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THE FEDERAL ROLE IN HEALTH CARE

I appreciate having the opportunity to come here to speak to you tonight with regard to the federal role in health care. The question of what the federal government should do, and how it should be done is one of the most controversial and most important public policy issues before the Congress today. Of course, this is not something new; the first national health insurance bill was

introduced in the Congress more than 40 years ago, and there has been a substantial federal involvement in health care since the enactment of the Medicare and Medicaid laws in the mid-1960s.

I. THE GOALS OF FEDERAL POLICY

We can begin with the presumption that there is a federal role in health care, and it will not go away. Total public expenditures in 1978 for health care were about $60 billion, over 40 percent of the total health care spending. Seventy-five percent of the $60 billion came from the federal government, mostly through the Medicare

and Medicaid programs.

At this date, to talk about whether there should be a federal role in health care or to discuss whether the federal government should be concerned with the cost of providing health care, are academic exercises which simply do not take into account the real world.

At this point, the question is not whether there should be federally paid for health insurance; the questions are who should receive federally-subsidized insurance, how much of a subsidy should be provided, and how should

it be provided. Similarly, the question is not whether the federal government should be concerned with the cost of health care -- the taxpayers, who are also consumers, as well as general principles of fiscal responsibility demand that we be concerned. The issues are whether certain types of actions are appropriate and in keeping with our form of government, and whether they would be effective.

The debate over federal health care policy is one that often becomes quite emotional, which is understandable when one considers the immense impact these policies

will have on millions of people. But the highly charged rhetoric that comes from all sides can only serve to remove attention from the many highly complex, pragmatic issues that must be considered if we are to pursue an enlightened federal policy.

I believe that the goal of federal policy should be to insure that all Americans can obtain decent health care at a cost the consumers and taxpayers of America can afford. It seems to me that if federal policy reaches this goal, then we have national health insurance. But I am somewhat reluctant to use this term because over

the forty and more years of debate, the term has become loaded down with different and often incompatible definitions and because of the emotions the phrase brings out in so many people.

II. FREE ENTERPRISE IN HEALTH CARE

I also believe that any federal policy relating to health care, to be successful, will have to be based on the free enterprise principles. If the federal government runs the system, it is likely to be over-regulated and has too much bureaucracy, with the end result that costs are excessive. There will be insufficient flexibility, and

innovation will be stifled. On the other hand, some governmental role will be necessary to enforce minimal health and safety standards, to help insure that those who cannot afford health care can get it, and to help channel health care resources into those areas, such as isolated rural areas and poor central cities, where it is difficult to get the providers of care to locate. By and large, this is what the federal government is trying to accomplish now, though I do not always agree with the way in which they go about it.

But, it is not enough to have a system based on the private sector, it must be based on free enterprise principles. There must be financial incentives to all parties, to the consumers, the insurance companies, and all of you to hold down costs.

The Congress must bear part of the responsibility for the lack of competition which presently exists. For example, as I am sure most of you know, Medicare will only reimburse a senior citizen for staying in a nursing home after he or she has first been in a hospital for 72 hours. The original purpose of this provision was to

insure that only senior citizens who require nursing home care went to a home. The effect has been to force doctors to place the elderly in a hospital, which is much more expensive than a nursing home, for 72 hours, even though hospitalization may not be required medically. Another example relates to preventive care. Medicare and Medicaid pay for all acute care, but virtually no preventive care, yet it is this preventive care that is certainly most cost effective in the long run. These are simple design changes that can be made in existing programs which will help control cost without in any way affecting the quality of care.

But the role that doctors (speaking generally) have played in our health care system is not beyond questioning either. I want to make it very clear that I am not talking about the quality of care you provide. There is no doubt in my mind that Americans receive the highest quality of care in the world, and for this you deserve a lot of credit.

But, from an anti-trust standpoint, some of the aspects of our health care system that have been put in place by the medical profession, disturb me. The justifi-

cation for their existence is that they are necessary to maintain minimum standards of care. Their impact, primarily, has been to restrict entry into the market and prevent competition between doctors, thereby driving up the cost of health care.

For example, in Michigan, Blue Cross-Blue Shield decided to require second opinions on major surgery. The Michigan Medical Association responded by agreeing, among themselves, not to deal with Blue Cross. Michigan doctors are presently in court defending themselves

against an anti-trust suit, as they should be. I realize that the question of whether second opinions are cost effective is controversial. But, the reaction of doctors in Michigan, acting as if the proposal was an attack on the medical profession itself, was uncalled for and, I believe, elf-destructive for it can only serve to irritate most people up in Michigan. And, if doctors in Michigan are not performing too many surgeries, the program will not prove to be cost effective and will wither away within a few years.

