the past year, Mr. Hoar has traveled on 4 different occasions to Bosnia and Herzegovina to promote education for democracy instruction in the schools.

Mr. Speaker, I wish to comment Jack Hoar for his dedication and commitment during the CIVITAS@Bosnia-Herzegovina summer training program. His work is helping to achieve the overall objective of building support for democracy in Bosnia and Herzegovina.

PEOPLE ARE NOT FOR HITTING

HON. ANDREW JACOBS, JR.

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, September 25, 1996

Mr. JACOBS. Mr. Speaker, the Menninger Clinic published a book awhile back entitled ''People are Not for Hitting''.

I have rarely seen a little boy hit another child without mumbling, you are a bad boy. As people grow older, they become more subtle about explaining their violence. But as the parent's creed says, ''The child who lives with violence, learns to do violence.''

The old saying is, spare the rod, spoil the child. Since there are innumerable ways to discipline and even punish children, the saying should be, spare the discipline, spoil the child. In fact, spoiling is one of the worst things you can do to a child. I call it the gentle brutality.

Here is what George Bernard Shaw said: ''If you strike a child, take care that you do so in anger. * * * A blow struck in cold blood neither can nor ever should be forgiven.''

The following statement by Meadow D'Arcy was published in Parade on September 15, 1996. It is excellent.

I feel that hitting children is a disgrace—something we will hang our heads in shame about in the future, as we do now with racism and sexism. We will be forced to tell our children how we were ignorant and simply did not know any better.

I know some one who hits her kids, and you can see the hurt and anger in their faces. Their mother believes that her older boy is a just plain bad kid and that hitting him is the only way to get him to stop doing things. He does do bad things. You can tell him something 20 times and he still won't listen. But I believe she created him. I believe that the badness is a result of the whippings, not the other way around.

We tell our children not to hit—by hitting them. But when we strike a child, we create a child full of fear, hatred and anger. Every time a child is hit, she gets a lesson in how to deal with her emotions. When faced with frustrations, she will hit too.

Image if you broke something at work and your boss slapped you. How would you feel? Humiliated, of course. We see our spankings as different. Why? We all agree that it is wrong for a man to hit a woman. But when it comes to children, we just shrug and say that it is part of growing up.

Children are becoming more and more violent with each other and with you and me. We blame this on so many sources but refuse to face the facts.

TRIBUTE TO LACASA

HON. PETER J. VISCLOSKY

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, September 25, 1996

Mr. VISCLOSKY. Mr. Speaker, I would like to commend the Latin American Community Alliance for Support and Assistance of Northwest Indiana, Inc. [LACASA], its board of directors, and its administrator, Ms. June Long, on LACASA's first annual fundraiser dinner. LACASA, whose office is located in Gary, IN, will hold this monumental event on Saturday, September 28, 1996, at the Patio Restaurant in Merrillville, IN.

The LACASA Board of Directors Officers include: Mrs. Aida Padilla, president and director of the Senior Companion Program; Mrs. Julie Tanis, vice president and public school teacher; Mr. Joaquin Rodriguez, secretary and community advocate; and Mr. Ray Acevedo, treasurer and photographer. Members of the board of directors include: Mrs. Bertha Cardenas, Mrs. Hortencia Hernandez, Mrs. Maria Magana, Mrs. Socorro Roman, Mr. Roeman Whitesell, Ms. Jeannette Hinton Padgett, Ms. Maria Vasquez, Mr. Martin Valtierra, Mr. Ben Luna, Mrs. Maria Lopez, Mrs. Mary Jean Maloney, and Ms. Finis Springer.

LACASA, which was organized in 1994, is dedicated to serving the Hispanic residents of northwest Indiana who experience difficulty in obtaining needed social and educational services. It serves northwest Indiana's Hispanic residents, who comprise 52 percent of the total population in this area, with quality services to meet their special needs.

