

# Address before the national convention of the Association of Schools of Public Health and the American Public Health Association: Leadership in the health professions: A new role of advocacy for the Association of Schools of Public Health

Senator Spark M. Matsunaga Papers

Senate, Public relations, Speeches, Organizations, Box PR73, Folder 120

<https://hdl.handle.net/10524/82498>

---

Items in eVols are protected by copyright, with all rights reserved, unless otherwise indicated.

*UHM Library Digital Collections Disclaimer and Copyright Information*

"LEADERSHIP IN THE HEALTH PROFESSIONS:  
A NEW ROLE OF ADVOCACY FOR THE  
ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH,"  
AN ADDRESS BY U.S. SENATOR SPARK MATSUNAGA  
BEFORE THE NATIONAL CONVENTION OF THE  
ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH AND  
THE AMERICAN PUBLIC HEALTH ASSOCIATION.

OCTOBER 31, 1977

WASHINGTON, D.C.

LADIES AND GENTLEMEN: ALOHA! AND THANK YOU VERY  
MUCH, DEAN MICHAEL, FOR YOUR WARM, HAWAIIAN-SPIRITED  
INTRODUCTION. IT IS MOST COMFORTING TO **BE** INTRODUCED  
BY SOMEONE WHO CAN PROPERLY PRONOUNCE MY NAME. EVER SINCE  
COMING TO WASHINGTON ALMOST 15 YEARS AGO, I'VE BEEN CALLED  
BY ALL KINDS OF NAMES. FOR EXAMPLE, ON ONE OCCASSION  
WHEN THE FORMER MAJORITY LEADER OF THE SENATE, MIKE  
MANSFIELD, UNDERTOOK TO INTRODUCE ME AT A LARGE GATHERING  
OF ADMIRING HAWAII DEMOCRATS, AFTER TELLING THEM WHAT  
CLOSE FRIENDS WE WERE AND WHAT A GREAT GUY I WAS, HE SAID  
"I HAVE THE GREAT HONOR AND PRIVILEGE TO INTRODUCE TO YOU  
YOUR FRIEND AND MINE CONGRESSMAN MATSA-MATSA-SPARKY!"

SO I STARTED OUT BY SAYING, "THANK YOU, SENATOR  
MANSA-MANSA-MIKE."

ON ANOTHER OCCASSION, ON JUNE 8, 1963, WHEN THEN  
PRESIDENT, JOHN F. KENNEDY, ARRIVED IN HAWAII, THERE WERE  
10,000 PEOPLE THERE TO GREET HIM AT THE HONOLULU  
INTERNATIONAL AIRPORT. HE UNDERTOOK TO ADDRESS THE  
WELCOMING CROWD AND STARTED OUT BY ADDRESSING THOSE WHO  
WERE WITH HIM ON THE TEMPORARY PLATFORM WHICH WAS BUILT  
FOR THE OCCASSION. LOOKING TO HIS LEFT, HE SAID,  
"GOVERNOR BURNS, SENATOR FONG," AND LOOKING TO HIS RIGHT,  
HE CONTINUED, "SENATOR INOUE, CONGRESSMAN GILL," THEN HE  
HESITATED AND POURED IT OUT WITH A BROAD SMILE, AS IF HE  
REALLY MEANT IT, "AND MY GOOD FRIEND SPARKY!" MY  
RE-ELECTION IN 1964 WAS THEN AND THERE ASSURED!

SINCE MOVING TO THE SENATE FROM THE HOUSE, I HAVE  
LEARNED THAT I AM NOT THE ONLY ONE WHO HAS HAD PROBLEMS.

EARLY IN APRIL OF THIS YEAR, SENATOR S. I. HIYAKAWA OF CALIFORNIA APPROACHED ME ON THE FLOOR OF THE SENATE ONE DAY AND SAID, "SPARKY, WILL YOU DO ME A FAVOR?" I RESPONDED, "CERTAINLY, YOU JUST NAME IT." HE THEN POINTED HIS INDEX FINGER AT ME FOR EMPHASIS AND SAID, "WILL YOU TELL YOUR FRIENDS NOT TO CALL ME 'SPARKY'?" // OF COURSE, WHEN SOMEONE CALLS ME SENATOR INOUE, I MERELY RESPOND WITH A "HI!", WITH MY BOTH HANDS UP IN THE AIR.

I COULD STAND HERE AND TELL YOU ALL MORNING ABOUT THE TRAVAILS OF A U.S. SENATOR FROM HAWAII WITH AN ORIENTAL COUNTENANCE, BUT I'M HERE TO DISCUSS HEALTH AND MEDICAL CARE IN THIS GREAT COUNTRY OF OURS.

