# the impact of medicare

## AN ANNOTATED BIBLIOGRAPHY OF SELECTED SOURCES





U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
OFFICE OF RESEARCH AND STATISTICS

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## NOTE

Since Medicare was enacted into law on July 30, 1965, all aspects of the program have undergone intensive scrutiny by medical care specialists and other professionals in the public and private sectors. As others continue to seek improvements in the program by assessing its impact on pre-existing patterns of organization, delivery, and the financing of medical care services, a review of these first analyses will prove helpful.

The literature on the subject of Medicare is voluminous and diverse. This report is a collection of selected references from periodicals, reports, and books published between August 1965 and December 1968. The Medicare reports of the Social Security Administration's Office of Research and Statistics are listed without annotations at the end.

The entries within each of the nine broad subject categories are arranged alphabetically according to the last names of the authors. An alphabetical index of authors is also provided.

This bibliography was prepared by Mary McGee, a social insurance research analyst in the ORS Division of Health Insurance Studies.

Ida C. Merriam
Assistant Commissioner for
Research and Statistics

December 1969

CONTENTS

## 1. ADMINISTRATION AND PLANNING

Amos, Franklyn B., M.D., and Morgan, Anne W. "Training for Medicare Responsibilities." Public Health Reports, vol. 81, October 1966, pp. 870-874.

Describes a course in hospital organization and administration sponsored by the New York State Department of Health and Columbia University. Some of the topics covered include hospital organization, administration, planning, and budgeting; the hospital's physical plant; medical auditing; hospital outpatient and social services; and educational functions. The course was offered consecutively at five host hospitals, and 215 persons from the department completed the 5 days of training.

Botts, William H. "Implementation of Medicare in the Smaller Institution." Hospitals, vol. 40, June 1, 1966, pp. 46-50.

Maintains that Medicare is geared to larger hospitals and that smaller hospitals must consider five basic factors in implementing the program: hospital location, size, occupancy rates, physician orientation, and scope of services. The author concludes that smaller hospitals will have to merge or affiliate with larger institutions in order to survive.

Carlova, John. "Medicare: How Hospitals Are Preparing." Medical Economics, March 21, 1966, pp. 48-61.

Discusses Medicare's impact on hospital planning. Integration of extended care facilities and home health services into hospital systems, construction of more semi-private rooms than wards, and improvement in quality of care are seen to be effects of the Medicare program.

-----. "Medicare Spurs Areawide Planning." Medical Economics, April 18, 1966, pp. 61-69.

Reviews the activities of voluntary areawide planning councils in preparation for Medicare. The councils'

emphasis is on extended care facilities, home health services, and outpatient departments rather than on new hospital facilities for the treatment of acute conditions. There were 76 councils in the Nation in 1966 and 15 more are being added yearly, mostly under the stimulus of Medicare.

Cashman, John W., M.D., and Galiher, Claudia B. "Medigame: A New Consumer Education Tool." Public Health Reports, vol. 83, December 1968, pp. 987-989.

Describes an educational game devised to simulate experience in using Medicare benefits.

Hamburg, A. Z., and LaBoccetta, A. C., M.D. "System Expedites Medicare Certification Procedures." Hospitals, vol. 42, November 16, 1968, pp. 72-73.

Describes the system used by the Philadelphia General Hospital for recertifying Medicare patients. A certification form and a calendar showing the dates corresponding to the 21st, 51st, and 81st days of hospitalization (when recertification is necessary) are inserted in the patient's medical record. The chart cover contains recertification dates that the doctor initials, enabling him and the medical record personnel to know at a glance the status of the certifications.

Marks, Anna E. "Implementing a Medicare Program in a Private Hospital." Nursing Outlook, vol. 16, February 1968, pp. 26-28.

Describes the way in which the nursing staff at Saint Barnabas Medical Center in Livingston, New Jersey, handled Medicare when it became effective. A special public health nursing coordinator was appointed to work with staff, social workers, and the members of patients' families. The major coordinating problem, which caused delays of up to a month in service, was found to be the requirement that a nurse's home health visit precede assignment of a home health aide.