Special programs that LACASA offers are: adult education, offered at various levels from basic adult education to preparation for the high school equivalency test; Head Start, which provides parenting skills training and an opportunity for parents to become empowered in the education of their children; and Access Assistance, which includes a food pantry, learning job search skills, and youth personal leadership and high school preparation instruction.

While LACASA already provides several beneficial services, it has plans to continue to improve the quality of life for northwest Indiana's Hispanic population. For those in need, LACASA hopes to provide transportation services to its programs, as well as agencies where its clients are referred. It would also like to offer tutoring services for Hispanic youth and establish health stations in an effort to assist Hispanic families in understanding their basic health needs and inform them about how to access the existing health care system. Finally, LACASA hopes to expand its services to the elderly, by familiarizing them with in-home care options to prevent unnecessary institutionalization.

LACASA is funded and receives support from the city of Gary-Community Development Block Grant, Lake Area United Way, Health and Human Services-ACYF, Gary Community School Corp., National Hispanic Institute, U.S. Hispanic Leadership Institute, Indiana Literacy Foundation, and Kankakee Workforce Development Services.

Mr. Speaker, I ask you and my other distinguished colleagues to join me in commending LACASA. This fine organization should be congratulated on its continuing efforts to preserve the Hispanic culture, while at the same time improving the quality of life for the Hispanic residents of Indiana's First Congressional District. May their first annual fundraiser be a successful and joyous event.

MEDICARE AND OUTPATIENT PHARMACEUTICAL BENEFITS: PROVIDING INCENTIVES FOR COST–EFFECTIVE MEDICALLY APPROPRIATE CARE

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, September 25, 1996

Mr. STARK. Mr. Speaker, Medicare's limited outpatient pharmaceutical coverage is inhibiting the implementation of cost-effective outpatient treatments that could benefit patients. Over the past decades, a shift of healthcare from the inpatient to the outpatient setting has occurred. The implementation of Medicare's Prospective Payment System in 1983 provided a strong incentive for hospitals to decrease patients' lengths of stay. Outpatient treatment, when appropriate, is generally much more cost effective than inpatient treatment. Although further shifts in inpatient to outpatient treatment for some conditions may be medically appropriate, the lack of Medicare coverage for the necessary outpatient treatment seems to be inhibitory. Medicare policy needs to facilitate medically appropriate, cost-effective treatments in order to keep pace with the 1990's and set the course for the next century. For this reason, I am introducing a bill which directs a review of Medicare payments in order to identify conditions for which provision of an outpatient pharmaceutical benefit would facilitate outpatient rather than inpatient treatment and be cost effective.

An example of Medicare's limited pharmaceutical coverage having an inhibitory effect on cost-effective care is the lack of general coverage for home intravenous antibiotic therapy. Numerous studies have shown that patients with certain diseases requiring prolonged antibiotic therapy can start their treatment in the hospital and then safely and effectively continue it at home. A hospital in Danbury, CT, recently published a cost-benefit analysis of a home intravenous antibiotic therapy program established for Medicare patients but paid for by the hospital itself; the savings to the hospital was found to be $6,111 per patient on average. If the hospital had not taken the initiative to start the home therapy program, these patients would have had to remain in the hospital, resulting in substantially increased costs.

Although Medicare generally reimburses hospitals on the basis of fixed diagnosis-related group [DRG] payments, it also reimburses an extra amount for patients who stay in the hospital much longer than average and qualify as outliers. Thus for certain patients, some costs due to prolonged hospitalization are shifted to Medicare. Alternatively, the hospital could cut its costs by transferring the patient to another inpatient facility such as a skilled nursing facility to finish treatment. In this case, Medicare still pays extra because it reimburses both the hospitals's DRG payment and the receiving facility's expenses for the patient's post-hospitalization extended care.