PERMIT ME AT THE VERY OUTSET TO MAKE MY POSITION VERY CLEAR WITH REGARD TO THE AMERICAN HEALTH CARE SYSTEM. ITS ACCOMPLISHMENTS HAVE BEEN NOTHING SHORT OF PRODIGIOUS. GREAT IMPROVEMENTS HAVE BEEN MADE IN THE HEALTH OF AMERICA'S POPULATION. AS YOU WELL KNOW, THE AGE-ADJUSTED

DEATH RATE FOR THE COUNTRY IS LESS THAN ONE-HALF OF WHAT IT WAS IN 1900; INFECTIOUS DISEASES HAVE BEEN MASTERED ALMOST COMPLETELY; MATERNAL AND INFANT MORTALITY RATES HAVE BEEN DRASTICALLY REDUCED; AND THE LIFE EXPECTANCY OF THE POPULATION HAS BEEN LENGTHENED.

MEDICAL TECHNOLOGY HAS PERMITTED INTERVENTIONS IN THE DISEASE PROCESS WITH CURES AND THERAPIES CONSIDERED IMPOSSIBLE ONLY A GENERATION AGO. HOWEVER, ALL OF THESE IMPROVEMENTS CANNOT BE ATTRIBUTED TO MEDICAL CARE ALONE. ADVANCES IN "OTHER" AREAS, SUCH AS SANITATION, ENGINEERING, HEALTH BEHAVIOR MODIFICATION, EPIDEMIOLOGY, AND NUTRITION HAVE HAD MARKED EFFECTS ON THE HEALTH OF THE AMERICAN POPULATION. THE ACHIEVEMENTS OF THE AMERICAN HEALTH CARE SYSTEM IN THE 20TH CENTURY TRULY APPROACH THE MIRACULOUS, AND OUR SCHOOLS OF PUBLIC HEALTH HAVE MADE AND WILL CONTINUE TO MAKE VITAL CONTRIBUTIONS TO OUR HEALTH CARE SYSTEM IN THESE "OTHER" AREAS.

CONCEDEDLY, THERE REMAIN MANY SERIOUS PROBLEMS IN  
OUR HEALTH CARE SYSTEM. ) FOR EXAMPLE, WE HAVE NOT OVERCOME  
ETHNIC AND LANGUAGE DIFFICULTIES. LET ME EXPLAIN: ONLY  
LAST YEAR A VERY SUCCESSFUL JAPANESE IMMIGRANT GARDNER,  
NOW A LANDSCAPE ARCHITECT IN CALIFORNIA, WENT TO AN  
AMERICAN DOCTOR TO HAVE HIS EYES EXAMINED. THE EYE, EAR,  
NOSE AND THROAT SPECIALIST MADE HIS DIAGNOSIS AND SAID,  
"MR. TANAKA, YOU HAVE A CATARACT." WHEREUPON MR. TANAKA  
RESPONDED, "OH, NO, NO! ME GOTTS ONE LINCOLN-CONTINENTAL."

omit

SERIOUSLY SPEAKING, OUR CURRENT MAJOR SOURCES OF  
CONCERN ARE: 1) THE SHARPLY ESCALATING COST OF MEDICAL  
CARE, 2) THE INCOMPLETE AND PARTIAL PROTECTION PROVIDED  
BY PRIVATE HEALTH INSURANCE, 3) THE INADEQUATE  
PROTECTION AGAINST THE COSTS OF CARE ASSOCIATED WITH  
CATASTROPHIC ILLNESS OR DISEASE, 4) THE UNEVEN  
DISTRIBUTION OF HEALTH AND MEDICAL CARE RESOURCES, AND  
5) THE GENERAL ABSENCE, WITHIN THE HEALTH AND MEDICAL CARE

INDUSTRY, OF INCENTIVES TO IMPROVE THE EFFICIENCY AND EFFECTIVENESS OF THE HEALTH CARE DELIVERY SYSTEM.

CLOSELY ASSOCIATED WITH THIS LAST CONCERN IS THE CONTINUED RELIANCE WITHIN THE HEALTH AND MEDICAL CARE INDUSTRY ON THE PHYSICIAN-SICKNESS ORIENTED, "MEDICAL" MODEL OF HEALTH AND MEDICAL CARE DELIVERY AS THE PRIMARY METHOD OF DELIVERING BASIC SERVICES TO THE GENERAL POPULATION. THERE IS STILL TOO LITTLE EMPHASIS BEING PLACED TODAY ON THE IMPORTANCE OF THE "PREVENTIVE" MODEL IN THE DELIVERY OF SUCH SERVICES, AND ON THE EFFECTS THAT THE WIDESPREAD USE OF SUCH A MODEL WOULD HAVE ON REDUCING THE INCIDENCE OF CERTAIN ACUTE AND CHRONIC ILLNESSES AND CERTAIN MAJOR MEDICAL COSTS ASSOCIATED WITH THOSE ILLNESSES. IN THIS CONNECTION, DR. LESTER BRESLOW, DEAN OF THE SCHOOL OF PUBLIC HEALTH AT U.C.L.A., AND HIS COLLEAGUES DESERVE COMMENDATION FOR CONDUCTING HIS RENOWNED LONGEVITY STUDY WHICH INDICATES THAT GOOD, "PREVENTIVE" PERSONAL HEALTH