"Medicare's First Half Year." Hospital Practice, vol. 2, February 1967, pp. 18-20.

Summarizes some of the problems encountered during Medicare's first half year, including difficulty with the method of certifying medical necessity for

services provided in the hospital, low standards of some participating hospitals, delays and complexities in billing, the struggle between hospital-based specialists and hospital administrators, complaints of hospital officials about the need for compensation to cover growth and development, and the relation of Medicare to Medicaid.

Penchansky, Roy. Health Services Administration. Cambridge, Mass.: Harvard University Press, 1968. 480 pp.

Contains 12 detailed cases in health service administration that should be useful in providing background material needed to analyze the effectiveness of Medicare's administration. The topics covered include: Britain's nationalized health service, the development of a psychiatric ward in the Grace-New Haven General Hospital, the Saskatchewan physicians' strike, the attempt of New York hospital workers to unionize, the formation of a clinic in Pennsylvania by the United Mine Workers, the attempts of the Massachusetts Public Health Service to establish "multiphasic" screening clinics, cooperative planning for a nursing school, a group practice arrangement in Russellton, Pa., the Massachusetts public assistance experience with drug costs and utilization, and health services in Chile.

The Significance of Medicare: A System for the Delivery of Comprehensive Medical Care, Proceedings from an Institute Co-sponsored by Home and Hospital for the Jewish Aged of the Philadelphia Geriatric Center and the Office for the Aging, Pennsylvania Department of Public Welfare, May 1967. 123 pp.

Consists of papers presented by participants from educational, hospital, nursing, public health and welfare, social work, and administrative fields to stimulate discussion of the difficulties involved in Medicare's implementation. The topics treated by the seven panels were the nature of the Medicare population, home health care, outpatient diagnostic and medical insurance, acute hospital care, extended care, resources for systems of comprehensive care, and implications for training and research. The problems highlighted were the lack of a unified system of services tc meet the medico-economic needs of old age; the lack of a unified approach to chronic illness in old age; the need for modifications in public assistance, social work, and medical practice; and the need for research on Medicare's impact.

Somers, Anne R. "Medicare Way to Make Planning Effective." The Modern Hospital, vol. 108, June 1967, pp. 100-103.

Presents three proposals to improve hospital planning through Medicare: include hospital planning for future growth as a requirement for certification; develop a single State agency to assist in hospital planning and to handle hospital licensing, Hill-Burton funding, and Medicare certification; pool on an areawide basis Medicare payments used for capital investment. According to the author, the advantages of these proposals include more efficient and less expensive use of resources, and strengthened hospital management.

"SSA's Machinery for Processing Medicare Claims." Hospitals, vol. 41, January 1, 1967, pp. 53-56.

Describes how the Social Security Administration codes, screens, and checks the stream of Medicare claims from intermediaries. Starting from the time a person nearing his 65th birthday completes an application for Medicare coverage, the complex process is followed through the claims procedure, recordkeeping, use of the phonetic code system for identifying the proper account number, and the master utilization record, which shows whether the patient's deduction has been met and how many benefit-days in a spell of illness remain, and the billing procedure.

U.S. Department of Health, Education, and Welfare. First Annual Report on Medicare, referred to the Committee on Ways and Means, 90th Congress, 2nd Session, House Document No. 90-331. Washington: U.S. Govt. Print. Off., 1968. 101 pp.

Covers the first 12 months of Medicare, as well as an 11-month preparation period preceding the implementation of the program. Treated at some length are organization of the administrative apparatus, steps in establishment of beneficiary entitlement and eligibility for participation by providers of services, and designing of reimbursement systems. The considerations involved in designing payment systems are discussed, as are changes made in the light of program experience.

-----. Second Annual Report--Operation of Medicare Program, referred to the Committee on Ways and Means, 91st Congress,

1st Session, House Document No. 91-57. Washington: U.S. Govt. Print. Off., 1969. 121 pp.