Many hospitals need an incentive to take the kind of initiative shown by the Danbury Hospital. The effort and startup costs involved in organizing certain outpatient programs may provide a disincentive. Also, the transfer of patients to extended care facilities may already provide a cost-saving option for the hospital, leaving Medicare to bear the loss. Although not all patients with a particular condition are medically appropriate candidates for outpatient therapy in place of continued inpatient therapy, many patients are probably lingering in inpatient facilities who could more cost-effectively be treated as outpatients. Medicare policy needs to be modified to address this problem by providing incentives for inpatient facilities to initiate cost-effective alternatives.

One such incentive is the coverage of pharmaceuticals that facilitate the treatment of patients in the outpatient rather than inpatient setting. Currently for most home intravenous antibiotic therapy the hospital or beneficiary must shoulder the cost. This policy contains a built-in disincentive because the beneficiary may not have the means to pay for it, and the hospital may find it more cost-saving to use one of the strategies I outlined earlier resulting in a significant loss to Medicare. Adding a pharmaceutical benefit with appropriate payment safeguards could facilitate outpatient treatment and result in a gain to Medicare, the hospital, and the patient.

Are there other diseases besides infections for which an outpatient pharmaceutical benefit would provide an incentive for cost-effective outpatient therapy? I suspect there are. Some strategies may be implementable now; in addition, as new drugs and technologies are developed, more outpatient therapies might be possible in the future. I welcome a thoughtful evaluation of this issue by health experts. We need to develop a policy that is flexible enough to accommodate future cost-saving strategies as they are developed.

The bill I am introducing today provides the groundwork for determining how Medicare policy may be modified to facilitate shifts in health care from the inpatient to the outpatient setting, when medically appropriate. Inherent in the bill is a strategy to ensure that Medicare, not just the hospital, captures the savings. The bill directs the Secretary of Health and Human Services to review and report to Congress within 6 months, all disease categories for which inpatient payments might be able to be reduced if an outpatient pharmaceutical benefit is provided. Coverage for pharmaceuticals will include appropriate payment safeguards. The bill acknowledges that reimbursement not only for the drug, but also for supplies, appliances, equipment, laboratory tests, and professional services needed for appropriate outpatient treatment will need to be factored into the cost-effectiveness analysis.

Specifically, the bill directs the Secretary to report which DRG payments can be reduced by refining the DRG or adjusting the DRG weighting factor, if an outpatient pharmaceutical benefit is provided. Implementation of this strategy could take a variety of forms. For example, reductions in DRG payments could be accomplished by using a formula to discount the payment for an individual patient, and providing only the individual patient with the outpatient benefit. In this strategy, the hospital could request a discounted DRG payment for a particular patient via a billing code. Potentially, the hospital could also specify the number of days of outpatient treatment it wishes to substitute for inpatient treatment. This substitution would ensure that Medicare's costs in providing the outpatient benefit do not exceed its savings in reducing the DRG payment. A financial incentive for the hospital can be built into the formula used for discounting the DRG payment.

Another strategy is to split certain DRG categories into one payment for patients who continue treatment in the hospital and a reduced payment for patients who continue treatment as an outpatient.

Alternatively, the DRG payments for all patients in a specific disease category could be reduced, even though some patients will remain hospitalized throughout their treatment while others will have a shortened hospital stay and continue treatment as outpatients.

Post-hospitalization outpatient therapies and home services are sometimes provided by the hospitals themselves, but may also be provided by independent agencies. When the inpatient and outpatient providers are the same, it will be easy to ensure that Medicare payments are contained. Outpatient reimbursement could be conditional on inpatient payment reductions, and a financial incentive for hospitals to chose the more cost-effective treatment could be built into the reimbursement. However, when the inpatient and outpatient providers are unrelated, it will be more difficult to ensure that Medicare payments will be less than they would have been if the patient had remained in the hospital. This is not, however, an insurmountable problem. One possible strategy that has been suggested is the use of lump sum payments per patient for the outpatient treatment of certain conditions. Certain DRG payments could be split into an inpatient component and a lump sum outpatient component; as long as the sum is less than the original inpatient payments, Medicare saves money. Medicare's inpatient payments for a disease category include the DRG payment, and any applicable outlier or extended care facility payments. Decisions about the percentage that should go to each provider, and incentives that lead to cost-effective care are difficult but potentially resolvable.