HABITS HAVE A SIGNIFICANT, POSITIVE IMPACT ON THE HEALTH, WELL-BEING, AND LONGEVITY OF INDIVIDUALS PRACTICING SUCH HABITS.

IN RECENT YEARS, ANNUAL EXPENDITURES IN THE UNITED STATES FOR HEALTH CARE HAVE REACHED ASTRONOMICAL PROPORTIONS: \$160 BILLION IS THE ESTIMATED EXPENDITURE FOR FISCAL YEAR 1977. THIS REPRESENTS AN ANNUAL PER CAPITA EXPENDITURE OF \$727 FOR EVERY MAN, WOMAN AND CHILD IN THIS COUNTRY. THE NATIONAL HEALTH BILL HAS RISEN SO RAPIDLY THAT IN THE LAST SIX YEARS IT HAS NEARLY DOUBLED; IN THE LAST 15 YEARS, MORE THAN QUADRUPLED; AND, SINCE 1950, IT HAS INCREASED MORE THAN ELEVEN-FOLD. IT IS ENTIRELY CONCEIVABLE THAT THE ANNUAL EXPENDITURES FOR HEALTH CARE IN THE U.S. WILL EXCEED \$200 BILLION WITHIN THE NEXT TEN YEARS WITHOUT ANY APPRECIABLE IMPROVEMENT BEING MADE IN THE HEALTH OF THE AVERAGE AMERICAN CITIZEN, UNLESS COST CONTAINMENT MEASURES ARE ENACTED OR A FUNDAMENTAL RESTRUCTURING OF THE

DELIVERY OF HEALTH AND MEDICAL CARE IN THIS COUNTRY TAKES PLACE.

INCREASED SPENDING FOR HEALTH CARE IS DUE TO A NUMBER OF FACTORS. FOR EXAMPLE, DURING THE 10-YEAR PERIOD BETWEEN 1966 AND 1976, NINE PERCENT OF THE INCREASE COULD BE ATTRIBUTED TO POPULATION GROWTH. THIRTY-EIGHT PERCENT OF THE INCREASE WAS DUE TO THE TYPICAL PERSON RECEIVING MORE MEDICAL CARE AND MORE COMPLEX SERVICES IN 1975 THAN IN 1966. HOWEVER, MORE THAN HALF OF THE INCREASE IN HEALTH CARE SPENDING DURING THIS PERIOD WAS ATTRIBUTABLE TO HIGHER PRICES. HEALTH CARE PRICES INCREASED ABOUT 50 PERCENT FASTER THAN OTHER PRICES DURING THIS PERIOD, EXCEPT WHEN THE ECONOMIC STABILIZATION PROGRAM CONTROLS WERE IN EFFECT.

TRADITIONALLY, EXPENDITURES FOR HEALTH AND MEDICAL CARE IN THE UNITED STATES HAVE BEEN FINANCED FROM PRIVATE SOURCES. HOWEVER, BEGINNING IN 1966 WITH THE ADVENT OF THE MEDICARE AND MEDICAID PROGRAMS, THE TREND HAS BEEN

TOWARD INCREASED PUBLIC FINANCING OF SUCH CARE. IN FISCAL YEAR 1976, GOVERNMENT OUTLAYS FOR HEALTH AND MEDICAL CARE ROSE BY 15.6 PERCENT COMPARED TO AN INCREASE OF 12.8 PERCENT IN PRIVATE SPENDING. AS A RESULT, THE FEDERAL, STATE, AND LOCAL GOVERNMENT'S SHARE OF THE NATION'S HEALTH BILL IS NOW MORE THAN 42 PERCENT; IN 1966, IT WAS ONLY ABOUT 25 PERCENT.

