REMARKS OF GOVERNOR THOMAS H. KEAN

FIRST PLENARY SESSION OF THE

NATIONAL GOVERNORS' ASSOCIATION WINTER MEETING

WASHINGTON, D. C.

SUNDAY, FEBRUARY 26, 1984

HEALTH COSTS ARE A GIANT "PAC MAN," CONSUMING OUR TAX DOLLARS AND EATING AWAY AT FEDERAL AND STATE BUDGET WITH ALMOST UNSTOPPABLE MOMENTUM.

HEALTH CARE IS THE SINGLE MOST INFLATIONARY FACTOR IN THE AMERICAN ECONOMY TODAY. LAST YEAR THE COST OF MEDICAL CARE ROSE ABOUT 12.5 PERCENT, TWICE THE INCREASE IN THE CPI.

THAT TOTAL BILL CAME TO ABOUT $321 BILLION. THAT'S A LEVY OF ALMOST $1,400 ON EVERY MAN, WOMAN AND CHILD IN THE COUNTRY. THAT BILL IS EXPECTED TO RISE TO $675 BILLION BY 1990.

IF AMERICAN BUSINESS IS TO SUSTAIN OUR ECONOMIC RECOVERY, IF BUSINESS IS TO PUT OUR WORKERS BACK TO WORK, THEN WE MUST BRING HEALTH CARE COSTS UNDER CONTROL:

- BECAUSE HEALTH CARE --- NOT LABOR, NOT ENERGY --- IS THE FASTEST RISING COST OF DOING BUSINESS.

- HEALTH CARE --- NOT TAXES --- IS THE MOST RAPIDLY WIDENING GAP BETWEEN A WORKERS' GROSS AND TAKE HOME PAY.

HEALTH INSURANCE PREMIUMS WILL COST UNITED STATES COMPANIES SOME $77 BILLION THIS YEAR.

THE BURDEN ON THE STATES FOR BOTH STATE EMPLOYEE HEALTH BENEFITS AND FOR MEDICAID IS ENORMOUS. STATES SPEND MORE THAN $15 BILLION FOR MEDICAID, ABOUT 10 PERCENT OF ALL GENERAL FUND EXPENDITURES. WHILE GENERAL EXPENDITURES INCREASED 12.7 PERCENT FROM 1981 TO 1983, STATE MEDICAID SPENDING INCREASED ALMOST 21 PERCENT.

BUT THE POINT OF OUR MEETING TODAY IS THAT THIS IS NOT A MEDICAID PROBLEM ONLY, BUT A SYSTEMIC ONE. ACTUALLY, WE HAVE DONE A REASONABLE JOB OF CONSTRAINING MEDICAID LATELY.

THAT THE PROBLEM IS SYSTEMIC IS DRAMATICALLY ILLUSTRATED BY THE FACT THAT WE STATES, AS EMPLOYERS, HAVE NOT BEEN ABLE TO HOLD DOWN BENEFIT COSTS FOR OUR OWN EMPLOYEES. WHILE MEDICAID ROSE 21 PERCENT, STATE EMPLOYEE HEALTH BENEFITS COSTS ROSE EXACTLY TWICE AS MUCH --- 42 PERCENT.

STATES HAVE RECOGNIZED THE SYSTEMIC PROBLEM, AND HAVE BEGUN TO TAKE ACTION. NEW JERSEY PIONEERED HOSPITAL PAYMENTS SET IN ADVANCE ON THE BASIS OF CASE MIX OR DIAGNOSIS-RELATED GROUPS --- DRGS.

OUR RATE OF INCREASE IN HOSPITAL OPERATING EXPENSES IS 4 OR 5 PERCENT LESS THAN THE NATIONWIDE AVERAGE. OUR FIVE-YEAR INCREASE IN HOSPITAL COSTS PER DAY WAS SECOND LOWEST IN THE NATION.