The controversy surrounding Peer Standard Review

Organizations (P.S.R.O.) is instructive in this regard. Doctors throughout the country fought the establishment of P.S.R.O.s as being, among other things, unnecessary. The Congress went ahead and established them anyway. Recently, the Congressional Budget Office released a preliminary report saying that the administrative cost of having P.S.R.O.s may be greater than the amount of unnecessary medical treatment that is uncovered. If the preliminary findings hold up, P.S.R.O.s are likely to be abolished. Doctors will have been vindicated and one public suspicion will have been laid to rest. Another

thing is important here: when Blue Cross-Blue Shield does something of this nature, it can reverse itself easily. When Congress acts, bureaucratic inertia can hold up a decision to reverse itself for some time.

The way many doctors have fought alternative payment mechanisms, such as health maintenance organizations, is something which can be questioned. It is true that many of the H.M.Os the federal government has tried to establish, have not proven financially viable. On the other hand, the H.M.O.s that have been established with private capital, such as Kaiser-Permanente in California

and Hawaii, have shown to be quite successful.

Many doctors have fought the establishment of this type of pre-payment scheme tooth and nail on the grounds that they do not work. While the federal attempt to establish a financially profitable operation has not had good results, attempts to stop privately established operations can only be called restraint of trade.

Another example, much closer to home, is the fight I had trying to establish the medical school at East Carolina University something I am sure many of you

remember. When I first raised the idea, in 1958, I was told there were already too many doctors in North Carolina. That is not even true today, and to take that kind of position only creates bad feelings and hurts the profession's credibility.

Sometimes, the debate over health care policy seems completely foreign to me. On the one hand, there are people arguing that we need to have a federally controlled and paid for health insurance system which will provide free medical care to all Americans. I am not comfortable with this, since I do not believe that the federal govern-

ment can run a health care system with the necessary adaptability, and it certainly cannot do so at an acceptable cost.

On the other hand, the position of the medical profession appears to be that the health care system should be completely controlled by it, with the inevitable result that it will be run for the profession's benefit.

Those who believe in a federally controlled health care system argue that competition does not work. What I find ironic about this charge is that the profession

sort of seems to agree with this view since, as a group, they have prevented true competition from ever taking place. If the policy issue before the Congress continues to be whether the health care system should be controlled by the government or by the medical profession, one day the government will win. But, if a system of real competition is established, one which minimizes federal involvement, I believe we can establish a system that will work so well it can withstand any attack.

III. THE PRINCIPLES OF FEDERAL POLICY

There are some necessary pre-conditions for such a system to work. First, there have to be enough doctors and other professionals around to insure that the supply side of the supply-and-demand equation does not dominate, in other words, that prices will not be determined by suppliers alone.

Second, most trade restrictions, such as advertising limits, are going to have to be removed. Of course, the advertisements cannot be allowed to make any claims whatsoever, but that is a question of false advertising.

Third, there have to be financial incentives to control costs. Deductibles and co-insurance payments have to be brought back on traditional health insurance plans, for those who can afford them. The only way we can, for example, be sure that people will wait until the next day and go to the doctor's office to get treated for a slight fever rather than go to the hospital emergency room, is if there is a financial incentive for them to do so. At present, by and large, the hospital visit is free and the trip to the doctor is not.

This is simply wrong.

With regard to insurance, there should be a choice of insurance plans available to the consumer and a variety of payment schemes, such as H.M.O.s, should be allowed to flourish if they are financially viable. In this regard, it is important to realize that all the consumers do not have to be educated and act in their own financial interest all the time in order

to police the market place. I read a study not too long ago, and I wish I remember where I saw it, that suggested that if 30 percent of the consumers in a given market act rationally that that is enough to police the market place.

Insurance practices can help in another area by designing policies in such a way as to encourage people to practice preventive medicine and to live healthier lifestyles.

A person who makes his annual visit to the doctor should not have to subsidize the health care of someone who will not visit the doctor.

Insurance companies are going to have to start to challenge excessive claims, rather than paying them and adding to the following year's premiums. Hospitals will have to help in this area by charging prices

that more accurately reflect the cost of the specific services, rather than using some services to subsidize others.