ALTHOUGH PRIVATE HEALTH INSURANCE COVERAGE HAS EXPANDED OVER THE YEARS, WE KNOW THAT MANY AMERICANS STILL HAVE RELATIVELY LITTLE, IF ANY, PROTECTION. IN 1974, 78 PERCENT OF THE POPULATION HAD SOME FORM OF PRIVATE COVERAGE AGAINST THE COST OF INPATIENT HOSPITAL CARE. WHILE 74 PERCENT OF THE POPULATION HAD PRIVATE COVERAGE FOR THE COSTS OF IN-HOSPITAL PHYSICIAN VISITS, ONLY 60 PERCENT WERE INSURED FOR PHYSICIAN CARE RENDERED IN THE HOME OR OFFICE. SOME 76 PERCENT HAD INSURANCE FOR OUT-OF-HOSPITAL DRUGS, BUT ONLY 33 PERCENT WERE INSURED

FOR ANY FORM OF NURSING HOME CARE, AND 16 PERCENT FOR DENTAL CARE. ALTHOUGH MANY PERSONS NOT COVERED UNDER PRIVATE INSURANCE PLANS RECEIVE ASSISTANCE FOR THEIR HEALTH CARE EXPENSES THROUGH PUBLIC PROGRAMS SUCH AS MEDICARE, MEDICAID, AND THE VETERANS ADMINISTRATION, AN ESTIMATED 22 MILLION PEOPLE, OR 12 PERCENT OF THE AMERICAN POPULATION, HAVE NO HEALTH INSURANCE PROTECTION UNDER EITHER PUBLIC OR PRIVATE PROGRAMS.

DESPITE THE PROTECTION PROVIDED BY PRIVATE PLANS, PRIVATE HEALTH INSURANCE MET ONLY 40 PERCENT OF CONSUMER EXPENDITURES FOR PERSONAL HEALTH CARE IN 1974. IN THE CASE OF HOSPITAL CARE, PRIVATE INSURANCE COVERED CONSIDERABLY MORE -- 77 PERCENT OF ALL CONSUMER EXPENDITURES. BUT ONLY 51 PERCENT OF CONSUMER COSTS FOR PHYSICIANS' CARE, AND 7 PERCENT OF CONSUMER EXPENDITURES FOR OTHER TYPES OF CARE WERE PAID FOR BY PRIVATE INSURANCE.

AS YOU KNOW, IT IS MOST DIFFICULT TO PROTECT PEOPLE

FROM HEALTH CARE COSTS OF A CATASTROPHIC NATURE.

ALTHOUGH SLIGHTLY MORE THAN HALF THE POPULATION UNDER 65 IS COVERED UNDER A MAJOR MEDICAL OR COMPREHENSIVE HEALTH PLAN, MANY OF THESE PLANS CONTAIN LIMITS ON MAXIMUM BENEFITS PER EPISODE OR PER LIFETIME WHICH MAKE THEM INADEQUATE IN THE FACE OF LONG-TERM ILLNESS OR THE NEED FOR EXOTIC MEDICAL TREATMENTS. PERSONS WITHOUT MAJOR MEDICAL OR COMPREHENSIVE COVERAGE ARE EVEN MORE VULNERABLE TO FINANCIAL RUIN IN THE FACE OF SUCH EXPENSES.

IT IS ALSO GENERALLY AGREED THAT THERE IS A DISTRIBUTION IMBALANCE OF EXPENSIVE HEALTH RESOURCES IN THE UNITED STATES. SUCH RESOURCES -- HEALTH CARE FACILITIES AND MANPOWER -- REPRESENT A SIGNIFICANT AND LONG-TERM FINANCIAL COMMITMENT OF BOTH PUBLIC AND PRIVATE FUNDS, AND MUST, THEREFORE, BE REDISTRIBUTED WITHIN THE NEXT FEW YEARS TO PROVIDE FOR A MORE EQUITABLE, EFFICIENT AND EFFECTIVE DISTRIBUTION OF HEALTH RESOURCES AMONG THE

GENERAL POPULATION.

A VARIETY OF COMPLEX, INTERRELATED FACTORS HAVE GENERATED INCREASES<sup>S</sup> IN COSTLY HEALTH RESOURCES, WHILE AT THE SAME TIME CONTRIBUTING<sup>12</sup> TO IMBALANCES IN THEIR DISTRIBUTION. ON THE ONE HAND, INCREASED PUBLIC DEMAND FOR SERVICES, MAJOR SCIENTIFIC AND TECHNOLOGICAL ADVANCES, COMPETITION AMONG HOSPITALS FOR ENLARGEMENT OF PLANTS AND THE ACQUISITION OF EXPENSIVE FACILITIES, PHYSICIAN GENERATED DEMAND, HEALTH INSURANCE COVERAGE WHICH EMPHASIZES INPATIENT CARE, AND PUBLIC PROGRAMS SUPPORTING RESOURCE DEVELOPMENT HAVE RESULTED IN AN OVERABUNDANCE OF RESOURCES IN SOME AREAS.

