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news from

Senator DANIEL K. INOUYE

Speech delivered by
David M. Peters
Exec. Ass't.

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I am extremely pleased to be with your during National Hospital Week to share with you some of my observations regarding our nation's hospice programs. In many ways, it is most fitting that the St. Francis Hospital, under the leadership of Sister Maureen, has developed an operational hospice program for Hawaii.

During her nearly 30 years in Hawaii, Sister Maureen has always spoken out, candidly and forcefully, on behalf of the consumer and, especially on behalf of those who were most in need of high quality health care.

Undoubtedly, in the years to come we will see a number of hospice programs developed across the nation. Our grandchildren will someday look back and naively conclude that "Hospices are so appropriate, so necessary, they must always have existed". Yet, today, we know that is simply not the case.

Hospices are officially experimental. The Department of Health, Education and Welfare feels that it must evaluate them, analyze them, dissect them. Someday, HEW may even recommend paying for them. But not today. There are too many unanswered questions, too many unknown factors. In short, it takes someone with the foresight and the compassion of Sister Maureen to create one, in spite of the bureaucracy's hesitations.

For a number of years now, I have concerned myself with our nation's health care system. As many of you may be aware, it was my lifelong ambition to be a physician. More specifically, I wanted to be a surgeon--and a good one. I wanted to be able to help those less fortunate than I, to help them be restored to their former state of good health. Unfortunately my World War II injuries made that dream an impossible one. However, I still continue to maintain a strong interest in our nation's health care system.

As you well know, back in the mid-1970s, our nation faced a major health care crisis. This was not a crisis resulting from a shortage of doctors, or from a lack of sophisticated technology, but rather from a true crisis of confidence. At that time it was labeled a medical malpractice crisis. True, there were some incompetent doctors that the medical profession refused to identify.

Further, the overall uncertainty of our nation's economy raised serious questions for our nation's insurance companies as to whether they desired to remain in the health care area. We saw scenes of highly-trained physicians going out on strike and then actively lobbying their state and national legislators for relief. Practitioners and hospitals were faced with extraordinary medical malpractice premiums--even those who never had a single suit filed against them. At that time, I introduced legislation at the federal level that would have treated medical malpractice incidents in the same manner that we presently treat Workers' Compensation cases. My proposal was essentially a "no-fault" approach. We would adequately compensate those who were injured and rely on active peer review mechanisms to weed out the incompetent practitioners, or perhaps,if appropriate, limit the scope of their licensure. My proposal was without question a radical one, but, in all candor, one that I feel is still necessary. Its time has, however, not yet come. Instead, we witnessed a number of state legislatures making a very credible effort to ensure that malpractice insurance would remain available. And they have succeeded, but at a cost. And, as usual, the additional costs involved have been passed on to the consumer. I would wager that today most of us are no longer aware of this increment.

Unfortunately, experts have convinced me that our response to the mid-1970s crisis was only a band-aid approach; that the fundamental causes of the medical malpractice crisis have not yet been seriously addressed. As a result, we must fully expect that crisis to reappear in the near future, and that it will be even worse than before.

In my judgment, our medical malpractice crisis demonstrated the lack of confidence in our nation's health care industry. Health care is a major industry. In fact, it is the third largest industry in the United States. Health is a very expensive industry. The United States today spends more on health care than any other nation in the world. Health presently accounts for 9.1 percent of our gross national product, the highest level in our nation's history. The federal government currently pays almost 40 percent of all health care expenditures. In fact, the federal government's expenditures for health comprises an astronomical 12.7 percent of the entire federal budget, and it is estimated that this could rise to 14.5 percent by 1984. Presently, only national defense, interest on the national debt, and income security programs command a larger share.

Yet, for all the money we spend and for all the complex technology we have developed, I am afraid that we have all-too-often forgotten one crucial element in the question, the patient. As I did my research on the medical malpractice crisis, and even today as I continue to study our nation's health care system, I repeatedly see decisions being made without real attention being paid as to how the patient will be affected.

On the one hand, we as a nation have accepted the Marcus Welby myth that the doctor is infallible, that he or she can do no wrong. At the same time, we have a problem caused by the high level of technology in our nation's health care system. It sometimes seems that our health care practitioners are too busy to take the time to explain the admittedly complex procedures involved.

I get dozens of letters each year from constituents who want to know why their hospital bill has a charge for Dr. X's services... They claim that they did not know anything about these services or even know who Dr. X was. So when something goes wrong, the patient feels cheated and betrayed. He has been led to believe that modern medicine is infallible, but he frequently must face the reality that it is not. And no one seems to care about him and his problems, so he sues. Maybe that way someone will finally listen.

I am very pleased to be here with you today at the Conference on Hospices. Those of us interested in hospice work have agreed, whether we realize it or not, to openly face the realities of our very imperfect health care system and our own individual mortality.

When I learned that a large portion of the audience would be made up of nurses and psychologists, I was especially pleased to accept this invitation. It is my judgment that your disciplines, in particular, have truly unique expertise in this area.

We know that from 60 to 80 percent of the visits being made to medical practitioners are, in fact, being made by patients who demonstrate emotional, rather than organic ethiology for their physical symptoms. Since the very essence of a hospice program presupposes a terminal disease, the administration of palliative care (medical relief of pain) and supportive services to the patient and his or her family, our traditional restoration and "cure" orientation is simply not appropriate. Instead, we start with the given fact that the identified patient is dying and that he or she and the family network must be assisted in learning how to most satisfactorily face death.

There are no easy answers and those of you who chose to work with the terminally ill are to be highly commended. In preparing my remarks, I asked the Department of Health, Education and Welfare what their plans were and what they felt should be done. As you might imagine, they also do not have any ready answers. The issues surrounding death have been with us since man first set foot on this planet. Each of us is an individual, and none of us really knows how we will face our own death.

Historians tell us that the fundamental concept of the hospice had its origin in homes established by religious orders during the middle ages in Europe--homes where pilgrims received care and personal attention as they traveled to the Holy Land. Institutions of early medicine evolved from these homes and incorporated the hospice concept of providing personal attention and care for the sick and dying poor.

A group of Catholic widows established a hospice in Lyon, France in 1841 for poor women with incurable cancer. In the mid-1800s, the founder of the Irish Sisters of Charity established a hospice for the dying in Dublin, Ireland. About 50 years later, several hospices were also reported in London, England. In 1971, the first formally organized hospice was founded in the United States. Today, less than a decade later, there are some 50 organizations in our nation that consider themselves hospices.