Contains legislative changes recommended by the HEW Secretary to improve the program--the extension of Medicare to disabled social security beneficiaries; coverage of some prescription drugs; financing the medical insurance portion of the program through payroll contributions; granting the Secretary greater authority over medical facilities' capital expenditures and incentive reimbursement mechanisms; broadening the "covered services" concept to include certain tests and the services of occupational therapists, social workers, and speech pathologists; and the establishing of the prevailing charge at a level that includes 75 percent of the fee range in a locality for a given service. Described in considerable detail are program operations and administration, including intermediary and carrier performance, reimbursement policies and procedures, program cost controls and utilization safeguards, beneficiary enrollment and premium collecting, and coordination between Medicare and medical assistance programs.

Walter, Charles. "Medicare: The Recertification Mess." Medical Economics, May 29, 1967, pp. 23-30.

Discusses the unnecessarily involved procedures for recertifying Medicare patients that have been instituted by many hospitals, and describes the recertification process in use at Philadelphia's Albert Einstein Medical Center.

White, William C., Jr. "Medicare From the Standpoint of the Carrier." Journal of the American Geriatric Society, vol. 15, November 1967, pp. 984-990.

Discusses problems carriers encounter in handling Part B claims. These include processing difficulties due to inadequate information, determining Part B reimbursement to a hospital-based physician, the widespread misunderstanding of the Part B deductible, the payment of rental charges for durable medical equipment, determination of whether certain "reasonable charges" are consistent with the letter of the law, and excessive utilization of services.

Witten, Carroll. "A Look at HIBAC--The Advisory Council on Medicare." GP, vol. 35, June 1967, pp. 173-181.

Describes the sixteen-man Health Insurance Benefits Advisory Council (HIBAC). Composed of private citizens, it advises the Secretary of Health, Education, and Welfare how Medicare can best be administered. It is concerned with such policies as conditions of participation and principles of reimbursement for providers of services, recertification requirements, reimbursement for hospital-based physicians, and determination of reasonable charges.

## 2. HOSPITAL REIMBURSEMENT

Arthur Young and Co. "A Study of the Financial Effects of the Federal Medicare Program on the Operations of California Hospitals." Done for the California Hospital Association, February 1967. 30 pp.

A study undertaken to determine the effect of Medicare's reimbursement formula on hospital finances and capacity to expand. By applying the reimbursement formula to data for the year preceding Medicare, it was found that 29 hospitals with 4,084 beds would have increased revenue and 53 hospitals with 8,668 beds decreased revenue. The aggregate loss for the 53 hospitals would have been 18 percent of their net income, resulting in a 5 percent reduction in financing ability. Some recommended changes include reimbursement in excess of cost, replacement-cost depreciation, growth allowances, consideration of extra costs incurred by Medicare patients, apportionment of stand-by costs on a hospital-wide basis according to days of patient care, allowances for bad debts of non-Medicare patients, and incentive provisions.

Brown, Madison B. "Administrative Implications of Public Law 89-97." Hospitals, vol. 41, February 16, 1967, pp. 55-59.

Discusses various aspects of Medicare and their implications for providers of health services. The article examines problems in reimbursement involving the definition of "reasonable costs," various methods of accelerated depreciation, the growth and development "allowance" factors, the technique used in the apportioning of costs between Medicare and non-Medicare patients, and the separation of the hospital component from the professional component of laboratory and radiological services.

Coldewey, George T. "Depreciation Under Medicare." Hospital Accounting, vol. 20, June 1966, pp. 26-29.

Discusses the definition and function of depreciation to clarify the argument over whether it should be based on current replacement cost or on recorded

historic cost. Although the principles of reimbursement under Medicare now specify that depreciation must be on historic cost, hospitals have the option of choosing an accelerated method of depreciation. Illustrated are the effects of these optional methods, and the maximizing of investment returns by funding the depreciated amount.

Hinderer, Harold. "Medicare and the Crystal Ball." Hospital Accounting, vol. 20, June 1966, pp. 3-4.