ON THE OTHER HAND, A LACK OF COHESIVE, SUSTAINED PLANNING IN THE PAST 25 YEARS HAS ALLOWED AND EVEN ENCOURAGED AN APPALLING SCARCITY OF HEALTH RESOURCES IN OTHER AREAS. IN SOME COMMUNITIES, VIRTUALLY NO HOSPITAL FACILITIES ARE AVAILABLE TO SERVE THE PUBLIC. ELSEWHERE,

OFTEN WITHIN THE SAME STATE, THERE MAY BE A SURPLUS OF BEDS, HEALTH MANPOWER AND EQUIPMENT RESOURCES.

A RELATED CONCERN WITH REGARD TO RESOURCES IS THEIR EFFICIENT UTILIZATION. INCREASING SPECIALIZATION AND OTHER FACTORS HAVE ESTABLISHED REQUIREMENTS FOR GREATER NUMBERS AND KINDS OF HEALTH MANPOWER. WITH RESPECT TO SCHOOLS OF PUBLIC HEALTH, THE MILBANK MEMORIAL FUND COMMISSION RECOMMENDED IN ITS REPORT ENTITLED, HIGHER EDUCATION FOR PUBLIC HEALTH, THAT "THERE SHOULD BE A MAJOR REDIRECTION AND REORGANIZATION OF HIGHER EDUCATION FOR PUBLIC HEALTH, BASED ON THE RECOGNITION THAT DIFFERENT GROUPS OF PERSONNEL WITH DIFFERENT FUNCTIONS WILL REQUIRE DIFFERENT KINDS OF EDUCATIONAL PROGRAMS." THE STUDY GOES ON TO STATE THAT "SCHOOLS OF PUBLIC HEALTH SHOULD CONCENTRATE THEIR EFFORTS PRIMARILY ON: 1) THE PREPARATION OF PEOPLE WHO WILL FUNCTION AS EXECUTIVES, PLANNERS, AND POLICY MAKERS, 2) THE PREPARATION OF EPIDEMIOLOGISTS AND BIOSTATISTICIANS, AND 3) THE PREPARATION OF RESEARCH SCIENTISTS AND EDUCATORS." I AM AWARE THAT THESE RECOMMENDATIONS ARE NOT UNANIMOUSLY ACCEPTED WITHIN THIS BODY AND ARE STILL AN ISSUE OF

INTENSE DISCUSSION; HOWEVER, THEY ARE AN EXAMPLE OF ONE VIEW NOW UNDER CONSIDERATION.

THERE IS ALSO CONCERN OVER THE POSSIBLY EXCESSIVE USE OF COSTLY HOSPITAL RESOURCES TO TREAT PERSONS WHO COULD BE MORE ECONOMICALLY SERVED IN OTHER WAYS. THE METHODS USED TO PAY FOR HEALTH CARE HAVE BEEN CRITICIZED BECAUSE THEY CONTAIN LITTLE BY WAY OF INCENTIVES FOR THE ECONOMICAL AND EFFICIENT USE OF FACILITIES, MANPOWER, AND SPECIAL SERVICES. SCHOOLS OF PUBLIC HEALTH HAVE PLAYED AND SHOULD CONTINUE TO PLAY A VITAL ROLE IN THE DESIGN AND ANALYSIS OF MORE ECONOMICAL AND EFFICIENT USES OF THESE HEALTH RESOURCES.

WHILE ALL OF THESE ISSUES ARE IMPORTANT CONCERNS IN AND OF THEMSELVES, THEY BECOME VITAL CONSIDERATIONS AS WE NEAR THE ENACTMENT OF A PROGRAM OF NATIONAL HEALTH INSURANCE. INCIDENTLY, I HAVE SUPPORTED THE ENACTMENT OF A NATIONAL HEALTH INSURANCE PROGRAM SINCE 1970. I AM CURRENTLY IN THE PROCESS OF REVISING MY NATIONAL HEALTH INSURANCE BILL FOR REINTRODUCTION

EARLY NEXT YEAR.

THERE IS A CONSENSUS TODAY AMONG HEALTH PROFESSIONALS, LEGISLATORS, AND PRIVATE CITIZENS THAT WE MUST ATTEMPT TO RESOLVE EACH OF THE PROBLEMS ASSOCIATED WITH OUR PRESENT HEALTH CARE DELIVERY SYSTEM BEFORE WE COMMIT OURSELVES TO NATIONAL HEALTH INSURANCE. TO THIS END, CONGRESS HAS RESPONDED IN THE LAST FEW YEARS WITH A VARIETY OF LEGISLATIVE PROPOSALS AND APPROPRIATIONS WHICH ADDRESS THESE CONCERNS WITHIN OUR PRESENT HEALTH CARE SYSTEM.