While there are no standard definitions, staffing patterns, or particular programs, truly interdisciplinary teams do work together to respond to the physical, psychological, and spiritual needs of the patient and family. This concern continues from the first recognition of the terminal nature of the illness through to the grave. Both the patient and his or her loved ones are helped to face their loss. National studies have shown that most people if given the choice would like to die at home, with dignity and a sense of pride. Yet, today only 10 percent have that opportunity. When a hospice exists, the figure rises to the 70 percent range.

The old Department of Health, Education and Welfare recently authorized special demonstration projects to explore various ways to deliver these necessary services. But even with this support, the real issue seems to be, how do we make the final days and hours as humane and dignified as possible, as there are no set rules to go by? The real key is the people involved--people like Sister Maureen and Sister Francine.

For the past seven years, I have been working very closely with my colleagues in the Senate to amend our present federal health legislation to ensure that mental health benefits, and especially those provided by our nation's psychiatric nurses, clinical psychologists, and clinical social workers would be reimbursable. It has been a long and difficult haul. This is due partly to the political inexperience of the non-physician professional discipline. It is also due partly to the ugly stigma that still surrounds the "mentally ill". To a very real extent, it is also because our federal programs are essentially health programs and the emotional issues surrounding mental health are generally not understood, nor really considered health issues. Accordingly, I fully expect that the issues surrounding reimbursement for hospice services will undergo similar scrutiny. No one would argue with me that mental health services are important, yet most of my colleagues do not understand them enough to feel comfortable about reimbursing them under a federal health program--whether this be the civilian health and medical program of the uniformed services (CHAMPUS), the federal employee health benefits act, or the Social Security Act. The same I am afraid will occur with hospice treatment.

Yet, we have made substantial progress. Five years ago, we were able to have clinical psychologists directly reimbursed as independent practitioners under the CHAMPUS program. Just last week, after three years of negotiations and debate, CHAMPUS, at my personal request, announced a nationwide 5-month experimental project in which they will directly reimburse the services of all certified nurse practitioners.

This expressly included psychiatric nurses. They will evaluate both the cost-effectiveness and quality of care issues surrounding nursing practice. This project was specifically recommended by the President's Commission on Mental Health, but it nonetheless took three long years of hard work to convince my colleagues that it would not bankrupt our defense budget. I am confident that when the data is finally in, we will have won our case.

CHAMPUS is, to some perhaps, a small program having an annual health budget of $500 million and serving 8.6 million dependents of active duty military personnel and various retirees. But the precedents are now there. Nursing services of an independent nature--such as those utilized in the hospice program--will finally be directly reimbursed. We are not talking exclusively about medical services, but instead about nursing and psychological services. This is, in my judgment, a very significant public policy difference.

On another front, I have been working closely with my colleagues in the Senate Finance Committee to see if we can come up with a very different approach to our current welfare program, one that would provide meaningful employment for those AFDC mothers on welfare and also provide a more meaningful existence for those presently living in nursing homes and various skilled nursing facilities. The specific proposal we have been discussing would authorize the Department of Health, Education and Welfare to establish a number of pilot projects in which the federal government will pay 90 percent of all costs of training and employing these welfare recipients in public health jobs, perhaps as home health aids for a hospice program. Our present intent is to provide up to 5 years of support for each recipient. My proposal has been approved twice by the Committee and Senator Long has indicated that he is cautiously optimistic that it will pass the Senate this year. In fact, since the Congressional Budget Office has conceded that it will save substantial money every year after the first, it may very well become public law this Session.

Keep in mind, we are talking about 90 percent of all costs--educational training and even salaries--being picked up by the federal government while still saving the federal taxpayers' money. And what will these AFDC mothers do? They will provide many of the types of services that are inherent to the hospice movement. Yes, I honestly think that we are finally making progress in humanizing our health care system.

Finally, there is no doubt in my mind that some form of national health insurance will be enacted into public law in the near future. This issue must now, of necessity, be considered on the "back burner" while the administration and the Congress focus instead upon the immediate crisis of Iran, our Nation's economy, and our ever-dwingling energy supply. Yet, the hard statistics underscoring the need for a comprehensive national health insurance program are still there.

Since the Administration of President Harry Truman, our nation's elected officials have been seriously exploring the possibility of enacting some form of national health insurance. To date, sixty nations around the globe have succeeded in developing their own unique approach, and of the industrialized countries, only the United States and South Africa have not yet done so.

In the United States, some 18 million Americans, most of them poor or nearly poor, have no health insurance at all; 19 million have health insurance which does not protect them against ordinary costs of hospitalization and physician costs, and an additional 46 million have inadequate insurance against large medical bills. In essence, today some 80 million Americans remain unprotected against devastating medical costs. Further, some 52 million Americans live in areas without sufficient access to health care, even if they could pay for it.

There can be little question that during the initial years of this debate, the concerted opposition or organized medicine to the perceived advance of "socialized medicine" was one of the major stumbling blocks to the enactment of any comprehensive national health insurance program or even of a national health policy. However, as the public policy debate continues, and as more and more concerned individuals and representative interest groups become involved, no one organization or ideological orientation will ever again have that much influence. For example, the readily identifiable participants, with their very diverse orientations, include the various provider groups, all of the major labor unions, the hospital associations, the insurance companies, small and large businesses (who, by the way, presently pay up to 25 percent of all health care costs), senior citizen organizations, etc.

Clearly, a consensus regarding the form that national health insurance should take has not yet evolved. However, for the first time the focus of the debate has shifted from purely ideological and professional guild issues, such as the "horrors of governmental medicine", to the more objective issues surrounding the cost of health care. The cost of health care is a highly emotional and volatile issue that directly affects all Americans. More importantly, it is a topic that no one professional discipline can claim is exclusively their province.

In my judgment, the ultimate form of national health insurance that we adopt will be intimately linked to our present medicare program. Medicare is a very interesting program. Its beneficiaries include almost every American citizen over the age of 65 and a number of our nation's disabled. Medicare and its sister program, Medicaid, were enacted into public law in 1965 and our nation's health care policy makers now possess 15 years of experience in implementing the programs. Presently, nearly 40 million Americans are covered under at least one of the two programs. Medicare is a nationwide health insurance program of an entitlement nature which has uniform benefits across the nation. It is 100 percent federally funded. It is, in essence, a mini-national health insurance program, and probably the forerunner of the national health insurance that we know will eventually come to pass.

Under Medicare, the mental health benefit package is considerably less comprehensive than the benefits for the more traditional physical/organic illnesses. For example, inpatient care in psychiatric hospitals is limited to 190 days over a person's life span. In sharp contrast, limitations for inpatient services in general hospitals for non-psychiatric care are framed in terms of each episode of illness without an overall limitation.