Fourth, the government is going to have to help this process along by encouraging the development of a more educated consumer. In short, we need more health education for consumers so they will become more capable of making rational, cost-effective decisions.

This is not a detailed description of what I feel should be done in this area, but I think I have made clear the direction in which I believe we should go. But, little progress along these lines will be made without the cooperation of the medical profession. It will be difficult enough to move the health care system in this direction over the opposition of those who claim competition cannot work and the

government must run matters. If the professionals, such as you, are opposed to this type of change, I guarantee nothing along these lines will take place.

IV. HOSPITAL COST CONTAINMENT

This brings me to the most pressing health care question before the Congress today -- hospital cost containment. I am for containing hospital costs; I assume everyone is.

But, I have a number of concerns about the hospital cost containment legislation being pushed by the Administration, legislation that is, according to the Administration, a temporary, stop-gap measure.

The Administration's rationale for the bill runs as follows: Hospital costs are rising at an excessive rate, thereby

adding to the inflation rate and prevent-
ing needed changes in the federal health
care programs.

To control this, they would establish
revenue ceilings for hospitals, taking into
account the size of the hospital, the type
of care it provides, and other factors.
Hospitals will live within these controls
by cutting the waste in hospital operations.

This is about as simple a description of the bill as one can make, one which does not take into account the many complexities, the exemptions, and so forth.

I have a number of concerns with the Administration bill, concerns which leave me unsympathetic to it. First, I am disturbed by the idea of putting in place another burearcracy for the purpose of regulating a whole sector of the economy,

especially when it is merely to enforce a temporary, stop-gap solution. This is especially true when one considers that estimates of the impact of this bill on the inflation rate range from 0.1 to 0.3 percent total for the next five years. That is not very much over a five year span.

Second, if this were an amendment to an appropriations bill, it would be the

equivalent of an across-the-board reduction. I have never liked across-the-board reductions because, almost inevitably, the bureaucrats cut services before cutting administration. The idea that services will be saved and bureaucracy cut, is nice in theory, but it seldom happens.

Third, this bill relies on a regulatory solution and as I explained earlier,

I believe a greater reliance on the market place is more appropriate. In this regard, it seems to me that setting a hospital's revenue ceiling by adding a percentage to its previous revenues penalizes the efficient and rewards the wasteful, something I feel defies logic.

Fourth, I am concerned that by controlling hospital revenues, we are putting hospitals in a position of rationing health

care. If services must be cut for a hospital to say within its ceiling, someone will have to decide what services should be cut. In many parts of the country, the largest problem is still the lack of services, not the excess thereof. I am certain the public does not want reductions in services, and I do not believe we want to put hospitals in the position of rationing health care without widespread public debate.

Fifth, there are too many exemptions in the proposed bill. It seems that every group in a position to defeat the bill has been exempted, including non-supervisory workers, children's hospitals, hospitals with fewer than 4,000 beds, veterans' facilities and so forth.

Finally, I am greatly concerned about the impact of the bill on North Carolina. Daily hospital charges in North Carolina

are lower than those in 43 states, $37 per day lower than the national average. In spite of this excellent record, the rate of increase last year was lower than the national average. Occupancy rates in our state is ninth in the nation, 78.2 percent. In short, our hospitals are more efficient. It would seem that the impact of a bill that penalizes the efficient and may lead to a cut in services would be disastrous

on a state like North Carolina.

On the other hand, the record of hospitals in some states has been unbelievably bad, and in those places, reforms are clearly necessary. And frankly, there was no movement towards making the necessary reforms and improvements in hospital operations until the Administration came along with their bill.

I believe that the threat of legislation has worked wonders. It clearly has led to reforms that otherwise would not have taken place, but I also believe that the threat has worked better than the bill itself would. I would hate to see the bill brought to the Senate floor and defeated because the progress that hospitals have made in the last year, with your help, might stop and even be reversed. After all,

we do not have financial incentives in place that might help to control costs. In other words, I do not like the bill. Yet defeating the bill would also be misinterpreted by the public.

My feeling is, and I have communicated this to the Administration, that the best solution would be to leave the bill right where it is now, in limbo. I have also suggested to the Administration that,

rather than pushing for passage of the bill at present, it might be better if they turned their attentions to the long-range reforms necessary for our health care system.

If the Administration does this, hopefully they will look at restoring free enterprise principles to our health care system. And, if they produce a good bill, I will help them get it enacted, and we will have a health care system that is better

than what is already the best system in

the world.

Thank you.