FOR EXAMPLE, IN 1974, CONGRESS MOVED TO COMBINE AND INTEGRATE HEALTH PLANNING EFFORTS THROUGH THE ENACTMENT OF THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT. WHILE IT IS STILL IN THE EARLY STAGES OF IMPLEMENTATION, THAT ACT IS INTENDED TO PROVIDE A MORE COORDINATED AND COMPREHENSIVE BASIS FOR HEALTH PLANNING AND RESOURCES DEVELOPMENT.

LAST OCTOBER, CONGRESS PASSED THE HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE ACT OF 1976. THIS NEW LAW EXTENDS, WITH SUBSTANTIAL REVISIONS, A NUMBER OF FEDERAL PROGRAMS OF ASSISTANCE FOR THE TRAINING OF HEALTH MANPOWER. IT WAS THE INTENT OF CONGRESS TO CORRECT, WITH THESE PROVISIONS, PROBLEMS ASSOCIATED WITH THE GEOGRAPHIC AND SPECIALTY MALDISTRIBUTION OF KEY HEALTH PROFESSIONALS IN THE NATION.

OTHER PROPOSALS CURRENTLY PENDING IN CONGRESS SEEK TO IMPROVE THE ACCESSIBILITY AND AVAILABILITY OF BASIC HEALTH CARE SERVICES IN THE COUNTRY BY AUTHORIZING THE DIRECT PAYMENT FOR SERVICES PROVIDED BY HEALTH CARE PROFESSIONALS NOT CURRENTLY ELIGIBLE FOR REIMBURSEMENT UNDER THE MEDICARE AND MEDICAID PROGRAMS. I HAVE SPONSORED A NUMBER OF SUCH PROPOSALS AND LOOK FORWARD TO FAVORABLE ACTION BY CONGRESS ON THESE MEASURES SOON AFTER WORK IS COMPLETED ON THE MAJOR PIECES OF HEALTH CARE LEGISLATION INTRODUCED EARLIER THIS YEAR.

AS YOU KNOW, CONGRESS IS NOW CONSIDERING TWO VERY

IMPORTANT LEGISLATIVE PROPOSALS WHOSE OBJECTIVE IS TO CONTAIN RAPIDLY-ESCALATING HOSPITAL COSTS. I HAVE COSPONSORED, ALONG WITH OTHER MEMBERS OF THE SENATE FINANCE COMMITTEE, ONE OF THESE PROPOSALS, SPECIFICALLY, S. 1470, THE MEDICARE-MEDICAID ADMINISTRATIVE AND REIMBURSEMENT REFORM ACT. THIS BILL WOULD ESTABLISH A NEW INCENTIVE-ORIENTED REIMBURSEMENT SYSTEM FOR ROUTINE HOSPITAL OPERATING COSTS INCURRED UNDER THE MEDICARE AND MEDICAID PROGRAMS. THE SYSTEM WOULD BE BASED ON A CLASSIFICATION SYSTEM OF HOSPITALS GROUPED BY THE NUMBER OF BEDS, TYPE, AND OTHER FACTORS. THE NEW MECHANISM, TO BE PHASED IN BY FISCAL YEAR 1981, WOULD REWARD HOSPITALS WHOSE ROUTINE OPERATING COSTS ARE BELOW AVERAGE, AND PENALIZE HOSPITALS WHOSE ROUTINE OPERATING COSTS EXCEED 120 PERCENT OF THE AVERAGE. THE SYSTEM WOULD PROVIDE EXCEPTIONS FOR HOSPITALS IN UNDERSERVED AREAS AND THOSE EXPERIENCING AN UNUSUAL PATIENT MIX. IN ADDITION, THIS BILL WOULD REQUIRE APPROVAL OF CAPITAL EXPENDITURES BY PLANNING AGENCIES FOR THE PURPOSES

OF MEDICARE AND MEDICAID REIMBURSEMENT, AND WOULD REQUIRE ALL APPROPRIATE STATES OR JURISDICTIONS TO APPROVE SUCH EXPENDITURES.

THE CARTER ADMINISTRATION HAS SUBMITTED ITS OWN PROPOSAL TO LIMIT HOSPITAL COSTS. THIS PROPOSAL, S. 1391, THE HOSPITAL COST CONTAINMENT ACT OF 1977, IS INTENDED TO BE A TEMPORARY HOSPITAL COST CONTAINMENT PROGRAM WHICH ESTABLISHES A LIMIT ON INCREASES IN HOSPITAL REVENUES FROM EACH CLASS OF PAYOR FOR INPATIENT SERVICES. THE LIMIT ON HOSPITAL INPATIENT REVENUES WOULD BE BASED ON A FORMULA REFLECTING GENERAL PRICE TRENDS IN THE ECONOMY PLUS AN ADDITIONAL AMOUNT TO ACCOMMODATE INCREASES IN THE INTENSITY OF PATIENT SERVICES. THE LIMIT WOULD BE APPROXIMATELY NINE PERCENT IN THE FIRST YEAR OF THE PROGRAM.

