"National Journal Health Policy Strategies"

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GOOD MORNING. I'M PLEASED TO BE HERE WITH YOU TODAY.

THE ISSUES THIS CONFERENCE WILL BE DISCUSSING GO TO THE HEART OF THE POLICY DEBATES FACING US IN THE NEXT DECADE.

ALL OF US SHARE A COMMON GOAL. ALL OF US AGREE THAT WE MUST DEVELOP WAYS TO CONTROL HEALTH CARE COSTS. ALL AMERICANS MUST BE ABLE TO AFFORD HEALTH CARE. ALL AMERICANS MUST BE ABLE TO RECEIVE MEDICAL CARE WHEN THEY NEED IT.

TODAY YOU WILL HEAR A LOT OF TALK ABOUT THE NOTION OF COMPETITION. REPRESENTATIVE STOCKMAN MAKES A PERSUASIVE CASE FOR THIS IDEA. SEVERAL OF MY COLLEAGUES ON THE SENATE FINANCE COMMITTEE MAKE AN EQUALLY CONVINCING ARGUMENT.

THEY SAY THIS MODEL SHOULD BE THE CENTERPIECE IN ANY HEALTH STRATEGY FOR THE EIGHTIES. THEY SING THE PRAISES OF THIS APPROACH AND ARGUE THAT THEIR PROPOSALS WOULD CORRECT MANY OF THE FLAWS IN THE WAY OUR SOCIETY TAKES CARE OF ITS SICK.
OTHERS DISAGREE. OPPONENTS OF COMPETITION CLAIM THE HEALTH CARE SYSTEM IS UNIQUE AND IMMUNE FROM THE TRADITIONAL PRINCIPLES GOVERNING THE MARKETPLACE.

GRANTED, THESE ARE BLACK AND WHITE ASSESSMENTS. AND, ALL OF US INVOLVED IN FORMULATING PUBLIC POLICY KNOW THAT NO CHOICE IS THAT CLEAR OR SIMPLE.

INDEED, THERE'S A LOT TO BE SAID FOR REDUCING GOVERNMENT'S ROLE IN THE HEALTH INDUSTRY. SOME OF THE PROPOSALS BEING PUT FORTH BY CONGRESSMAN STOCKMAN AND OTHERS CAN BE -- AND SHOULD BE -- ENACTED.

BUT, BEFORE WE RUSH HEADLONG INTO THE AGE OF COMPETITION, LET'S TAKE A CLOSER LOOK AT HOW THESE PROPOSALS WOULD WORK.

ANYTIME A NATIONAL PROGRAM IS PROPOSED, IN MY JUDGMENT IT MUST MEET ONE CRITICAL TEST: IS THE PROBLEM THIS PROGRAM WOULD SOLVE, REALLY A NATIONAL PROBLEM. OR, IS THE PROBLEM JUST A REGIONAL PROBLEM, OR ONE FOUND IN CERTAIN INCOME LEVELS, OR UNIQUE TO ONE GROUP OF PEOPLE.

IF THE PROBLEM IS NOT NATIONAL, THEN THE SOLUTION SHOULDN'T BE NATIONAL.

TOO OFTEN THOSE OF US IN CONGRESS HAVE CREATED WHOLE NEW PROGRAMS WHEN THE MORE SENSIBLE APPROACH WOULD HAVE BEEN TO TINKER AND ADJUST EXISTING PROGRAMS. AND, AS A RESULT, ENTIRELY NEW PROBLEMS ARE CREATED. THERE REALLY IS SOMETHING TO THAT OLD MAXIM THAT THE CURE IS WORSE THAN THE DISEASE.
IN MY VIEW, THIS IS PARTICULARLY TRUE OF MANY OF THE COMPETITION PROPOSALS. BECAUSE, IN FACT, THE PROBLEM COMPETITION ADDRESSES REALLY IS NOT A NATIONAL PROBLEM. THEREFORE A NATIONAL SOLUTION ONLY IS GOING TO CREATE NEW PROBLEMS IN OTHER AREAS.

IN MY VIEW, THE COMPETITION MODELS BEING CONSIDERED WOULD PROVIDE LITTLE OR NO IMPROVEMENT IN THE QUALITY AND COST OF MEDICAL CARE FOR THE 49 MILLION AMERICANS WHO LIVE IN MEDICALLY UNDERSERVED AREAS.

WHILE THESE APPROACHES THEORETICALLY WOULD SOLVE SOME OF THE HEALTH PROBLEMS FOR URBAN AMERICANS, THEY WOULD BE OF LITTLE AID TO RURAL AMERICANS.

COMPETITION PROPOSALS ARE LITTLE MORE THAN A FORM OF Deregulation OF THE HEALTH INDUSTRY. DESPITE THE FACT THAT DeregULATION IS POLITICALLY ATTRACTIVE, IT IS NOT THE CURE-ALL MANY CLAIM IT TO BE.