Discusses the effect of Medicare's reimbursement formula on the hospitals' rates and rate-setting mechanisms, the composition of departmental charges, and X-ray and drug charges. Budgeting and management controls, the effects of accelerated depreciation and the 2-percent "plus factor" on investments, and the changing patterns of financing capital expansion are also discussed.

"Hospitals vs. Medicare: Who Pays for Growth?" Hospital Practice, vol. 2, August 1967, pp. 62-64.

Discusses the controversy over the inclusion of growth and development costs in hospital reimbursement. The Government contends its program is to pay only for the cost of services, that its reimbursement policy is at least as liberal as that of private insurance and Blue Cross, and that it already provides for depreciation costs. Hospitals claim that they are $10 billion behind in unmet needs for growth. Behind the controversy lie philosophical differences about how expansion and services (such as maternity services) that are ordinarily run at a loss should be financed.

Ingram, James C. "The Case Against RCC." Hospitals, vol. 41, April 16, 1967, pp. 38-41.

Contends that the RCC (ratio of charges to costs) concept violates accepted economic principles when it reimburses a hospital solely for costs accruing to Medicare patients, asserting that costs should be allocated not only to direct users of a service but also to those who benefit indirectly from it. The article further discusses how hospital administrators can manipulate their charge structure to increase the reimbursement for Medicare patients, the lack of direct or indirect control to prevent this practice, and how it may result in a complete loss of any relationship between charges and costs.

-----, and Colman, J. Douglas. "Implications of a Study of the Age Differential in Hospital Costs." Hospitals, vol. 41, March 16, 1967, pp. 19-19d, 141.

Summarizes a study made by the Associated Hospital Service of New York on the per-diem cost differential in caring for aged and non-aged patients in six New York hospitals. The findings indicate higher per-diem costs of routine services and of medical and surgical nursing services for the aged, lower per-diem costs of special services for the aged, and failure of the RCC (ratio of charges to cost) reimbursement method to reflect accurately the cost differential for the two age groups.

Johnson, Everett A. "Cost Calculations Show Where Medicare Reimbursement Formula Fails." Hospitals, vol. 41, March 1, 1967, pp. 42-47.

Develops cost calculations for operating a hypothetical hospital under Medicare to illustrate the thesis that the Medicare program is putting hospitals into a financially precarious position. Examines such areas as changing financial relationships in the hospital field, capital fund needs of hospitals, the impact of charity cases and bad debts on hospital revenues and operating funds, the effect of inflation and technological improvements in medicine on capital requirements of hospitals, and some built-in "incentives for inefficiency" of the current Medicare reimbursement formula.

Leveson, Irving. "Medical Care Cost Incentives: Some Questions and Approaches for Research." Inquiry, vol. 5, December 1968, pp. 3-13.

Attempts to define the problem of medical care cost incentives, examines the alternatives, and suggests necessary research. The author maintains that costs and outputs must be defined before reimbursement methods can be selected. Output could be defined as a specified combination of procedures and patients could be classified according to symptoms and test results in order to compare costs. The author suggests research on costs of providers of care, end results of medical care, various organizational structures, alternative ways of allocating capital, alternative methods of production, and pricing policies.

Link, Hans. "How to Maximize Medicare Reimbursement." Hospital Accounting, vol. 21, September 1967, pp. 3-5.

Contends that hospitals can realize considerable savings (up to an additional $75,000 a year for a 200-bed hospital) by maximizing reimbursements through a number of methods. Among them are including the value of volunteer services; using accelerated depreciation; funding depreciation and then borrowing from the fund, with the interest becoming an allowable expense for reimbursement; calculating nursing time for Medicare as opposed to non-Medicare patients; and using surplus obstetrical beds for Medicare patients.

"Medicare Nursing Costs." Journal of the American Geriatrics Society, vol. 15, September 1967, pp. 869-70.

Summarizes a report made by the American Hospital Association to determine whether elderly patients required more nursing care than younger patients. Some 250,000 observations were made of 5,056 patients, of whom one-third were aged 65 or over. The findings were that aged patients require 22 percent more nursing time each day than non-aged patients. Medicare makes no provision for this differential in its payments to hospitals and it is estimated that this oversight costs California hospitals $13,250,000 annually.