I SHOULD POINT OUT THAT THE PROPOSAL WHICH I HAVE COSPONSORED AND THAT OF THE ADMINISTRATION ARE NOT COMPETITIVE. THE FIRST WHICH IS LARGELY COSPONSORED BY

MEMBERS OF THE SENATE FINANCE COMMITTEE PROPOSES A LONG-TERM BASIC STRUCTURAL ANSWER TO THE PROBLEM OF RISING HOSPITAL COSTS, WHEREAS THE ADMINISTRATION'S PROPOSAL CALLS FOR A SHORT-TERM INTERIM CAP ON CHARGES UNTIL A LONG-TERM SOLUTION CAN BE ESTABLISHED.

I PERSONALLY HAVE NOT YET REACHED A DECISION ON THE MERITS OF THE ADMINISTRATION'S PROPOSAL. I AM SOMEWHAT UNCERTAIN ABOUT THE WISDOM OF A CAP ON HOSPITAL CHARGES -- FOR SEVERAL REASONS. FIRST, A CAP MAY BECOME A FLOOR. SECOND, WITH ALL OF ITS EXCEPTIONS, THE CAP MAY BE INEFFECTIVE AS A CEILING. THIRD, A CAP BY ITS VERY NATURE IS ARBITRARY AND TENDS TO PENALIZE THOSE WHO HAVE BEEN EFFICIENT IN THE PAST AND REWARD THOSE WHO HAVE BEEN INEFFICIENT. AND FOURTH, SWITCHING FROM OUR CURRENT CONTROL MECHANISMS ON REIMBURSEMENT TO THE NEW CONCEPT OF A CAP FOR ONE OR TWO YEARS, AND THEN TO YET ANOTHER CONTROL CONCEPT AS EMBODIED IN MY BILL, MAY CAUSE SUCH CHAOS WITHIN THE HOSPITAL FIELD AS TO CANCEL OUT THE DUBIOUS SAVINGS

INVOLVED. HOWEVER, I DO SHARE THE ADMINISTRATION'S CONCERN ABOUT INCREASING HOSPITAL COSTS AND WILL STRONGLY SUPPORT EFFORTS TO SEEK AN APPROPRIATE SOLUTION TO THIS CRITICAL PROBLEM. THE SENATE FINANCE COMMITTEE IS CURRENTLY IN THE PROCESS OF CONSIDERING EACH OF THESE PROPOSALS IN DETAIL AS WELL AS A PROPOSAL INTRODUCED BY SENATOR RICHARD SCHWIEKER TO PROVIDE STATE CONTROL OVER HOSPITAL COSTS, AND AN EXPANDED AND REVISED VERSION OF S. 1470 WHICH MEETS MOST OF THE OBJECTIONS RAISED AGAINST THE ORIGINAL BILL DURING FINANCE COMMITTEE HEARINGS HELD LAST SUMMER.

I SHOULD MENTION ONE OTHER AREA OF SPECIAL CONCERN TO THE CONGRESS. AS YOU MAY KNOW, CONGRESS RECENTLY PASSED A BILL, S. 143, INTENDED TO IMPROVE THE DETECTION AND PROSECUTION OF FRAUD AND ABUSE UNDER THE MEDICARE AND MEDICAID PROGRAMS. AS A COSPONSOR OF THE MEASURE, I WAS INVITED TO THE WHITE HOUSE LAST TUESDAY TO WITNESS THE PRESIDENT SIGN IT INTO LAW. I AM FULLY AWARE OF THE FACT THAT THE ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH, AND THE

AMERICAN PUBLIC HEALTH ASSOCIATION BOTH ENDORSED THIS PROPOSAL. I CONGRATULATE AND COMMEND BOTH ORGANIZATIONS FOR THEIR LEADERSHIP AND ADVOCACY IN THIS AREA.

AS HEALTH PROFESSIONALS YOU SHOULD KNOW THAT THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE IS CURRENTLY UNDERGOING A STRUCTURAL AND, IN SOME INSTANCES, A PROGRAMATIC REORGANIZATION. NEXT YEAR CONGRESS AND ITS COMMITTEES WHICH HAVE JURISDICTION OVER THE PUBLIC HEALTH SERVICE PROGRAMS WILL UNDERTAKE A MASSIVE REEVALUATION OF THOSE PROGRAMS IN ACCORDANCE WITH THE PRESIDENT'S INTENTION TO IMPLEMENT A ZERO-BASED BUDGETING SYSTEM IN THE EXECUTIVE BRANCH WITHIN THE NEXT FEW YEARS.