The bill also directs the Secretary to determine which outlier payments can be reduced in number, and the disease categories for which these outlier payments are made, if an outpatient pharmaceutical benefit is provided. Similarly, the Secretary is directed to determine whether patient transfers to post-hospitalization extended care facilities can be avoided, thereby reducing payments, if an outpatient pharmaceutical benefit is provided. Strategies similar to the ones I described for reducing DRG payments could potentially be applied to these payment areas.

By reviewing these types of payments, disease categories which have potential for Medicare cost-savings will be identified. As I described previously when I introduced a bill addressing outpatient parenteral antimicrobial therapy, certain infections are likely candidates. However, there may be a number of other areas of medicine, where cost-saving outpatient treatment could appropriately be substituted for inpatient treatment, now or in the future.

The bill directs the Secretary to determine the savings that can be obtained by reducing inpatient payments while providing coverage for beneficiaries' outpatient drugs and services. In addition to potential savings from reduced DRG, outlier, or extended care payments, savings may accrue from the decreased risk of hospital-acquired infections. This is because the longer patients remain in an inpatient setting, the more at risk they are for a nosocomial infection which generally lengthen hospital stay, increase costs, and result in increased morbidity and mortality. Modernizing Medicare to provide incentives for cost-effective medically appropriate care holds promise for benefiting patients, providers, and Medicare.

TAIWAN'S 85TH NATIONAL DAY

HON. ROBERT A. UNDERWOOD
OF GUAM
IN THE HOUSE OF REPRESENTATIVES

Wednesday, September 25, 1996

Mr. UNDERWOOD. Mr. Speaker, this coming October 10, Taiwan, the Republic of China, will commemorate its 85th National Day.

Eighty-five years ago, the Chinese people under the leadership of Dr. Sun Yat-sen successfully expelled centuries-old tyrannical rule. Dr. Sun's adoption of a political system dedicated to the ideals of democracy and based on the consent of the governed was a great victory for democracy in the continent of Asia which, until then, was widely known for tyranny and despotism. The Chinese people's efforts, under Dr. Sun's leadership has come to symbolize a people's aspiration, desire and capacity to stand their ground, take control, and choose their own destiny. This nation's rejection of tyranny and oppression announced to the rest of the world that the desire for freedom is not a concept unique to Western peoples. The people of Asia, as elsewhere, desire and deserve dignity and freedom.

Although Dr. Sun did not live to see the full fruition of his labors, capable leaders like Generalissimo Chang Kai-shek built upon his legacy and provided the essential leadership and guidance which enabled the newly created democracy to survive it's toughest tests.

Taiwan has since become one of the wealthiest nations in the world. The last few years has seen the republic's economy grow at a spectacular rate. In addition to being one of our closest associates in Asia, Taiwan has steadily matured as an economic stronghold. Taiwan is currently the sixth largest trading partner to the United States.

As the delegate from Guam, I recognize the fact that the island and people that I represent share deep cultural and historical ties with Taiwan. As a matter of fact, my constituency includes Taiwanese immigrants. As in numerous other locales, these immigrants have integrated themselves with our island community over the years and have emerged as a vital force in the development and growth of Guam. In addition, Taiwanese tourists contribute to the island's economy. Made possible by the visa-waiver program recently implemented for Taiwanese citizens Guam has greatly benefited from the business these people bring.

On behalf of the people of Guam I would like to congratulate President Lee Teng-hui, Foreign Minister John H. Chang, Representative Jason Hu, Director-General Clark Chen and the Taiwanese all over the world in the commemoration of Taiwan's 85th National