Pendall, Rudolph J. "RCC: The Maryland Experience." Hospitals, vol. 41, April 16, 1967, pp. 41-43.

Describes the experience of Maryland hospital administrators experimenting with the RCC (ratio of charges to cost) concept. He maintains that it is satisfactory provided the method is applied universally, and will probably be in use for some time.

Riggs, Thomas E. "Will Smaller Hospital Accounting Adequately Account to Medicare?" Hospitals, vol. 40, June 1, 1966, pp. 89-92.

Discusses the implications of Medicare for the accounting system in smaller hospitals. Four areas are examined: relation of hospital and physician charges, specific reimbursable costs, the concept of "reasonable" costs, and Medicare accounting and management information. To assist smaller institutions

in meeting Medicare's accounting requirements, the author suggests certain accounting methods, presents an accounting check list, and recommends use of the cost allocation program of the Hospital Administrative Service (HAS).

Seago, W. E. "Selecting a Medicare Reimbursement Formula." Journal of Accountancy, vol. 126, August 1968, pp. 31-41.

Compares the two methods used in determining hospital reimbursement--departmental and combination methods. When the average rate charged Medicare patients is higher than that charged all patients, the departmental method yields more reimbursement than the combination method, making it advisable for hospitals to switch formulas. Since a request for changing methods must be made before the end of the first month of the period for which the change is to be applied, the author concludes that management must be aware of information needs and plans during the previous year.

Sigmond, Robert M. "Hospital Effectiveness: A Complex Concept Promises Concrete Results." Hospitals, vol. 42, August 1, 1968, pp. 50-55.

Discusses the concept of hospital effectiveness in relation to the community, and recommends that hospitals (and organizations dealing with them) apply various incentives to make this concept an operational goal. Medicare's incentive reimbursement experiments are cited as a good opportunity to try out incentives for hospital effectiveness. The experiments involve no financial risks for hospitals, since the Government will meet additional costs resulting from them.

"'State Medicine' in Trouble in U.S." U.S. News and World Report, vol. 62, May 22, 1967, pp. 75-76.

Reports the financial difficulties of hospitals under Medicare and Medicaid. Article states that hospitals must charge other patients more ($1.31 additional per patient-day, in one hospital) in order to recoup losses on Medicare patients, who comprise one-third of all patients. Hospitals are asking that the 2-percent allowance over costs be raised to 10 percent.

Tebbel, George I., and Grothouse, Ralph H. "AHA's Cost Allocation Program--A Versatile Management Tool." Hospitals, vol. 42, November 1, 1968, pp. 52-56.

Discusses the development of Medicare reimbursement reports by the American Hospital Association's cost allocation program. CAP separates physicians' fees from other hospital revenues and expenses, calculates hospital reimbursement by both the departmental and combination methods, and calculates outpatient reimbursement for both Parts A and B. The author concludes that CAP is flexible enough to produce other third-party payer reimbursements from one set of input data.

Thompson, John D., et al. "Age a Factor in Amount of Nursing Care Given, AHA Study Shows." Hospitals, vol. 42, March 1, 1968, pp. 33-39.

Presents the results of the American Hospital Association's 1966 study of nursing activities in 55 short-term general hospitals, showing that aged patients receive more nursing care than non-aged patients. The scope and methodology are described. Nationwide estimates could not be made because the hospitals studied were not representative, and because of differences in the amount of services provided by other than nursing personnel.

Tierney, Thomas. "Government's Effect on the Delivery of Hospital Care." Best's Insurance News, vol. 68, August 1967, pp. 46-48.

Discusses three major aspects of the Medicare reimbursement formula, including a factor for creating new hospital capital within third-party reimbursement formulas, the relationship between hospital charges and costs, and the amount of nursing care required by aged patients. The author is director of the Social Security Administration's Bureau of Health Insurance.