MASSACHUSETTS, NEW YORK, AND MARYLAND HAVE ALL-PAYOR SYSTEMS ALSO. WEST VIRGINIA, MAINE AND WISCONSIN RECENTLY PASSED LEGISLATION TO DEVELOP SIMILAR SYSTEMS. MINNESOTA HAS CREATED AN ENVIRONMENT THAT FOSTERS COMPETITION THROUGH HEALTH MAINTENANCE ORGANIZATIONS. CALIFORNIA HAS ITS MEDICAID PROVIDERS BIDDING AGAINST EACH OTHER.

MANY GOVERNORS ARE CONFRONTING THE ISSUE NOW. I KNOW THAT MANY OF YOU HAVE NOT MADE BASIC DECISIONS SUCH AS WHETHER TO FOSTER A REGULATORY APPROACH, A COMPETITIVE APPROACH, OR SOME COMBINATION.

TO SEEK GUIDANCE, GOVERNOR LAMM AND I CONVENED A HEARING OF HEALTH FINANCING EXPERTS IN DECEMBER. OUR WITNESSES DRAMATICALLY DESCRIBED THE DIMENSIONS OF THE PROBLEM AND THEIR RECOMMENDED APPROACHES AND SOLUTIONS. PROCEEDINGS FROM THIS HEARING HAVE BEEN MAILED TO YOU, AND I URGE YOU TO TAKE A LOOK AT THEM.

I WOULD LIKE TO SHARE WITH YOU SOME OF THE POINTS I LEARNED AT THAT HEARING.

OF THE PROJECTED INCREASE IN HEALTH COSTS BY 1990, 57 PERCENT WILL BE DUE TO GENERAL INFLATION, 7 PERCENT DUE TO MEDICAL CARE INFLATION, AND 8 PERCENT DUE TO POPULATION INCREASES.

THAT LEAVES 28 PERCENT DUE TO CHANGES IN MEDICAL TECHNOLOGY AND PATIENT CARE USE AND TREATMENT PRACTICES. IF WE ARE TO HAVE ANY IMPACT, IT WILL BE ON THIS 28 PERCENT OF THE INCREASE.

FIRST, WE MUST GAIN CONTROL OF HIGH TECHNOLOGY. TECHNOLOGICAL BREAKTHROUGHS AND RISING EXPECTATION HAVE LOWERED THE USEFUL LIFE OF A HOSPITAL PLANT FROM 25 YEARS TO 15, AND OF EQUIPMENT FROM 7 YEARS TO 4 OR 5 YEARS.

FOR EXAMPLE, IN NEW JERSEY, CAPITAL INVESTMENT FOR CAT SCANNERS TOTALS ABOUT $73 MILLION. NOW, HOWEVER, A NEW TECHNOLOGY --- NUCLEAR MAGNETIC RESONANCE, FOR NMR --- IS ALREADY MAKING CAT SCANNERS OBSOLETE.

ALREADY 26 OF THE 90 HOSPITALS IN MY STATE HAVE INDICATED THEIR INTENTION TO ACQUIRE THIS SYSTEM -- AT A COST OF UP TO $4 MILLION EACH, AND ABOUT $1 MILLION EACH YEAR IN OPERATING COSTS. THIS FOR A MACHINE WHOSE CLINICAL VALUE IS STILL BEING INVESTIGATED! EVEN THE PENTAGON WOULD SIT UP AND TAKE NOTICE.

IT IS PROBABLY NOT POSSIBLE TO CONTROL SIGNIFICANTLY WHAT IS ALREADY IN PLACE. BUT WE MUST STOP ANY MORE EXCESSIVE INVESTMENT IN MULTI-MILLION DOLLAR TECHNOLOGY.

IN THIS RESPECT, I MUST CONGRATULATE NEW YORK'S COMMISSIONER OF HEALTH, WHO HAS JUST DENIED AN NMR TO A MAJOR HOSPITAL --- ON THE VERY REASONABLE GROUNDS THAT PATIENTS CAN USE THE BRAND NEW EQUIPMENT AT AN INSTITUTION WHICH IS ACROSS THE STREET AND CONNECTED BY A TUNNEL.