IN MANY CASES, FOR RURAL AMERICANS, DeregULATION HAS BECOME SYNONYMOUS WITH POORER SERVICES AND INCREASED COSTS. IN MY HOME STATE OF MONTANA, THE LACK OF RAILROAD COMPETITION, FOR EXAMPLE, HAS RESULTED IN SOME OF THE HIGHEST FREIGHT RATES FOR GRAIN SHIPMENTS IN THE NATION.

WHILE WE ALL AGREE THAT HEALTH CARE COSTS MUST BE CUT, FOR RURAL AMERICANS, DeregULATING THE HEALTH INDUSTRY IS NOT GOING TO SOLVE THE PROBLEM.

LET'S LOOK AT SOME OF THE STATISTICS:
On a per patient basis, there are nearly three times as many doctors in metropolitan areas as in rural areas;

- There is only one doctor for every 2,400 rural Americans compared with one doctor for every 500 city-dwellers;
- The average age of rural physicians is higher than for urban doctors;
- One hundred and thirty-eight rural counties -- with a combined population of 500,000 -- have no doctor;
- The infant mortality rate in rural medically-underserved areas is three times the national norm;
- Only 30 percent of women of child-bearing age are rural, but they account for 50 percent of maternal deaths;
- People living in rural areas make fewer visits to doctors than those in urban areas. For example, rural people make one-fourth as many visits as urban people to obstetricians. They make one-sixth as many visits to pediatricians. They make one-half as many visits to ophthalmologists. They make one-third as many visits to orthopedics and dermatologists.

These are compounded by the fact that increasingly rural hospitals are fighting for their very survival.

Deregulation of the health care industry is not going to solve these problems. In fact, the chances are good that it would only make them worse.
FOR EXAMPLE, MOST OF THE PRO-COMPETITIVE PROPOSALS WOULD REQUIRE EMPLOYERS TO OFFER THEIR EMPLOYEES AT LEAST THREE BENEFIT PLANS, INCLUDING BOTH THE TRADITIONAL TYPES AND PRE-PAID PLANS.

OFFERING THIS KIND OF CHOICE WOULD, IT IS ARGUED, ENCOURAGE EMPLOYEES TO SHOP AROUND, AND PRESUMABLY PROVIDE AN INCENTIVE TO SELECT THE MOST EFFICIENT, COST-EFFECTIVE PLAN.

THAT'S THE PREMISE. BUT NOTHING POINTS OUT THE FUNDAMENTAL DIFFERENCES BETWEEN CITIES AND RURAL AREAS THAN THIS PROPOSAL.

FOR THOSE OF YOU WHO JAM WASHINGTON'S SUBWAYS EACH MORNING OR WHO FIGHT THROUGH TRAFFIC JAMS TO GET TO WORK OR WHO LINE UP AT SUPERMARKETS TO GRAB YOUR GROCERIES, SUCH A CHOICE OF PLANS MAY WELL RESULT IN LOWER HEALTH INSURANCE COSTS.

BUT IMAGINE HOW A FARMER OR RANCHER WHO EMPLOYS MAYBE ONE OR TWO PEOPLE WOULD REACT. FIRST OF ALL, HE PROBABLY DOESN'T PROVIDE HEALTH INSURANCE COVERAGE. THE SIZE OF THE GROUP THAT WOULD BE COVERED UNDER AN EMPLOYER-SPONSORED GROUP HEALTH INSURANCE POLICY IS MIGHTY SMALL.

THE SAME IS TRUE FOR ALL THE SMALL BUSINESSMEN WHO RUN THE LOCAL GROCERY STORE, OR DRUG STORE. THERE ARE FEW LARGE DRUG STORE CHAINS IN MONTANA. IN MOST TOWNS, ONE OR TWO OR MAYBE THREE PEOPLE RUN THE DRUG STORE.
ONLY HALF THE COMPANIES EMPLOYING 10 OR FEWER PEOPLE OFFER HEALTH INSURANCE COVERAGE, WHILE VIRTUALLY ALL FIRMS EMPLOYING MORE THAN 100 WORKERS PROVIDE THIS PROTECTION.

NATIONALLY, 12 PERCENT OF AMERICANS UNDER 65 ARE NOT COVERED BY SOME SORT OF HEALTH INSURANCE. BUT WHEN YOU BREAK THAT DOWN THE STATISTICS ARE MUCH MORE POWERFUL. IN RURAL AREAS, 30 PERCENT ARE NOT COVERED, COMPARED TO ONLY 10 PERCENT IN CITIES.

NINE MILLION RURAL AMERICANS HAVE NO HEALTH INSURANCE COVERAGE AT ALL.

FOR THESE AMERICANS, MULTIPLE CHOICE INSURANCE PROGRAMS ARE JUST ANOTHER ONE OF THOSE PROGRAMS DESIGNED ONLY FOR BIG-CITY AMERICANS.