U.S. Department of Health, Education, and Welfare. Social Security Administration. Reimbursement Incentives for Hospital and Medical Care: Objectives and Alternatives (Office of Research and Statistics, Research Report No. 26). Washington: U.S. Govt. Print. Off., 1968. 80 pp.

Includes five papers that discuss the historical and theoretical aspects of reimbursement and describe possible reimbursement plans. The topics covered are

the legislative history of reimbursements and the possibility of incentive reimbursements, the economic consequences of various incentive plans, a plan basing reimbursement on the average increase in cost for a control group in hospitals, a proposal granting a specified annual payment for each enrolled person to whom the hospital is obligated to provide services, and a capitation method for reimbursing the entire range of covered medical service.

Walsh, David W. "Prepayment and Reimbursement." Hospitals, vol. 42, April 1, 1968, pp. 135-138.

Reviews some of the 1967 literature on prepayment and reimbursement, including the following categories: planning and controls, reimbursement in relation to hospitals' financial needs, RCC (ratio of charges to cost) reimbursement method, and criticisms of the Medicare program. The author suggests concepts of areawide planning and incentive reimbursements be approached with caution, as planning authorities could use the former as a punitive measure, and hospitals could spend the accrued incentive rather than save it for capital expansion.

## 3. HOME HEALTH, EXTENDED CARE, AND PSYCHIATRIC SERVICES

American Medical Association. The Extended Care Facility: A Handbook for the Medical Society. Chicago, 1967. 167 pp.

Compiled to aid the medical profession in providing, supervising, and evaluating extended care. Several model utilization review plans with forms and outlines of procedures are presented. The appendix includes the Social Security Administration's definition of extended care, model patient transfer forms, and a listing of services available in extended care facilities.

"As Medicare Begins." Consumer Reports, vol. 31, June 1966, pp. 288-293.

Reviews Medicare benefits and the extent and type of supplementary private insurance plans available, and provides an economic analysis of the premium charges and benefits under alternative private health insurance plans. The article concludes that medical care for the elderly and medically needy of all ages will be available in the future regardless of ability to pay.

Baltz, Florence L., and Reardon, Ross A. "Medicare and Nursing Homes." Nursing Outlook, vol. 14, June 1966, pp. 55-56.

States that Medicare will affect nursing homes in the following areas: development of a common standard, public and professional acceptance, advancement of the theory of professional care, payment of reasonable costs for welfare patients, increased acceptance of coverage by private insurance carriers, and expansion of the nurse's role.

Bernstein, Leon. "Extended Care Facilities Report on Impact of Medicare." Modern Nursing Home, vol. 21, November-December 1967, pp. 82-85, 125.

Discusses the results of a survey undertaken to determine Medicare's effect on extended care facilities. Some of the findings were: the proportion of facili-

ties with 90-100 percent occupancy increased from one-half to two-thirds; about one-third of the facilities surveyed reported plans to expand; there has been an 18-percent increase in use of home health agency services by patients discharged from extended care facilities.

Buckley, John. "Medicare and Accounting." Accounting Review, vol. 41, January 1966, pp. 75-82.

Discusses Medicare's effect on health institutions accounting systems. A survey conducted by the California Department of Social Welfare showed that 74 percent of nursing homes had adequate but dissimilar records, while 26 percent had incomplete records. Concludes that several changes in methods may be necessary and that Medicare will lead to an emphasis on institutional accounting.

Cashman, John W., M.D. "Qualifying for Medicare." Nursing Homes, vol. 15, April 1966, pp. 20-23.

Outlines the conditions of participation for nursing homes under Medicare and provides detailed discussion of three requirements: the transfer agreement between the hospital and nursing home, the patient-care policy for medical and other services, and the utilization review procedure.

"The Effect of Medicare on 200 Home Health Agencies." Nursing Outlook, vol. 16, January 1968, pp. 42-45.

The major effects on the nursing services were increases in paper work, workload, caseload of elderly patients, staff, income, and costs. Recommended changes included elimination of the $50 deductible and 20-percent coinsurance under Part B, and reimbursement of medicine costs for nonhospitalized patients.

