5-20-1988

National Rural Health Association

Max S. Baucus

Let us know how access to this document benefits you.

Follow this and additional works at: https://scholarworks.umt.edu/baucus_speeches

Recommended Citation
https://scholarworks.umt.edu/baucus_speeches/426

This Speech is brought to you for free and open access by the Archives and Special Collections at ScholarWorks at University of Montana. It has been accepted for inclusion in Max S. Baucus Speeches by an authorized administrator of ScholarWorks at University of Montana. For more information, please contact scholarworks@mso.umt.edu.
Senator * or Department*: BAUCUS

Instructions:
Prepare one form for insertion at the beginning of each record series.
Prepare and insert additional forms at points that you want to index.
For example: at the beginning of a new folder, briefing book, topic, project, or date sequence.

Record Type*: Speeches

MONTH/YEAR of Records*: May-1988
(Example: JANUARY-2003)

(1) Subject*: Health
(select subject from controlled vocabulary, if your office has one)

(2) Subject* Environment/Natural Resources

DOCUMENT DATE*: 05/20/1988
(Example: 01/12/1966)

* "required information"
Thank you, Jim (Jim Ahrens, President, Montana Hospital Association).

Like most Americans, my interest in health care began with a personal experience. When I ran for Congress in 1974, I actually walked. I walked across Montana -- over 600 miles. That's like walking from Washington to Chicago.

From the rugged geyser country of Yellowstone Park, to the powerful forests around the Yaak -- a logging community near the Canadian border -- I met with folks and learned about the concerns of rural Montana.

At the end of the first day I got terrible shinsplints. And the closest thing to a health clinic was a hot springs in Chico, or the local saloon in Yaak called the Dirty Shame.
I finally got my shinsplints treated -- by an athletic trainer in Bozeman. And I learned something. I learned first hand of the challenges all of you face every day. Trying to provide health care in the corners of our land is no easy task.

Much has changed since 1974. Back then Watergate dominated the front pages. Ronald Reagan was a retired governor from California. Bob Van Hook -- your Executive Director -- was just starting a career in health care in a small clinic down the road in central Virginia.

Total health care spending back then was about $100 billion. Next year we will spend that much on Medicare alone.

Health care spending today is nearly 12 percent of GNP -- about $500 billion a year. Fourteen years ago government pundits and health purveyors swore that we'd never go above 8 percent of GNP.
Who would ever think that we would spend more on health than on defense. But we do. We do because of technology, inflation, insurance, and consumer demand for the best possible services regardless of cost.

The trend is expected to continue. Experts foresee health spending to triple by the year 2000 -- to $1.5 trillion a year!

And that's assuming the trail we walk is smooth and straight, not curved and rocky.

It assumes no new major health programs for catastrophic illness or long term care, and no return to double-digit inflation in health care costs.

And it assumes the baby boom generation won't put new demands on the health care system in the years ahead.

But before we look to the future for rural health care, it's important to have a better understanding of what happened in the recent past.
In the 70's things seemed pretty good -- the sky was the limit for government budgets for health. The market was growing. Health was hot.

And so were health care costs. So hot, they climbed at an annual clip of roughly 12 percent.

However, in the 1980's the world changed. We entered a new era of fiscal austerity.

Massive federal deficits forced the government to take a budget-driven approach to health care. Which is like trying to satisfy the appetite a Grizzly bear with a marshmallow.

Desperate to control health costs, the government looked for solutions. And what was one of the answers? The Medicare prospective payment system.

Without a doubt, this is the most visible example of our budget-driven approach to health care.
It is a clear example of how the government chose to worship at the alter of efficiency rather than focus on ways to provide both better service and value.

In 1983, the prospective payment system was a tailor-made solution for an Administration that had come to Washington preaching orthodox free-market theory.

Don't get me wrong. There is nothing wrong with efficiency in government programs. In fact, we could stand a whole lot more of it.

But efficiency shouldn't be held out as the sole standard, the goal above all others, for federal policy.

Efficiency may be fine if you're trying to sell potatoes, but you and I know that health care is more than just a commodity -- it's people.

Soon after the prospective payment system was in place, it became evident that city folks were
getting a better deal than people in the country. A much better deal.

-- Medicare profits for urban hospitals were, on the average, about *twice* as high as those for rural hospitals.

-- One out of every ten rural hospitals were actually *losing* money serving Medicare patients.

-- And, for rural hospitals with fewer than 50 beds, Medicare losses were running as much as twenty percent.

By 1986, the third year of the new payment system, the trend had become even more clear.

-- Urban profit margins, while showing some decline, were *nearly nine times higher than the average rural level*.

-- One in every ten rural hospitals was being paid 33 percent below its costs for serving Medicare patients.
-- And losses for many of the smallest rural hospitals had hit a staggering level of minus 48 percent.

As in many other federal policies -- such as airline deregulation and telephone deregulation -- the blind pursuit of efficiency became an albatross around the neck of rural America.

By 1986 it was clear that, for rural hospitals, the federal payment policy was a one-way ticket to oblivion.

Fortunately you didn't take this problem lying down. This Association was quickly organized. "Prairie Home Companion" became a "lean, mean fighting machine." You were determined to make Washington understand that city folks weren't going to walk off with the whole pie.

Legislation -- drafted with your help -- was introduced in Congress to correct imbalances in the system.
The Rural Health Care Improvement Act of 1986 and the Rural Health Care Viability Act of 1987 both contained provisions that, for the first time strengthened the rural health care system.