Further, outpatient care for an organic illness, requires that the individual pay 20 percent of the cost in the form of a co-payment. If the diagnosis is mental illness, he must instead pay a 50 percent co-payment with a $250 overall annual limit on reimbursement. No such comparable overall limit on outpatient physical health care services exists, instead, the "usual and customary" fee schedule is utilized.

Of greater importance for the proponents of high quality mental health coverage, is the basic policy determination contained in Medicare to not directly reimburse non-medical practitioners as independent providers. This position was expressly endorsed by the Department of Health, Education and Welfare in 1968 and has not been modified since. In essence, this policy establishes that the physician shall be the point of entry for all health care determinations and that other health professionals shall not be recognized as independent providers. Underlying this notion is the sincere feeling that physical and mental illness may overlap, particularly in the elderly who are the prime beneficiaries of Medicare, and that the non-medical practitioner simply is not trained to diagnose organically caused illnesses. As you can gather, the issue of whether a physician is trained to pick up the emotional component is nowhere addressed.

My bills would directly alter the para-professional status of our nation's non-medical health care providers by allowing each to define for itself the level of educational training necessary for independent practice and then provide these individuals with complete parity under medicare. This was a specific recommendation of the President's Commission on Mental Health and I am very pleased that last Session, at my request, the Senate Finance Committee held hearings on various proposals to increase the mental health coverage under Medicare and Medicaid. This was the first time in seven years that the issue had been directly addressed and, as a direct outgrowth of the testimony, I have now become convinced that it is legislatively possible to amend both Medicare and Medicaid to provide for the direct reimbursement of each of the four core mental health professions, as long as their services are found to meet the test of being safe, effective, and appropriate. Each of the traditional disciplines have expressed enthusiasm for this approach which I am confident should also result in considerably new research funds being made available directly from the Social Security Trust Fund. It is a truly exciting possibility--for the first time being able to say that mental health will no longer be treated as a stepchild to physical medicine.

I am sure that you can see the significance of this approach to our nation's hospice programs. For your information, during one of our nation's drafting sessions, a representative of the administration actually raised the issue of whether providing "supportive services" to the terminally ill should be considered therapeutic.

Was it "effective" he asked? "We know that the patient will never be restored to his or her prior level of function". No one really knows how to respond, for once again, we had crossed that line and were no longer talking about our traditional medical health care system.

I am confident that as the public policy debate continues and, especially, as we begin to accord nursing services complete parity with the more traditional medical services this will become a non-issue. I am convinced that we will, as a matter of public policy, adopt the position that what must come first in health care is not technology, but a concern for the patient and for his or her family in their totality. Once we have accepted this fundamental philosophy, many, many programmatic and reimbursement changes will, of necessity, flow. I very much appreciate being able to play a small part in the evolution of this change.

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HOSPICE

I AM EXTREMELY PLEASED TO BE WITH YOU DURING NATIONAL HOSPITAL WEEK TO SHARE WITH YOU SOME OF MY OBSERVATIONS REGARDING OUR NATION'S HOSPICE PROGRAMS. IN MANY WAYS IT IS MOST FITTING THAT THE ST. FRANCIS HOSPITAL, UNDER THE LEADERSHIP OF SISTER MAUREEN, HAS DEVELOPED AN OPERATIONAL HOSPICE PROGRAM FOR HAWAII.

DURING HER NEARLY 30 YEARS IN HAWAII, SISTER MAUREEN HAS ALWAYS SPOKEN OUT, CANDIDLY AND FORCEFULLY, ON BEHALF OF THE CONSUMER AND, ESPECIALLY ON BEHALF OF THOSE WHO WERE MOST IN NEED OF HIGH QUALITY HEALTH CARE.

UNDOUBTEDLY, IN THE YEARS TO COME WE WILL SEE A NUMBER OF HOSPICE PROGRAMS DEVELOPED ACROSS THE NATION. OUR GRAND-CHILDREN WILL SOMEDAY LOOK BACK AND NAIVELY CONCLUDE THAT "HOSPICES ARE SO APPROPRIATE, SO NECESSARY, THEY MUST ALWAYS HAVE EXISTED". YET, TODAY, WE KNOW THAT IS SIMPLY NOT THE CASE.

HOSPICES ARE OFFICIALLY EXPERIMENTAL. THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE FEELS THAT IT MUST EVALUATE THEM, ANALYZE THEM, DISSECT THEM. SOMEDAY HEW MAY EVEN RECOMMEND PAYING FOR THEM. BUT NOT TODAY. THERE ARE TOO MANY UNANSWERED QUESTIONS, TOO MANY UNKNOWN FACTORS. IN SHORT, IT TAKES SOMEONE WITH THE FORESIGHT AND THE COMPASSION OF SISTER MAUREEN TO CREATE ONE, IN SPITE OF THE BUREAUCRACY'S HESITATIONS.

FOR A NUMBER OF YEARS NOW, I HAVE CONCERNED MYSELF WITH OUR NATION'S HEALTH CARE SYSTEM. AS MANY OF YOU MAY BE AWARE, IT WAS MY LIFELONG AMBITION TO BE A PHYSICIAN. MORE SPECIFICALLY, I WANTED TO BE A SURGEON -- AND A GOOD ONE. I WANTED TO BE ABLE TO HELP THOSE LESS FORTUNATE THAN I, TO HELP THEM BE RESTORED TO THEIR FORMER STATE OF GOOD HEALTH. UNFORTUNATELY, MY WORLD WAR II INJURIES MADE THAT DREAM AN IMPOSSIBLE ONE. HOWEVER, I STILL CONTINUE TO MAINTAIN A STRONG INTEREST IN OUR NATION'S HEALTH CARE SYSTEM.

AS YOU WELL KNOW, BACK IN THE MID-1970'S, OUR NATION FACED A MAJOR HEALTH CARE CRISIS. THIS WAS NOT A CRISIS RESULTING FROM A SHORTAGE OF DOCTORS, OR FROM A LACK OF SOPHISTICATED TECHNOLOGY, BUT RATHER FROM A TRUE CRISIS OF CONFIDENCE. AT THAT TIME IT WAS LABELED A MEDICAL MALPRACTICE CRISIS. TRUE, THERE WERE SOME INCOMPETENT DOCTORS THAT THE MEDICAL PROFESSION REFUSED TO IDENTIFY.