DID WE NOT ALL CHEER WHEN BARNEY CLARK LIVED WITH THE WORLD'S FIRST ARTIFICIAL HEART? AT THE SAME TIME THAT WE APPLAUD HIS COURAGE AND THIS TREMENDOUS MEDICAL ADVANCE, WE SHOULD REMIND OURSELVES THAT THE COST, EVEN AFTER THE PROCEDURE IS PERFECTED, IS LIKE TO BE AT LEAST $50,000 PER PATIENT AND PERHAPS AS MUCH $100,000 IN THE FIRST YEAR FOLLOWING SURGERY.

WITH 50,000 PEOPLE A YEAR PROJECTED AS SUITABLE CANDIDATES, TH EXPENDITURE WOULD BE $2.5 BILLION TO $5 BILLION ANNUALLY.

SECOND, WE MUST ALSO CONTROL "LOW" TECHNOLOGY; BY THIS I MEAN THE ROUTINE LABORATORY TESTS AND PROCEDURES AND DRUGS THAT COST LITTLE, BUT BY THEIR SHEER VOLUME CONTRIBUTE PERHAPS MORE TO COST ESCALATION THAN HIGH-TECH ITEMS.

FOR EXAMPLE, A STUDY IN THE MID-1970'S SHOWED THAT INVESTMENT FOR EQUIPMENT WAS $600 MILLION IN ONE YEAR, WHILE SPENDING ON LAB TEST INCREASED BY $1 BILLION. INCREASES FOR LABORATORY AND X-RAY TESTS HAVE BEEN 10 TO 15 PERCENT FOR A DECADE.

IF YOU TREATED PERFORATED APPENDICITIS IN 1951, YOU ORDERED AN AVERAGE OF 5 TESTS; IF YOU TREATED A CASE IN 1971, YOU ORDERED SIX TIMES AS MANY, OR 31 TESTS.

THIRD, WE HAVE TO FACE THE PROBLEM OF THE NUMBER OF DOCTORS AND THEIR SPECIALIZATION. IT IS PROJECTED THAT THERE MAY BE MORE THAN 535,000 DOCTORS IN 1990, A SURPLUS OF 60,000 OVER PROJECTED NEED. THERE MAY BE 650,000 BY THE YEAR 2000, A SURPLUS OF 135,000.

OUR BIGGEST PROBLEM IS NOT NUMBERS, BUT THE FACT THAT FULLY 85 PERCENT OF PHYSICIANS ARE SPECIALISTS, A LEVEL HIGHER THAN ANY OTHER COUNTRY IN THE WORLD. THESE ARE THE DOCTORS USING THE HIGH TECHNOLOGY --- OFTEN, IN FACT, DEFINED BY THE TECHNOLOGY.

ONE OF OUR WITNESSES IN THE DECEMBER HEARING FOUND THAT A GENERAL INTERNIST CAN TRIPLE HIS NET INCOME IF HE HAS A HEAVY, BUT JUSTIFIABLE CASELOAD OF ROUTINE EKGS, CHEST X-RAYS, LAB TESTS, AND SIGMOIDOSCOPIES, COMPARED WITH COLLEAGUES WHO DID NONE OF THESE BUT SAW 15 PERCENT MORE PATIENTS. GYNECOLOGISTS, UROLOGISTS, AND GASTROENTEROLOGISTS EARN 8 TO 12 TIMES AS MUCH PER HOUR WHEN THEY USE THEIR TECHNOLOGIES.

GIVEN THESE INCENTIVES, IS IT A WONDER THAT OUR MEDICAL SYSTEM PERFORMS MORE SURGERY AND INVASIVE DIAGNOSTIC PROCEDURES THAN ANY OTHER COUNTRY IN THE WORLD? ONE WITNESS SAID IN DECEMBER, "THERE AREN'T ENOUGH CORONARY ARTERIES FOR THE CARDIOLOGISTS!"