Elwell, Richard N. "Medicare--A Means for Merging Pathways to Service." Hospitals, vol. 42, February 1, 1968, pp. 61-64.

Contends that title XVIII could alter patterns of mental health services by assisting in the coordination of State and local programs. It suggests that utilization review of a total community would disclose two areas in need of development--programs for specific subgroups, and screening and referral programs.

"The Extended Care Paradox." Hospital Practice, vol. 1, November 1966, pp. 22-23.

Discusses the effect of Medicare on the quality of extended care. With certification requirements less stringent than originally intended, it is feared by the authors that elderly patients who previously would have convalesced in hospitals will now be transferred to extended care facilities with inferior services.

Gibson, Robert. "Medicare and the Maintenance of Treatment Standards." Mental Hospitals, November 1965, pp. 28-30.

Contends that Medicare may endanger standards in psychiatric hospitals, as follows: increased demand may lead to accreditation of substandard hospitals; requiring intensive treatment may exclude patients primarily in need of rest and a change of environment; utilization review may lead to insistence on the type of treatment involving the shortest hospital stay.

Hall, Madelyn. "The Indispensable Home Health Aide." Nursing Outlook, vol. 16, January 1968, pp. 38-41.

Describes the Medicare experiences of the Community Nursing Services of Philadelphia, which provides services of home health aides. Although the number of aides increased from 11 to 35 and the number of visits rose from 382 to 928 in the June 1966-June 1967 period, their visits to patients aged 65 and over increased from 70 percent only to 72 percent of the total, indicating that Medicare was not solely responsible for the increase. The article also describes source of financing, selection, training, and supervision of the home health aides.

Harvey, Elmer L. "Let's Change Medicare Because We Care." Professional Nursing Home, vol. 10, October 1968, pp. 8-11.

Discusses the present interpretation of "covered care" in an extended care facility. The major problem is inability of the admitting physicians, utilization committees, and fiscal intermediaries to agree on criteria for authorizing or denying the Medicare payment. The author recommends allowing Medicare beneficiaries a limited number of lifetime benefit-days in a qualified extended care facility, granting to the fiscal intermediaries full responsibility for determining Medicare payments, and reappraising the 3-day hospitalization requirements.

"How They Review Extended-Care Patients." Medical Economics, November 27, 1967, pp. 98-104.

Describes utilization review in nine extended care facilities of Montgomery County, Maryland, that were approved under Medicare. Results of the program include limitation of Medicare benefits to qualified patients, the increasing professionalism of extended care facilities, and the increasing awareness on the part of physicians of elderly patients' needs.

"Is Extended-Care Dollar Buying Its Money's Worth?" Hospital Practice, vol. 2, May 1967, pp. 20-21.

Discusses the misuse of Government funds by nursing homes, indicating that low quality care is not always attributable to lack of funds. Inadequate policing results in some fraud, such as obtaining household supplies for nursing homes under the guise of "drugs." Also discussed are problems resulting from the attempt to link Medicare standards for nursing homes to Medicaid, which may result in a lowering of Medicare standards.

Lipscomb, Wendell R. "The Impact of Medicare on Psychiatry." The American Journal of Psychiatry, vol. 124, January 1968, pp. 910-918.

Discusses the positive impact of Medicare on the psychiatric profession. The author maintains that Medicare should result in a more accurate classification of mental illness, intensive treatment rather than custodial care, and the acceptability of insuring against mental illness.

Maureen, Sister, O.S.F., R.N. "The Impact of Federal Legislation on Home Health Services." American Journal of Public Health and the Nation's Health, vol. 57, July 1967, pp. 1147-1152.

Describes the community coordinated home care program based at St. Francis Hospital in Honolulu, and how it has been affected by Medicare. The demand for home care services has not risen as much as anticipated, due perhaps to the provision of care by plantation owners for whom many of the islanders work. According to the author, the new Federal health care legislation will promote expansion of services with which private and public health agencies collaborating in community health programs must attempt to keep pace.