THE FUNDAMENTAL ASSUMPTION ABOUT COMPETITION IS THAT A CHOICE EXISTS BETWEEN AT LEAST TWO ALTERNATIVES. BUT IN RURAL AREAS RARELY DO SUCH CHOICES EXIST. THUS, FOR RURAL AMERICANS, THE LIKELIHOOD THAT THEY CAN CHOOSE AMONG COMPETING HEALTH INSURANCE PLANS IS SEVERELY LIMITED. AFTER ALL, HOW MUCH COMPETITION SHOULD WE EXPECT FOR PLANS OFFERED RURAL FAMILIES SERVED BY A SINGLE HOSPITAL?

IN ADDITION, MOST OF THE COMPETITION MODELS ARE PREMISED ON ENHANCING CONSUMER COST-CONSCIOUSNESS BY IMPOSING HIGH DEDUCTIBLES, CO-INSURANCE AND CO-PAYMENT REQUIREMENTS.
thus, there is actually an incentive not to seek necessary medical care -- increasing the potential need for acute care.

if this is the case for rural areas, the impact of greater consumer cost sharing will be compounded by the lack of available and alternative sources of health care.

and, while people who live in Washington are usually just a short ambulance ride away from the nearest acute care facility, many rural Americans are hundreds of miles from the nearest hospital equipped for such emergencies.

In Montana, for example, the newest ambulance is not made by Ford or GM -- it's being produced by this nation's helicopter manufacturers and is used to transport emergency cases from remote parts of our state to hospitals.

There is no doubt that we must encourage the development of experimental and innovative ways to provide medical care in rural areas. And, there are several examples of how costs can be cut without reducing the quality of service.

one of the most noteworthy is the Safeco approach in northwest Washington State. Under Safeco, the entire health care delivery system is organized around one physician. This doctor becomes the financial manager for the patient by providing for all his medical needs. The physician is rewarded for organizing the patient's health care needs in an efficient way.
IT IS TOO EARLY TO DRAW A DEFINITIVE CONCLUSION ABOUT THE EFFECTIVENESS OF THIS APPROACH. BUT, PARTICIPATION IN SAFECO APPEARS TO RESULT IN LESS NEED FOR HOSPITALIZATION.

THE CONCEPTS BEHIND SAFECO WOULD SEEM TO APPLY AS WELL TO RURAL AREAS. YET, EVEN THE SAFECO CONCEPT PRESUPPOSES A CHOICE OF DOCTORS WHO CAN BECOME THE FISCAL MANAGER -- A CHOICE GENERALLY LACKING IN SPARSELY-POPULATED TOWNS.

BUT THE SAFECO APPROACH DOES REPRESENT THE KIND OF ATTITUDE WE SHOULD ADOPT. SAFECO IS A SOLUTION TO AN ACTUAL PROBLEM. IT IS TAILORED TO THE SPECIFIC NEEDS OF A PARTICULAR AREA.

IT IS NOT AN ATTEMPT TO FORCE A NATIONAL SOLUTION ON A PROBLEM THAT IS NOT NATIONAL IN SCOPE.

DEREGULATION IS ATTRACTIVE. TOO OFTEN FEDERAL REGULATORS HAVE GONE OVERBOARD AND THE RESULT HAS BEEN EXCESSIVE REGULATION. CERTAINLY, SIMPLIFYING AND STREAMLINING THESE REGULATIONS IS ESSENTIAL.

BUT LET US NOT MAKE DECISIONS TODAY THAT RESULT IN NEW PROBLEMS IN FUTURE YEARS. WE ALL KNOW THAT OUR SYSTEM FOR PROVIDING HEALTH CARE TO AMERICANS IS FLAWED.

BUT WE ALSO MUST REMEMBER THAT OURS IS THE BEST SYSTEM IN THE WORLD.
WE MUST MAKE SURE THAT THE SOLUTIONS FIT THE PROBLEMS, OR AS THOMAS JEFFERSON SAID, "THE PATCH MUST FIT THE HOLE."

THIS KIND OF COMMON SENSE WILL PAY DIVIDENDS IN THE FUTURE.

I WOULD LIKE TO CLOSE WITH A THOUGHT FROM MARK TWAIN THAT MAY HELP US EVALUATE MAJOR NEW DEREGERATION PROPOSALS.

TWAIN SAID: "WE SHOULD BE CAREFUL TO GET OUT OF AN EXPERIENCE ONLY THE WISDOM THAT IS IN IT -- AND STOP THERE; LEST WE BE LIKE THE CAT THAT SITS DOWN ON A HOT STOVE-LID. SHE WILL NEVER SIT DOWN ON A HOT STOVE-LID AGAIN -- AND THAT IS GOOD; BUT ALSO SHE WILL NEVER SIT DOWN ON A COLD ONE ANYMORE."

TOO OFTEN POLICYMAKERS IMITATE THE CAT'S ACTIONS BY THROWING OUT OLD PROGRAMS AND REPLACING THEM COMPLETELY WITH NEW ONES. I PREFER TWAIN'S APPROACH. LET'S MAKE THE CHANGES THAT REALLY NEED TO BE MADE -- AND STOP THERE.