JUST A FEW DAYS AGO, THE A.M.A. ITSELF CALLED ON ITS MEMBERS TO INSTITUTE A VOLUNTARY FREEZE ON DOCTORS' FEES THIS YEAR. I HEARTILY APPLAUD THIS GOOD-FAITH EFFORT --- SINCE DOCTORS' FEES HAVE RISEN THIS YEAR FASTER THAN OTHER COSTS. AND THOSE FEES MAKE UP 20 PERCENT OF THE NATION'S ANNUAL HEALTH CARE BILL --- $65 BILLION OF THE $325 BILLION WE SPEND EVERY YEAR.

FOURTH, WE MUST DEAL WITH THE HUGE COSTS OF DEFENSIVE MEDICINE --- THE COSTS OF BOTH MALPRACTICE INSURANCE AND THE EXCESSIVE TESTS AND PROCEDURES ORDERED BECAUSE A DOCTOR IS PROTECTING HIMSELF AGAINST A POSSIBLE LAWSUIT.

THIS IS AN AREA WHERE GOVERNMENT OFFICIALS PHYSICIANS; AND MEMBERS OF THE LEGAL PROFESSION MUST WORK TOGETHER FOR REFORM.

THE AMERICAN MEDICAL ASSOCIATION ESTIMATES THAT PHYSICIANS AND HOSPITALS NATIONWIDE PAY $3 BILLION A YEAR FOR MALPRACTICE LIABILITY PROTECTION. NEUROSURGEONS IN THE HIGHEST COST STATES PAY $56,000 FOR ONE MILLION DOLLARS OF COVERAGE. IF A NEUROSURGEON AVERAGES THREE OPERATIONS A WEEK, OR 150 A YEAR, HIS MALPRACTICE PREMIUM ADDS $373 TO EACH AND EVERY OPERATION.

FIFTH, OUR SOCIETY AS A WHOLE --- GOVERNORS, FEDERAL OFFICIALS, OFFICERS OF THE COURTS, CITIZENS, AND HEALTH CARE PROVIDERS --- MUST FACE DECISIONS ON WHAT CONSTITUTES APPROPRIATE CARE.

FOR EXAMPLE, WE HAVE TO CONFRONT THE PROBLEM OF HEROIC EFFORTS WHEN DEALING WITH A PATIENT IN THE LAST YEAR OF LIFE. MEDICARE ALONE, FOR EXAMPLE, SPEND $17 BILLION, OR 28 PERCENT OF ITS BUDGET, FOR HOSPITAL AND NURSING HOME CARE IN THE LAST YEAR OF LIFE.

IF WE KEEP SPENDING AT THIS PACE, WHAT WILL MEDICARE COST WHEN THERE ARE 36 MILLION PEOPLE OVER AGE 65 IN THE YEAR 2000, OR 53 MILLION --- 17 PERCENT OF THE POPULATION --- IN THE YEAR 2020.

MANY CITIZENS ARE TAKING MATTERS INTO THEIR OWN HANDS BY DRAFTING DOCUMENTS STATING THAT THEY WANT TO SET A LIMIT ON HOW FAR DOCTORS CAN GO TO RESUSCITATE THEM.

IN THESE LAST COMMENTS, I HAVE RAISED THE QUESTIONS OF INVOLUNTARY HEALTH CARE RATIONING. IS IT INEVITABLE? OR CAN WE PREVENT THE NEED FOR RATIONING? CAN WE AVOID THE AWFUL CHOICES IT COULD FORCE?

A REPORT JUST PUBLISHED BY THE BROOKINGS INSTITUTE CONCLUDES THAT WE WILL NOT BE ABLE TO AFFORD THE CARE WE HAVE BEEN USED TO --- AND THAT SIGNIFICANT RESTRAINT WILL RESULT ONLY FROM DENYING BENEFITS: FROM NOT BUYING THE ARTIFICIAL HEARTS, LIVER TRANSPLANTS, INTENSIVE CARE, CHEMOTHERAPY, AND OTHER EXPENSIVE TREATMENT ALREADY AVAILABLE OR JUST BEING DEVELOPED.

LET US BE HONEST AND SAY THAT WE ARE ALREADY RATIONING HEALTH CARE RIGHT NOW --- BUT RATIONING ONLY TO THE POOR. IS IT ANYTHING BUT RATIONING WHEN, IN 1982 AND 1983, 11 STATES LIMITED THE NUMBER OF DAYS MEDICAID PATIENTS CAN REMAIN IN THE HOSPITAL?