FURTHER, THE OVERALL UNCERTAINTY OF OUR NATION'S ECONOMY RAISED SERIOUS QUESTIONS FOR OUR NATION'S INSURANCE COMPANIES AS TO WHETHER THEY DESIRED TO REMAIN IN THE HEALTH CARE AREA. WE SAW SCENES OF HIGHLY TRAINED PHYSICIANS GOING OUT ON STRIKE AND THEN ACTIVELY LOBBYING THEIR STATE AND NATIONAL LEGISLATORS FOR RELIEF. PRACTITIONERS AND HOSPITALS WERE FACED WITH EXTRAORDINARY MEDICAL MALPRACTICE PREMIUMS -- EVEN THOSE WHO NEVER HAD A SINGLE SUIT FILED AGAINST THEM. AT THAT TIME, I INTRODUCED LEGISLATION AT THE FEDERAL LEVEL THAT WOULD HAVE TREATED MEDICAL MALPRACTICE INCIDENTS IN THE SAME MANNER THAT WE PRESENTLY TREAT WORKERS' COMPENSATION CASES.

MY PROPOSAL WAS ESSENTIALLY A "NO-FAULT" APPROACH. WE WOULD ADEQUATELY COMPENSATE THOSE WHO WERE INJURED AND RELY ON ACTIVE PEER REVIEW MECHANISMS TO WEED OUT THE IMCOMPETENT PRACTITIONERS, OR PERHAPS, IF APPROPRIATE, LIMIT THE SCOPE OF THEIR LICENSURE. MY PROPOSAL WAS WITHOUT QUESTION A RADICAL ONE, BUT, IN ALL CANDOR, ONE THAT I FEEL IS STILL NECESSARY. ITS TIME HAS, HOWEVER, NOT YET COME.

INSTEAD, WE WITNESSED A NUMBER OF STATE LEGISLATURES MAKING A VERY CREDIBLE EFFORT TO ENSURE THAT MALPRACTICE INSURANCE WOULD REMAIN AVAILABLE. AND THEY HAVE SUCCEEDED, BUT AT A COST. AND, AS USUAL, THE ADDITIONAL COSTS INVOLVED HAVE BEEN PASSED ON TO THE CONSUMER. I WOULD WAGER THAT TODAY MOST OF US ARE NO LONGER AWARE OF THIS INCREMENT.

UNFORTUNATELY, EXPERTS HAVE CONVINCED ME THAT OUR RESPONSE TO THE MID-1970S CRISIS WAS ONLY A BAND-AID APPROACH; THAT THE FUNDAMENTAL CAUSES OF THE MEDICAL MALPRACTICE CRISIS HAVE NOT YET BEEN SERIOUSLY ADDRESSED. AS A RESULT, WE MUST FULLY EXPECT THAT CRISIS TO REAPPEAR IN THE NEAR FUTURE, AND THAT IT WILL BE EVEN WORSE THAN BEFORE.

IN MY JUDGMENT, OUR MEDICAL MALPRACTICE CRISIS DEMONSTRATED THE LACK OF CONFIDENCE IN OUR NATION'S HEALTH CARE INDUSTRY. HEALTH CARE IS A MAJOR INDUSTRY. IN FACT, IT IS THE THIRD LARGEST INDUSTRY IN THE UNITED STATES. HEALTH IS A VERY EXPENSIVE INDUSTRY. THE UNITED STATES TODAY SPENDS MORE ON HEALTH CARE THAN ANY OTHER NATION IN THE WORLD. HEALTH PRESENTLY ACCOUNTS FOR 9.1 PERCENT OF OUR GROSS NATIONAL PRODUCT, THE HIGHEST LEVEL IN OUR NATION'S HISTORY.

THE FEDERAL GOVERNMENT CURRENTLY PAYS ALMOST 40 PERCENT OF ALL HEALTH CARE EXPENDITURES. IN FACT, THE FEDERAL GOVERNMENT'S EXPENDITURES FOR HEALTH COMPRISES AN ASTRONOMICAL 12.7 PERCENT OF THE ENTIRE FEDERAL BUDGET, AND IT IS ESTIMATED THAT THIS COULD RISE TO 14.5% BY 1984. PRESENTLY, ONLY NATIONAL DEFENSE, INTEREST ON THE NATIONAL DEBT, AND INCOME SECURITY PROGRAMS COMMAND A LARGER SHARE.

YET, FOR ALL THE MONEY WE SPEND AND FOR ALL THE COMPLEX TECHNOLOGY WE HAVE DEVELOPED, I AM AFRAID THAT WE HAVE ALL-TOO-OFTEN FORGOTTEN ONE CRUCIAL ELEMENT IN THE QUESTION, THE PATIENT. AS I DID MY RESEARCH ON THE MEDICAL MALPRACTICE CRISIS, AND EVEN TODAY AS I CONTINUE TO STUDY OUR NATION'S HEALTH CARE SYSTEM, I REPEATEDLY SEE DECISIONS BEING MADE WITHOUT REAL ATTENTION BEING PAID AS TO HOW THE PATIENT WILL BE AFFECTED.

ON THE ONE HAND WE AS A NATION HAVE ACCEPTED THE MARCUS WELBY MYTH THAT THE DOCTOR IS INFALLIBLE, THAT HE OR SHE CAN DO NO WRONG. AT THE SAME TIME, WE HAVE A PROBLEM CAUSED BY THE HIGH LEVEL OF TECHNOLOGY IN OUR NATION'S HEALTH CARE SYSTEM. IT SOMETIMES SEEMS THAT OUR HEALTH CARE PRACTITIONERS ARE TOO BUSY TO TAKE THE TIME TO EXPLAIN THE ADMITTEDLY COMPLEX PROCEDURES INVOLVED.

I GET DOZENS OF LETTERS EACH YEAR FROM CONSTITUENTS WHO WANT TO KNOW WHY THEIR HOSPITAL BILL HAS A CHARGE FOR DR. X's SERVICES. THEY CLAIM THAT THEY DID NOT KNOW ANYTHING ABOUT THESE SERVICES OR EVEN KNOW WHO DR. X WAS. SO WHEN SOMETHING GOES WRONG, THE PATIENT FEELS CHEATED AND BETRAYED. HE HAS BEEN LED TO BELIEVE THAT MODERN MEDICINE IS INFALLIBLE, BUT HE FREQUENTLY MUST FACE THE REALITY THAT IT IS NOT. AND NO ONE SEEMS TO CARE ABOUT HIM AND HIS PROBLEMS, SO HE SUES. MAYBE THAT WAY SOMEONE WILL FINALLY LISTEN.

I AM VERY PLEASED TO BE HERE WITH YOU TODAY, AT THE CONFERENCE ON HOSPICES. THOSE OF US INTERESTED IN HOSPICE WORK HAVE AGREED, WHETHER WE REALIZE IT OR NOT, TO OPENLY FACE THE REALITIES OF OUR VERY IMPERFECT HEALTH CARE SYSTEM AND OUR OWN INDIVIDUAL MORTALITY.