IN THE LIGHT OF THIS AND THE PROBABLE ENACTMENT OF A PROGRAM OF NATIONAL HEALTH INSURANCE WITHIN THE NEXT FIVE YEARS, IT WILL BE VITALLY IMPORTANT FOR THE ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH AND ITS INDIVIDUAL MEMBER INSTITUTIONS TO BECOME EVEN MORE ACTIVELY INVOLVED WITH THE CONGRESS IN PROPOSING AND EVALUATING HEALTH LEGISLATION.

THE ASSOCIATION AND MANY OF ITS MEMBER INSTITUTIONS,  
PARTICULARLY THOSE WHICH ARE LOCATED CLOSE TO  
WASHINGTON, D.C., HAVE BEEN INVOLVED IN THE CONSIDERATION  
OF MANY PIECES OF HEALTH LEGISLATION IN THE PAST. SUCH  
TECHNICAL ASSISTANCE HAS BEEN GREATLY APPRECIATED BY  
MEMBERS OF CONGRESS.

HOWEVER, IN VIEW OF THE IMPORTANT ROLE WHICH THE  
ASSOCIATION AND ITS MEMBER SCHOOLS HAVE PLAYED, AND WILL  
NO DOUBT CONTINUE TO PLAY, IN THE TRAINING OF HEALTH  
PROFESSIONALS, AND IN VIEW OF THE REDUCED FUNDING WHICH THE  
SCHOOLS MAY RECEIVE WHEN THE LABOR-HEALTH, EDUCATION, AND  
WELFARE APPROPRIATIONS BILL IS IMPLEMENTED, AND IF A  
SUPPLEMENTAL APPROPRIATION FOR THE SCHOOLS IS NOT PASSED  
SHORTLY THEREAFTER, IT IS PARTICULARLY IMPORTANT THAT THE  
SCHOOLS INCREASE THEIR VISIBILITY IN THE FUTURE.

TO ACCOMPLISH THIS GOAL, THE SCHOOLS AND THE ASSOCIATION  
OF SCHOOLS OF PUBLIC HEALTH SHOULD ENHANCE THEIR CLOSE  
RELATIONSHIPS WITH THE MEMBERS OF THE CONGRESSIONAL HEALTH

COMMITTEES AND MORE IMPORTANTLY, WITH THE MEMBERS OF THE CONGRESSIONAL DELEGATION FROM THE STATES IN WHICH THE SCHOOLS ARE LOCATED. SPEAKING FROM PERSONAL EXPERIENCE, THE SCHOOL OF PUBLIC HEALTH IN MY OWN STATE OF HAWAII HAS BEEN INVALUABLE TO ME IN MY LEGISLATIVE EFFORTS BY PROVIDING NEEDED TECHNICAL ASSISTANCE, TESTIMONIES AT HEARINGS, CORRESPONDENCE, AND KNOWLEDGEABLE CONGRESSIONAL INTERNS. THIS HAS BEEN DUE IN NO SMALL PART TO THE EFFORTS OF MY GOOD FRIEND, THE DEAN OF THE SCHOOL, JERROLD MICHAEL.

LASTLY, I PROPOSE THAT THE ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH AND ITS MEMBER SCHOOLS ASSUME THE ROLE OF LEADERSHIP TRAINING AND ADVOCACY FOR BROAD, LONG RANGE, HEALTH POLICY PLANNING AND IMPLEMENTATION. TO DATE, NO ORGANIZATION HAS ESTABLISHED A CLEAR, UNIFIED POSITION OF LEADERSHIP IN THIS AREA. IT WOULD PLEASE ME GREATLY TO SEE THE ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH AND THE AMERICAN PUBLIC HEALTH ASSOCIATION ASSUME THIS TASK WHICH

IS EXTREMELY IMPORTANT IN THE FUTURE OF OUR NATION'S  
HEALTH CARE SYSTEM.

I HOPE THAT MY REMARKS HAVE COMMUNICATED THE CONCERN  
OF THE CONGRESS AND MY PERSONAL INTEREST IN THE HEALTH  
CARE PROBLEMS OF THE NATION AND OUR DESIRE TO CORRECT THE  
DEFICIENCIES IN THE PRESENT SYSTEM. IT IS MY CONSIDERED  
JUDGMENT THAT THE SATISFACTORY RESOLUTION OF PROBLEMS  
SUCH AS THESE MUST PRECEDE THE ENACTMENT OF A NATIONAL  
HEALTH INSURANCE PROGRAM.

THANK YOU VERY MUCH.