.1 billion or 7.7 per cent of our Gross National Product. This represents an annual cost to each American of $394, an increase of 11 per cent over 1972.

As responsible legislators and as concerned citizens, we must address ourselves to the question of where the responsibility rests for our drastically increasing health costs. Are our doctors overpaid? Are our hospitals making excessive profits? I can assure you that neither of these is the case. In recent years the gap between the increase in doctor's fees and the cost of living index has been narrowing. Doctor's fees have reached a level where they are running neck-and-neck with general cost increases. And although

the cost of a hospital stay has increased dramatically in recent years, less than 4 per cent of the total number of hospital beds in this country are run for profit. In fact, last year almost every hospital in Hawaii not only did not make a profit, but operated at a deficit. We must search elsewhere for an answer.

I think it is time for us to take a long and hard look at what we as individuals have been demanding of our health systems. As all of us know, we live today in a time of rapidly spiralling costs. It is not so many years ago that our hospital aides were paid $.50 cents an hour to scrub urinals and mop hospital floors. Today, the minimum wage for this same work exceeds $2.50 an hour. This improvement in wage scales for the lowest paid health workers was long overdue. It is equally true that salaries for the other health professions have increased dramatically. However, I am confident that upon close investigation you will find that they have barely kept pace with our overall cost of living rise, rather than fueling inflationary fires.

The further I look at our nation's health care system, the more concerned I become about the extent to which each of us as individuals have been making unreasonable demands upon the medical profession. Each of us, of course, demands only the best of health care. We demand ready access to all of the latest diagnostic tests. We demand private rooms with color televisions and even wine with our meals. We want to exercise the right to sue everytime we think a more expensive diagnostic test was not ordered or that there was insufficient consultation. We may get what we demand, but I am afraid it is at a cost to our society that we can ill-afford.

I would like to take the opportunity today to share with you some of the more basic questions that we in the Congress have been asking.

We don't pretend to know the answers to these questions and, therefore, want very much to elicit your thoughts regarding the basic issues involved. Hopefully, by working together, some generally acceptable solutions will evolve.

My first question is essentially a broad-ranged and highly philosophical one: What would be the effect of the various roles that the Federal Government might take with regards to the actual delivery of health services? This is an extremely basic and all-encompassing question and our efforts to resolve it to date have not been successful. Some of my colleagues feel quite adamantly that the Federal Government should be content to allocate a certain percentage of the annual budget for health and then trust the judgment of organized medicine and the other health providers to determine what should be done with these funds.

A smaller group, but composed of individuals equally committed, feel that the government should become actively involved in the daily practice of medicine. These individuals feel that we should establish national standards for licensure and daily practice; that we

should work actively towards distributing our health resources to those areas where there is the most need, and that we should radically change our nation's medical care system. I would suggest to you that we are still quite far from resolving this very basic issue and I doubt that a general consensus will evolve in the near future.

A second, but equally important series of questions relates to the economics of health care. More specifically, who should we expect to bear the financial burden for the government's increasing involvement and what specific funding mechanisms would be most effective in dispersing federal funds?

We have traditionally been a nation that has placed a very high value on individual accomplishment and individual responsibility. However, in our deliberations, the suggestion has more and more frequently been raised that perhaps it is time to begin emphasizing a societal or group focus, rather than continuing to rely on our customary individual orientation.

As you may know, the American Medical Association has proposed a "Medicredit Plan" under which individuals would be given special tax credits for purchasing private health insurance policies. This approach has received some support from the Congress and if passed, it would essentially serve to bolster our present private practice, fee-for-service orientation.

At the same time, however, an entirely different approach has been suggested by the recent Kennedy-Mills Comprehensive National Health Insurance Act of 1974. Under this plan the role of the private insurance company would essentially be eliminated, or, at the least, greatly reduced. Every employee would be assessed a 1 per cent tax on earnings up to $20,000. His employer would pay a 3 per cent tax on the same amount. From this sizeable fund a comprehensive health program would be provided for every citizen.

Regardless of the format eventually decided upon, it is incumbent upon us to learn from our experiences with the Medicare-Medicaid programs. It distresses me greatly that almost no one seems to be satisfied with the results of the very expensive efforts under expensive programs.

We must also be concerned about the very complex difficulties inherent in trying to insure high quality services while at the same time not limiting the creativity and flexibility which is so necessary for innovative care. The horrors of governmental bureaucratic rigidity are legion--yet, somehow we must develop basic standards and criteria by which to judge our performance.