And let me tell you, your lobbying, your letter writing, and your educating really paid off. Almost every single provision from those two bills is now law. That's quite a track record for an association as young as yours. And I'm honored to have worked with you.

What was done was simple. The concerns of rural communities were taken from the outer fringes of the health policy debate and placed front and center --- right where they belong.

Just look at what we've accomplished:

We've narrowed the urban/rural hospital payment gap from over 20 percent to below 15 percent.

We have exempted sole community hospitals from cuts in Medicare payments for capital. That
should help provide a reliable source of money for modernization and investments in medical technology.

We have expanded eligibility for the swing bed program and the rural referral center program.

We've provided rewards for physicians who give primary care, and who practice in medically underserved communities.

We've begun to make real reductions in about a dozen high-priced specialty services where reimbursement levels had become over-inflated.

For rural health clinics, we directed HHS to increase and permanently index the federal payment limits.

And we have begun to encourage greater independence for non-physician health professionals by allowing them more opportunities to bill Medicare directly for their services.
In addition to these reimbursement reforms, we have now established a new Office of Rural Health within HHS. We've created a permanent set-aside of funds to support rural health studies.

And we've directed that future Medicare rules and regulations be analysed for their effect on rural health care before, not after, they are published.

All totalled, in the last two years we have enacted over 25 separate provisions intended to address specific rural health problems.

But let's be realistic. For too long we've been on the defensive. Sure, we won important battles, but they were when the other team had the ball on "first and ten" with "goal to go."

Together we've made sure that rural health care won't be left out in the cold to fend for itself anymore. But as Vince Lombardi often said "the best defense is a good offense." And this is the best time to put that advice to work for us.
The time is ripe for you to change tactics -- to switch from defense to offense. And the timing couldn't be better for such a move.

There will be little if any new action by the Administration on rural health this year.

Soon there will be a new Administration. And in this town, change means opportunity. It will be important for you to use the momentum of the past to build on the future. To take the offensive. To develop constructive agendas.

As I see it, there are three key areas in which to focus: isolation, equity, and access.

More must be done to reduce the isolation of rural medical communities. We can better use satellite technology to link rural health professionals to urban teaching centers and specialists. HHS has authority to start a pilot program -- I'd like to see it expanded.
Just because you choose to practice medicine in Cutbank, Montana doesn't mean you should be cut off from medical advances coming out of UCLA.

There must be equity in the system. We've got to make sure the federal government pays its fair share of the bill. And we have to make sure that the unique problems of rural communities do not fall on deaf ears in Washington.

We can establish higher payment updates for rural hospitals, and provide financial rewards for primary care services and physicians practicing in rural areas.

There should be equity in reimbursement among urban and rural health care services. And we must re-examine rural safety net programs such as the Sole Community Hospital Designation and the Rural Health Clinics Program.

No one is asking that sole community hospitals and rural clinics be given a blank check. But I don't believe in a policy that sends
all the profits to New York and Chicago and leaves you hanging out to dry.

And while we work to strengthen federal programs, we need stepped up efforts to improve access to quality health care in the heartland.

We could reward states which increase their Medicaid reimbursement for obstetrical care. There's no longer any question that the failure of Medicaid payments to keep pace with rising costs has contributed to the decline in obstetrical services in rural communities.

With your help, I think we can let Congress know that the few dollars spent on the National Health Service Corps, the Title 7 training programs for health professionals, the community health centers, and health education centers make a very big difference in rural communities.

And we need to devise new incentives to attract more doctors to the country. A new pilot loan forgiveness program should help. I hope so.
What this all boils down to -- putting the rules, the regulations and such aside -- is preserving a quality of life. Your quality of life.

Rural hospitals are not cold dispensers of pills and advice. They are often the heart of their communities. The largest employers in town. And a place where family members are born and pull together in times of crisis.

For the past seven years our government has turned a cold shoulder to the needs of rural America. If it wasn't flashy, if it wasn't fast, if it wasn't efficient -- it wasn't important.

Look at our airlines. The only way you can get to Smalltown U.S.A. these days is to be squeezed through some airport hub like cheese through a strainer. I know, I do it all the time when I go home to Montana.

If anything, we keep teaching Washington that there is more to rural America than farms and
ranches. That smalltown America has dreams and ambitions just as urban America does.

That's a tough task. There is a terrible disease in this town -- it's called Potomac Fever. It affects the brain -- narrows the mind -- clouds the thinking. And the only cure is a visit to rural America.

Last May I invited Dr. Bill Roper from HCFA to join me on some visits to rural hospitals in eastern Montana. I think it gave him a better appreciation of our concerns.

You need to do the same -- get more government officials out from behind their desks in Washington and into your hospitals and health centers. Give them first-hand experience with what is going on in your town. Just like I got first-hand experience walking the towns of Montana.

The key is getting our message across. We have shown that we can make a difference when those of us who care about rural health care speak.
up and have concrete, constructive solutions to offer.

But we need to keep building on the rural health agenda. And you, as members of the National Rural Health Association, need to stay in the forefront by developing new proposals -- by developing the next agenda.

Your concerns go well beyond those of the narrow interests of the specialty societies and institutions. You are defending the pulse of our heartland. That's your greatest strength and you need to use it.

In Washington, opportunity knocks not once, but many times. The key is in the timing. And right now is the best time for all of us to prepare our next agenda for rural health care.

I will be here to work with you. You have my support. Because I know times have changed a great deal since my walking days in 1974. The difference now is that I'm not walking alone. I'm
walking with you. And that makes all the difference.

Thanks.