WHEN I LEARNED THAT A LARGE PORTION OF THE AUDIENCE WOULD BE MADE UP OF NURSES AND PSYCHOLOGISTS, I WAS ESPECIALLY PLEASED TO ACCEPT THIS INVITATION. IT IS MY JUDGMENT THAT YOUR DISCIPLINES, IN PARTICULAR, HAVE TRULY UNIQUE EXPERTISE IN THIS AREA.

WE KNOW THAT FROM 60 TO 80 PERCENT OF THE VISITS BEING MADE TO MEDICAL PRACTITIONERS ARE, IN FACT, BEING MADE BY PATIENTS WHO DEMONSTRATE EMOTIONAL, RATHER THAN ORGANIC ETHIOLOGY FOR THEIR PHYSICAL SYMPTOMS. SINCE THE VERY ESSENCE OF A HOSPICE PROGRAM PRESUPPOSES A TERMINAL DISEASE, THE ADMINISTRATION OF PALLIATIVE CARE (MEDICAL RELIEF OF PAIN) AND SUPPORTIVE SERVICES TO THE PATIENT AND HIS OR HER FAMILY, OUR TRADITIONAL RESTORATION AND "CURE" ORIENTATION IS SIMPLY NOT APPROPRIATE.

INSTEAD, WE START WITH THE GIVEN FACT THAT THE IDENTIFIED PATIENT IS DYING AND THAT HE OR SHE AND THE FAMILY NETWORK MUST BE ASSISTED IN LEARNING HOW TO MOST SATISFACTORILY FACE DEATH.

THERE ARE NO EASY ANSWERS AND THOSE OF YOU WHO CHOSE TO WORK WITH THE TERMINALLY ILL ARE TO BE HIGHLY COMMENDED.

IN PREPARING MY REMARKS, I ASKED THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE WHAT THEIR PLANS WERE AND WHAT THEY FELT SHOULD BE DONE. AS YOU MIGHT IMAGINE, THEY ALSO DO NOT HAVE ANY READY ANSWERS. THE ISSUES SURROUNDING DEATH HAVE BEEN WITH US SINCE MAN FIRST SET FOOT ON THIS PLANET. EACH OF US IS AN INDIVIDUAL, AND NONE OF US REALLY KNOWS HOW WE WILL FACE OUR OWN DEATH.

HISTORIANS TELL US THAT THE FUNDAMENTAL CONCEPT OF THE HOSPICE HAD ITS ORIGIN IN HOMES ESTABLISHED BY RELIGIOUS ORDERS DURING THE MIDDLE AGES IN EUROPE -- HOMES WHERE PILGRIMS RECEIVED CARE AND PERSONAL ATTENTION AS THEY TRAVELED TO THE HOLY LAND. INSTITUTIONS OF EARLY MEDICINE EVOLVED FROM THESE HOMES AND INCORPORATED THE HOSPICE CONCEPT OF PROVIDING PERSONAL ATTENTION AND CARE FOR THE SICK AND DYING POOR.

A GROUP OF CATHOLIC WIDOWS ESTABLISHED A HOSPICE IN LYON, FRANCE IN 1841 FOR POOR WOMEN WITH INCURABLE CANCER. IN THE MID-1800s, THE FOUNDER OF THE IRISH SISTERS OF CHARITY ESTABLISHED A HOSPICE FOR THE DYING IN DUBLIN, IRELAND. ABOUT 50 YEARS LATER, SEVERAL HOSPICES WERE ALSO REPORTED IN LONDON, ENGLAND. IN 1971, THE FIRST FORMALLY ORGANIZED HOSPICE WAS FOUNDED IN THE UNITED STATES. TODAY, LESS THAN A DECADE LATER, THERE ARE SOME 50 ORGANIZATIONS IN OUR NATION THAT CONSIDER THEMSELVES HOSPICES.

WHILE THERE ARE NO STANDARD DEFINITIONS, STAFFING PATTERNS, OR PARTICULAR PROGRAMS, TRULY INTERDISCIPLINARY TEAMS DO WORK TOGETHER TO RESPOND TO THE PHYSICAL, PSYCHOLOGICAL, AND SPIRITUAL NEEDS OF THE PATIENT AND FAMILY. THIS CONCERN CONTINUES FROM THE FIRST RECOGNITION OF THE TERMINAL NATURE OF THE ILLNESS, ON THROUGH TO THE GRAVE. BOTH THE PATIENT AND HIS OR HER LOVED ONES ARE HELPED TO FACE THEIR LOSS.

NATIONAL STUDIES HAVE SHOWN THAT MOST PEOPLE IF GIVEN THE CHOICE WOULD LIKE TO DIE AT HOME, WITH DIGNITY AND A SENSE OF PRIDE. YET, TODAY ONLY 10 PERCENT HAVE THAT OPPORTUNITY. WHEN A HOSPICE EXISTS, THE FIGURE RISES TO THE 70 PERCENT RANGE.

THE OLD DEPARTMENT OF HEALTH, EDUCATION AND WELFARE RECENTLY AUTHORIZED SPECIAL DEMONSTRATION PROJECTS TO EXPLORE VARIOUS WAYS TO DELIVER THESE NECESSARY SERVICES. BUT EVEN WITH THIS SUPPORT, THE REAL ISSUE SEEMS TO BE; HOW DO WE MAKE THE FINAL DAYS AND HOURS AS HUMANE AND DIGNIFIED AS POSSIBLE, AS THERE ARE NO SET RULES TO GO BY? THE REAL KEY IS THE PEOPLE INVOLVED...PEOPLE LIKE SISTER MAUREEN AND SISTER FRANCINE.

FOR THE PAST SEVEN YEARS, I HAVE BEEN WORKING VERY CLOSELY WITH MY COLLEAGUES IN THE SENATE TO AMEND OUR PRESENT FEDERAL HEALTH LEGISLATION TO ENSURE THAT MENTAL HEALTH BENEFITS, AND ESPECIALLY THOSE PROVIDED BY OUR NATION'S PSYCHIATRIC NURSES, CLINICAL PSYCHOLOGISTS, AND CLINICAL SOCIAL WORKERS WOULD BE REIMBURSABLE. IT HAS BEEN A LONG AND DIFFICULT HAUL. THIS IS DUE PARTLY TO THE POLITICAL INEXPERIENCE OF THE NON-PHYSICIAN PROFESSIONAL DISCIPLINE.