IS IT ANYTHING BUT RATIONING WHEN 6 STATES DROPPED PATIENTS AGED 18 TO 21 FROM MEDICAID; WHEN 17 STATES REDUCED THE AMOUNT, SCOPE OR DURATION OF MEDICAID-COVERED SERVICES; OR WHEN REIMBURSEMENT IS SET SO LOW THAT THREE-QUARTERS OF A STATE'S PHYSICIANS REFUSE TO TREAT MEDICAID PATIENTS?

THE BROOKINGS REPORT SHOWS THAT IF WE ARE FORCED TO RATION HEALTH CARE, IT WILL BE A WRENCHING EXPERIENCE --- A SOCIAL AND POLITICAL NIGHTMARE. QUITE LITERALLY --- AS IN GREAT BRITAIN, WHICH THE AUTHORS STUDIED --- WE WOULD HAVE TO PREPARE FOR PEOPLE TO DIE FOR LACK OF TREATMENT WHICH WOULD OTHERWISE BE AVAILABLE.

IN ENGLAND, TRIAGE --- CHOOSING WHO WILL DIE --- IS AN EVERYDAY PRACTICE. THE DOCTOR CANNOT PLACE A 70-YEAR OLD PATIENT WITH TERMINAL CANCER IN AN INTENSIVE BED FOR FEAR THAT THE BED MY BE NEEDED FOR A 25-YEAR OLD ACCIDENT VICTIM.

PATIENTS WITH CHRONIC KIDNEY FAILURE WHO ARE OLD, OR WHO HAVE OTHER COMPLICATIONS, ARE COMMONLY DENIED DIALYSIS, AND DIE FOR LACK OF IT.

THESE ARE BUT TWO EXAMPLES IN THIS DISTURBING STUDY. YOU SHOULD READ IT. IT MAY BE A LOOK INTO THE CRYSTAL BALL OF OUR OWN FUTURE, IF WE DO NOT ACT NOW TO PREVENT IT.

PERHAPS WE CAN ACT BEFORE IT IS TOO LATE TO AVOID THE WORST OF IT. BUT I FEAR THAT AMERICANS HAVE NOT REALIZED THE CRISIS WE FACE. LET ME READ FROM A DOCTOR'S LETTER TO THE EDITOR IN THE <u>NEW ENGLAND JOURNAL OF MEDICINE:</u>

"OPTIMIZATION OF SURVIVAL AND NOT OPTIMIZATION OF COST EFFECTIVENESS IS THE ONLY ETHICAL IMPERATIVE...ETHICAL PHYSICIANS DO NOT BASE THEIR PRACTICES ON THEIR PATIENT'S ABILITY TO PAY OR CHOOSE DIAGNOSTIC OR THERAPEUTIC PROCEDURES ON THE BASIS OF THEIR COSTS."

THIS THINKING REFLECTS NOT ONLY A LARGE SEGMENT OF THE MEDICAL COMMUNITY, BUT THE PUBLIC AT LARGE.

AND OF CURSE WE SHOULD DO OUR BEST TO SAVE LIVES AND TO GIVE THE BEST POSSIBLE CARE. BUT OFTEN, THE BEST CARE OR ADEQUATE CARE IS NOT THE MOST EXPENSIVE CARE. AND WE'VE GOT TO TAKE COSTS INTO CONSIDERATION. IF LESS EXPENSIVE PROCEDURES WILL DO THE JOB, THEN THOSE ARE THE ONES DOCTORS AND HOSPITALS PERSONNEL SHOULD USE.

WE MUST BE AWARE OF THE ECONOMICS OF MEDICAL CARE. WE CANNOT SIMPLY IGNORE THEM. IF WE DO NOT TAKE IMMEDIATE STEPS TO CONTAIN HEALTH CARE COSTS, THEN RATIONING MAY INDEED BE OUR FUTURE. IT WOULD BE A GRIM FUTURE INDEED.