A very real dilemma faces us: on the one hand we must provide effective fiscal constraints and avoid needless duplications of expensive services and facilities; yet, on the other hand, we must avoid the situation where we have insurance clerks making what are essentially clinical decisions. As a first step in trying to resolve this problem, we

have passed the PSRO, or Professional Standards Review Organization legislation. However, it is still far too early to assess how well this effort will work in practice although the early reports on the experience in Utah are most heartening.

When I agreed to accept this invitation to address you today, it was suggested that I might provide a status report for you on the progress of the Health Manpower legislation since it is due to expire this year and the specific legislation that is finally enacted to replace it will have a major impact on our university.

Many of the men and women pursuing their education here at the unversity have health careers in mind. It is of vital concern, therefore, to both yourselves and students across the nation that share your dreams that the Administration is essentially attempting to completely remove the Federal Government from health education. Where ever possible, funds are being impounded or internally transferred and programs are being phased out.

Both the House of Representatives and the Senate have expressed their strong vocal opposition to this approach and are expected in the near future to pass major new legislation or failing that, to enact continuing legislation. Unfortunately, however, although both Houses of Congress seem to agree on the basic problems, our proposed solutions are radically different. It is an understatement to say that the Conference Committee has a very difficult time ahead of it.

The basic areas of general concerns are: The increasing geographical maldistribution of physicians, the trend toward specialization, our increasing reliance on foreign-trained physicians, and the lack of national licensing standards. One out of 13 doctors are located in nonmetropolitan areas--practically one person in five lives in these areas. Four out of five doctors now choose to limit their medical practice to a specialized field; only one in five are general practitioners. One out of every five physicians in active practice is a graduate of a foreign medical school. Among interns and residents the figure exceeds one in four. It is obvious, federal action must be taken to alleviate these alarming trends; the direct focus will be to meet this challenge at its roots, that is, at the university level.

Congress is currently deadlocked in its search for an acceptable form of National Health Insurance. I would like to take this opportunity to share with you some thoughts concerning the likelihood of National Health Insurance being passed in the near future. Only last month, the Democratic Caucus adopted a resolution calling for the passage of a comprehensive national health insurance program. I fully supported this resolution and am pleased to note that the primary sponsors of two of the major bills presently before us are the chairmen of the House and Senate Subcommittees which have jurisdication over these areas, Congressman Wilbur Mills and Senator Ted Kennedy. Each of these gentlemen has expressed his personal confidence that the Congress will pass some form of National Health Insurance late this session or early in the next.

Support for various forms of National Health Insurance does not lie solely within the halls of Congress. Almost every major labor union has made this a top priority matter. The American Medical Association is actively lobbying for their own proposal and President Nixon has made his "Comprehensive National Health Insurance Plan" the subject of a nationwide radio address. I personally believe that it is unrealistic to expect a comprehensive bill to pass this session. However, I have no doubt that next session, a truly comprehensive National Health Insurance bill will be passed.

Although it is still far too early to tell what the actual form of this major legislation will be, I am confident that it will contain at least two fundamental changes. First, there will be an increasing emphasis on providing preventive and child care services. For a long time now, we have talked about the importance of preventive programs and I think that we will finally begin to see the implementation of our rhetoric. Second, there is no question that we need a total rethinking of our health manpower utilization. To date, we have been operating under the assumption that the physician should be the focal point of our health system. However, it is becoming increasingly clear that this is no longer necessarily the case. Instead, we need to begin to take a much closer look at the actual tasks involved and to develop comprehensive systems with appropriate orchestration which will be responsive to our actual needs and utilize our health resources in an efficient manner. In this light, I recently introduced legislation that would extend the Medicare coverage to services of both psychologists and registered nurses. I think these bills are extremely timely since the standards for almost all of the National Health Insurance proposals have essentially been modeled after Medicare.

The laws I have proposed in Congress will only plug a small crack in the health-costs dam. To prevent a flood, a thorough National Health Insurance must be enacted in the near future. It is obvious our current system has major deficiencies. As university students you should be aware of these facts and should reject the notion that we Americans enjoy the best of all possible medical care systems.

As Hawaiians, we must realize that we share with the mainlanders the plight of increased medical expenses. As of 1970, the State of Hawaii had the seventh highest expense per patient day. The average cost per day for room and food in a hospital approaches $100 a day. Hawaii also have a less-than-average number of practicing physicians per population and these are not well distributed among our population.

The question facing both Congress and Hawaii seems to be not so much whether action is needed, but what kind of action and how it should be implemented. Time finds the situation worsening. The appropriate congressional action is the obvious cure. However, the doctors agree on the diagnosis but see no clear-cut prescription to cure the problem. The order for National Health Insurance has been sent to the pharmacy; it's time it was administered to a dying patient!