IT IS ALSO DUE PARTLY TO THE UGLY STIGMA THAT STILL SURROUNDS THE "MENTALLY-ILL". TO A VERY REAL EXTENT, IT IS ALSO BECAUSE OUR FEDERAL PROGRAMS ARE ESSENTIALLY HEALTH PROGRAMS AND THE EMOTIONAL ISSUES SURROUNDING MENTAL HEALTH ARE GENERALLY NOT UNDERSTOOD, NOR REALLY CONSIDERED HEALTH ISSUES. ACCORDINGLY, I FULLY EXPECT THAT THE ISSUES SURROUNDING REIMBURSEMENT FOR HOSPICE SERVICES WILL UNDERGO SIMILAR SCRUTINY.

NO ONE WOULD ARGUE WITH ME THAT MENTAL HEALTH SERVICES ARE IMPORTANT, YET MOST OF MY COLLEAGUES DO NOT UNDERSTAND THEM ENOUGH TO FEEL COMFORTABLE ABOUT REIMBURSING THEM UNDER A FEDERAL HEALTH PROGRAM -- WHETHER THIS BE THE CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS), THE FEDERAL EMPLOYEE HEALTH BENEFITS ACT, OR THE SOCIAL SECURITY ACT. THE SAME I AM AFRAID WILL OCCUR WITH HOSPICE TREATMENT.

YET, WE HAVE MADE SUBSTANTIAL PROGRESS. FIVE YEARS AGO, WE WERE ABLE TO HAVE CLINICAL PSYCHOLOGISTS DIRECTLY REIMBURSED AS INDEPENDENT PRACTITIONERS UNDER THE CHAMPUS PROGRAM. JUST LAST WEEK, AFTER THREE YEARS OF NEGOTIATIONS AND DEBATE, CHAMPUS, AT MY PERSONAL REQUEST, ANNOUNCED A NATIONWIDE 5-MONTH EXPERIMENTAL PROJECT IN WHICH THEY WILL DIRECTLY REIMBURSE THE SERVICES OF ALL CERTIFIED NURSE PRACTITIONERS.

THIS EXPRESSLY INCLUDED PSYCHIATRIC NURSES. THEY WILL EVALUATE BOTH THE COST-EFFECTIVENESS AND QUALITY OF CARE ISSUES SURROUNDING NURSING PRACTICE. THIS PROJECT WAS SPECIFICALLY RECOMMENDED BY THE PRESIDENT'S COMMISSION ON MENTAL HEALTH, BUT IT NONETHELESS TOOK THREE LONG YEARS OF HARD WORK TO CONVINCE MY COLLEAGUES THAT IT WOULD NOT BANKRUPT OUR DEFENSE BUDGET. I AM CONFIDENT THAT WHEN THE DATA IS FINALLY IN, WE WILL HAVE WON OUR CASE.

AT THE NATIONAL PLANNING LEVEL

CHAMPUS IS, TO SOME PERHAPS, A SMALL PROGRAM HAVING AN ANNUAL HEALTH BUDGET OF $500 MILLION AND SERVING 8.6 MILLION DEPENDENTS OF ACTIVE DUTY MILITARY PERSONNEL AND VARIOUS RETIREES. BUT THE PRECEDENTS ARE NOW THERE. NURSING SERVICES OF AN INDEPENDENT NATURE -- SUCH AS THOSE UTILIZED IN THE HOSPICE PROGRAM -- WILL FINALLY BE DIRECTLY REIMBURSED. WE ARE NOT TALKING EXCLUSIVELY ABOUT MEDICAL SERVICES, BUT INSTEAD ABOUT NURSING AND PSYCHOLOGICAL SERVICES. THIS IS, IN MY JUDGMENT, A VERY SIGNIFICANT PUBLIC POLICY DIFFERENCE.

ON ANOTHER FRONT, I HAVE BEEN WORKING CLOSELY WITH MY COLLEAGUES IN THE SENATE FINANCE COMMITTEE TO SEE IF WE CAN COME UP WITH A VERY DIFFERENT APPROACH TO OUR CURRENT WELFARE PROGRAM, ONE THAT WOULD PROVIDE MEANINGFUL EMPLOYMENT FOR THOSE AFDC MOTHERS ON WELFARE AND ALSO PROVIDE A MORE MEANINGFUL EXISTENCE FOR THOSE PRESENTLY LIVING IN NURSING HOMES AND VARIOUS SKILLED NURSING FACILITIES.

THE SPECIFIC PROPOSAL WE HAVE BEEN DISCUSSING WOULD AUTHORIZE THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE TO ESTABLISH A NUMBER OF PILOT PROJECTS IN WHICH THE FEDERAL GOVERNMENT WILL PAY 90 PERCENT OF ALL COSTS OF TRAINING AND EMPLOYING THESE WELFARE RECIPIENTS IN PUBLIC HEALTH JOBS, PERHAPS AS HOME HEALTH AIDS FOR A HOSPICE PROGRAM.

OUR PRESENT INTENT IS TO PROVIDE UP TO 5 YEARS OF SUPPORT FOR EACH RECIPIENT. MY PROPOSAL HAS BEEN APPROVED TWICE BY THE COMMITTEE AND SENATOR LONG HAS INDICATED THAT HE IS CAUTIOUSLY OPTIMISTIC THAT IT WILL PASS THE SENATE THIS YEAR. IN FACT, SINCE THE CONGRESSIONAL BUDGET OFFICE HAS CONCEDED THAT IT WILL SAVE SUBSTANTIAL MONEY EVERY YEAR AFTER THE FIRST, IT MAY VERY WELL BECOME PUBLIC LAW THIS SESSION.

KEEP IN MIND, WE ARE TALKING ABOUT 90 PERCENT OF ALL COSTS -- EDUCATIONAL, TRAINING AND EVEN SALARIES -- BEING PICKED UP BY THE FEDERAL GOVERNMENT WHILE STILL SAVING THE FEDERAL TAXPAYERS' MONEY. AND WHAT WILL THESE AFDC MOTHERS DO? THEY WILL PROVIDE MANY OF THE TYPES OF SERVICES THAT ARE INHERENT TO THE HOSPICE MOVEMENT. YES, I HONESTLY THINK THAT WE ARE FINALLY MAKING PROGRESS IN HUMANIZING OUR HEALTH CARE SYSTEM.

FINALLY, THERE IS NO DOUBT IN MY MIND THAT SOME FORM OF NATIONAL HEALTH INSURANCE WILL BE ENACTED INTO PUBLIC LAW IN THE NEAR FUTURE. THIS ISSUE MUST NOW, OF NECESSITY, BE CONSIDERED ON THE "BACK BURNER", WHILE THE ADMINISTRATION AND THE CONGRESS FOCUS INSTEAD UPON THE IMMEDIATE CRISIS OF IRAN, OUR NATION'S ECONOMY, AND OUR EVER-DWINDLING ENERGY SUPPLY. YET, THE HARD STATISTICS UNDERSCORING THE NEED FOR A COMPREHENSIVE NATIONAL HEALTH INSURANCE PROGRAM ARE STILL THERE.

SINCE THE ADMINISTRATION OF PRESIDENT HARRY TRUMAN, OUR NATION'S ELECTED OFFICIALS HAVE BEEN SERIOUSLY EXPLORING THE POSSIBILITY OF ENACTING SOME FORM OF NATIONAL HEALTH INSURANCE. TO DATE, SIXTY NATIONS AROUND THE GLOBE HAVE SUCCEEDED IN DEVELOPING THEIR OWN UNIQUE APPROACH, AND OF THE INDUSTRIALIZED COUNTRIES, ONLY THE UNITED STATES AND SOUTH AFRICA HAVE NOT YET DONE SO.

IN THE UNITED STATES, SOME 18 MILLION AMERICANS, MOST OF THEM POOR OR NEARLY POOR, HAVE NO HEALTH INSURANCE AT ALL; 19 MILLION HAVE HEALTH INSURANCE WHICH DOES NOT PROTECT THEM AGAINST ORDINARY COSTS OF HOSPITALIZATION AND PHYSICIAN COSTS, AND AN ADDITIONAL 46 MILLION HAVE INADEQUATE INSURANCE AGAINST LARGE MEDICAL BILLS. IN ESSENCE, TODAY SOME 80 MILLION AMERICANS REMAIN UNPROTECTED AGAINST DEVASTATING MEDICAL COSTS. FURTHER, SOME 52 MILLION AMERICANS LIVE IN AREAS WITHOUT SUFFICIENT ACCESS TO HEALTH CARE, EVEN IF THEY COULD PAY FOR IT.

THERE CAN BE LITTLE QUESTION THAT DURING THE INITIAL YEARS OF THIS DEBATE, THE CONCERTED OPPOSITION OF ORGANIZED MEDICINE TO THE PERCEIVED ADVANCE OF "SOCIALIZED MEDICINE" WAS ONE OF THE MAJOR STUMBLING BLOCKS TO THE ENACTMENT OF ANY COMPREHENSIVE NATIONAL HEALTH INSURANCE PROGRAM OR EVEN OF A NATIONAL HEALTH POLICY. HOWEVER, AS THE PUBLIC POLICY DEBATE CONTINUES, AND AS MORE AND MORE CONCERNED INDIVIDUALS AND REPRESENTATIVE INTEREST GROUPS BECOME INVOLVED, NO ONE ORGANIZATION OR IDEOLOGICAL ORIENTATION WILL EVER AGAIN HAVE THAT MUCH INFLUENCE.

FOR EXAMPLE, THE READILY IDENTIFIABLE PARTICIPANTS, WITH THEIR VERY DIVERSE ORIENTATIONS, INCLUDE THE VARIOUS PROVIDER GROUPS, ALL OF THE MAJOR LABOR UNIONS, THE HOSPITAL ASSOCIATIONS, THE INSURANCE COMPANIES, SMALL AND LARGE BUSINESSES (WHO BY THE WAY PRESENTLY PAY UP TO 25 PERCENT OF ALL HEALTH CARE COSTS), SENIOR CITIZEN ORGANIZATIONS, ETC.

CLEARLY, A CONSENSUS REGARDING THE FORM THAT NATIONAL HEALTH INSURANCE SHOULD TAKE HAS NOT YET EVOLVED. HOWEVER, FOR THE FIRST TIME THE FOCUS OF THE DEBATE HAS SHIFTED FROM PURELY IDEOLOGICAL AND PROFESSIONAL GUILD ISSUES, SUCH AS THE "HORRORS OF GOVERNMENTAL MEDICINE", TO THE MORE OBJECTIVE ISSUES SURROUNDING THE COST OF HEALTH CARE. THE COST OF HEALTH CARE IS A HIGHLY EMOTIONAL AND VOLATILE ISSUE THAT DIRECTLY AFFECTS ALL AMERICANS. MORE IMPORTANTLY, IT IS A TOPIC THAT NO ONE PROFESSIONAL DISCIPLINE CAN CLAIM IS EXCLUSIVELY THEIR PROVINCE.

IN MY JUDGMENT, THE ULTIMATE FORM OF NATIONAL HEALTH INSURANCE THAT WE ADOPT WILL BE INTIMATELY LINKED TO OUR PRESENT MEDICARE PROGRAM. MEDICARE IS A VERY INTERESTING PROGRAM. ITS BENEFICIARIES INCLUDE ALMOST EVERY AMERICAN CITIZEN OVER THE AGE OF 65 AND A NUMBER OF OUR NATION'S DISABLED. MEDICARE AND ITS SISTER PROGRAM, MEDICAID, WERE ENACTED INTO PUBLIC LAW IN 1965 AND OUR NATION'S HEALTH CARE POLICY MAKERS NOW POSSESS 15 YEARS OF EXPERIENCE IN IMPLEMENTING THE PROGRAMS.

PRESENTLY NEARLY 40 MILLION AMERICANS ARE COVERED UNDER AT LEAST ONE OF THE TWO PROGRAMS. MEDICARE IS A NATIONWIDE HEALTH INSURANCE PROGRAM OF AN ENTITLEMENT NATURE WHICH HAS UNIFORM BENEFITS ACROSS THE NATION. IT IS 100 PERCENT FEDERALLY-FUNDED. IT IS, IN ESSENCE, A MINI-NATIONAL HEALTH INSURANCE PROGRAM, AND PROBABLY THE FORERUNNER OF THE NATIONAL HEALTH INSURANCE THAT WE KNOW WILL EVENTUALLY COME TO PASS.

UNDER MEDICARE, THE MENTAL HEALTH BENEFIT PACKAGE IS CONSIDERABLY LESS COMPREHENSIVE THAN THE BENEFITS FOR THE MORE TRADITIONAL PHYSICAL/ORGANIC ILLNESSES. FOR EXAMPLE, INPATIENT CARE IN PSYCHIATRIC HOSPITALS IS LIMITED TO 190 DAYS OVER A PERSON'S LIFE SPAN. IN SHARP CONTRAST, LIMITATIONS FOR INPATIENT SERVICES IN GENERAL HOSPITALS FOR NON-PSYCHIATRIC CARE ARE FRAMED IN TERMS OF EACH EPISODE OF ILLNESS WITHOUT AN OVERALL LIMITATION.

FURTHER, OUTPATIENT CARE FOR AN ORGANIC ILLNESS, REQUIRES THAT THE INDIVIDUAL PAY 20 PERCENT OF THE COST IN THE FORM OF A CO-PAYMENT. IF THE DIAGNOSIS IS MENTAL ILLNESS, HE MUST INSTEAD PAY A 50 PERCENT CO-PAYMENT WITH A $250 OVERALL ANNUAL LIMIT ON REIMBURSEMENT. NO SUCH COMPARABLE OVERALL LIMIT ON OUTPATIENT PHYSICAL HEALTH CARE SERVICES EXISTS, INSTEAD, THE "USUAL AND CUSTOMARY" FEE SCHEDULE IS UTILIZED.

OF EVEN GREATER IMPORTANCE FOR THE PROPONENTS OF HIGH QUALITY MENTAL HEALTH COVERAGE, IS THE BASIC POLICY DETERMINATION CONTAINED IN MEDICARE TO NOT DIRECTLY REIMBURSE NON-MEDICAL PRACTITIONERS AS INDEPENDENT PROVIDERS. THIS POSITION WAS EXPRESSLY ENDORSED BY THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE IN 1968 AND HAS NOT BEEN MODIFIED SINCE.

IN ESSENCE, THIS POLICY ESTABLISHES THAT THE PHYSICIAN SHALL BE THE POINT OF ENTRY FOR ALL HEALTH CARE DETERMINATIONS AND THAT OTHER HEALTH PROFESSIONALS SHALL NOT BE RECOGNIZED AS INDEPENDENT PROVIDERS. UNDERLYING THIS NOTION IS THE SINCERE FEELING THAT PHYSICAL AND MENTAL ILLNESSES MAY OVERLAP, PARTICULARLY IN THE ELDERLY WHO ARE THE PRIME BENEFICIARIES OF MEDICARE, AND THAT THE NON-MEDICAL PRACTITIONER SIMPLY IS NOT TRAINED TO DIAGNOSE ORGANICALLY CAUSED ILLNESSES. AS YOU CAN GATHER, THE ISSUE OF WHETHER A PHYSICIAN IS TRAINED TO PICK UP THE EMOTIONAL COMPONENT IS NOWHERE ADDRESSED.

MY BILLS WOULD DIRECTLY ALTER THE PARA-PROFESSIONAL STATUS OF OUR NATION'S NON-MEDICAL HEALTH CARE PROVIDERS BY ALLOWING EACH TO DEFINE FOR ITSELF THE LEVEL OF EDUCATIONAL TRAINING NECESSARY FOR INDEPENDENT PRACTICE AND THEN PROVIDE THESE INDIVIDUALS WITH COMPLETE PARITY UNDER MEDICARE.

THIS WAS A SPECIFIC RECOMMENDATION OF THE PRESIDENT'S COMMISSION ON MENTAL HEALTH AND I AM VERY PLEASED THAT LAST SESSION, AT MY REQUEST, THE SENATE FINANCE COMMITTEE HELD HEARINGS ON VARIOUS PROPOSALS TO INCREASE THE MENTAL HEALTH COVERAGE UNDER MEDICARE AND MEDICAID. THIS WAS THE FIRST TIME IN 7 YEARS THAT THE ISSUE HAD BEEN DIRECTLY ADDRESSED AND, AS A DIRECT OUTGROWTH OF THE TESTIMONY, I HAVE NOW BECOME CONVINCED THAT IT IS LEGISLATIVELY POSSIBLE TO AMEND BOTH MEDICARE AND MEDICAID TO PROVIDE

TO PROVIDE FOR THE DIRECT REIMBURSEMENT OF EACH OF THE FOUR CORE MENTAL HEALTH PROFESSIONS, AS LONG AS THEIR SERVICES ARE FOUND TO MEET THE TEST OF BEING SAFE, EFFECTIVE, AND APPROPRIATE. EACH OF THE TRADITIONAL DISCIPLINES HAVE EXPRESSED ENTHUSIASM FOR THIS APPROACH WHICH I AM CONFIDENT SHOULD ALSO RESULT IN CONSIDERABLY NEW RESEARCH FUNDS BEING MADE AVAILABLE DIRECTLY FROM THE SOCIAL SECURITY TRUST FUND.

IT IS A TRULY EXCITING POSSIBILITY -- FOR THE FIRST TIME BEING ABLE TO SAY THAT MENTAL HEALTH WILL NO LONGER BE TREATED AS A STEPCHILD TO PHYSICAL MEDICINE.

I AM SURE THAT YOU CAN SEE THE SIGNIFICANCE OF THIS APPROACH TO OUR NATION'S HOSPICE PROGRAMS. FOR YOUR INFORMATION, DURING ONE OF OUR NATION'S DRAFTING SESSIONS, A REPRESENTATIVE OF THE ADMINISTRATION ACTUALLY RAISED THE ISSUE OF WHETHER PROVIDING "SUPPORTIVE SERVICES" TO THE TERMINALLY ILL SHOULD BE CONSIDERED THERAPEUTIC.

PEW

WAS IT "EFFECTIVE" HE ASKED? "WE KNOW THAT THE PATIENT WILL NEVER BE RESTORED TO HIS OR HER PRIOR LEVEL OF FUNCTION." NO ONE REALLY KNOWS HOW TO RESPOND, FOR ONCE AGAIN, WE HAD CROSSED THAT LINE AND WERE NO LONGER TALKING ABOUT OUR TRADITIONAL MEDICAL HEALTH CARE SYSTEM.

I AM CONFIDENT THAT AS THE PUBLIC POLICY DEBATE CONTINUES AND, ESPECIALLY, AS WE BEGIN TO ACCORD NURSING SERVICES COMPLETE PARITY WITH THE MORE TRADITIONAL MEDICAL SERVICES THIS WILL BECOME A NON-ISSUE. I AM CONVINCED THAT WE WILL, AS A MATTER OF PUBLIC POLICY, ADOPT THE POSITION THAT WHAT MUST COME FIRST IN HEALTH CARE IS NOT TECHNOLOGY, BUT A CONCERN FOR THE PATIENT AND FOR HIS OR HER FAMILY IN THEIR TOTALITY. ONCE WE HAVE ACCEPTED THIS FUNDAMENTAL PHILOSOPHY, MANY, MANY PROGRAMMATIC AND REIMBURSEMENT CHANGES WILL, OF NECESSITY, FLOW. I VERY MUCH APPRECIATE BEING ABLE TO PLAY A SMALL PART IN THE EVOLUTION OF THIS CHANGE.