Maxwell, Virginia B., and Woodward, Lowell H. A Descriptive Study of the Characteristics and Flow of ECF Patients in Montgomery County, Maryland, January 1, 1967, Through June 30, 1967. Montgomery County Health Department, 1968. 21 pp.

Reports on a study of extended care admissions, showing the patient-flow to be from hospital to extended care facility to home. The impact of Medicare is that patients having certain diagnoses that previously would have kept them in hospitals are now being sent to extended care facilities; proportionately more patients in the 65-74 age group are using extended care facilities.

Moss, Frank E. "Extended Care Benefits Under Medicare: Implications for Hospitals and Nursing Homes." Hospitals, vol. 41, January 16, 1967, pp. 49-52.

Discusses the major differences between extended care facilities and nursing homes, and describes some of the problems involved when nursing homes apply for participation under Medicare. The author suggests that hospitals assume the responsibility for setting standards through the transfer agreements.

"NOW: More Help for Old People." U.S. News and World Report, vol. 26, January 9, 1967, pp. 60-62.

Describes some problems involved in providing enough extended care beds to meet the increasing demand created, in part, by the tight money situation and the increasing shortage of nurses.

Penchansky, Roy. "Changes in Nursing Homes: Legislative Pressures and Institutional Barriers." Nursing Homes, vol. 14, November 1965, pp. 17-33.

Contends that Medicare will result in improved nursing home care. Hospitals through increased utilization will be led to seek association with good extended care facilities. Certification requirements provide a standard of care for nursing homes but hindrances to their improvement include the different types of patient care they provide, the small size of many of them, and small per-diem welfare payments that require nursing homes to meet only minimum standards.

"Rep. Hall Cites Defects in Extended Care Plan." Geriatric Times, vol. 2, June 1968, pp. 1, 6, & 10.

Cites weaknesses in Medicare's planning for extended care facilities, contending that the number of available beds was grossly overestimated: 5 months after the effective date of the extended care program, the 3,957 nursing homes qualified for participation had a capacity of only 281,000 beds--70,000 short of projected needs. Congressman Durward Hall, Representative from Missouri, who is also a physician, recommends revising certification requirements, simplifying reimbursement formulas, and upping reimbursement schedules.

Stotsky, Bernard. "Aftercare Without Fanfare." Journal of the American Geriatrics Society, vol. 15, October 1967, pp. 901-907.

Describes, within historical framework, problems concerned with aftercare for psychiatric patients. The recent trend has been to transfer patients from State hospitals to local nursing homes that generally are ill-equipped to provide psychiatric care. Medicare's limitations in this respect are that it may force psychiatric patients out of nursing homes without providing for their treatment exclusively by psychiatry, according to the author.

-----, et al. "Medicare: A Disaster for the Aged Psychiatric Patient?" Journal of Psychology, vol. 67, November 1967, pp. 341-345.

Presents the results of a study of 18 psychiatric patients in three nursing homes that qualified as extended care facilities under Medicare, and 88 patients in 13 nursing homes that did not qualify. The effects of qualifying nursing homes as extended care facilities include: the transferred patients experience feelings of depression and insecurity; mental hospitals are forced to use substandard homes for long-term patients; nurses must sacrifice patient-care time to attend to increased paper work.

U.S. Department of Health, Education, and Welfare. Financing Care of Mentally Ill Under Medicare and Medicaid: A Report

to the House Committee on Ways and Means and the Senate Committee on Finance (an interim report), December 1968. 40 pp.

Provides some background information on the extent of mental illness in the U.S., a description of the legislative history of psychiatric benefits under Federal programs, data on participating hospitals under Medicare and State participation under Medicaid, an outline of both programs' coverage of psychiatric benefits, and a description of sources of forthcoming data and questions useful in evaluating the psychiatric benefit limitations under Medicare and Medicaid.

-----. Public Health Service. "Home Health Agencies After One Year of Medicare: Report of a Conference, September 14-15, 1967." 50 pp.

Discusses the problems of home health agencies relating to organization, administration, personnel, financing, evaluation responsibility, provision of services, and the relationships of these agencies to the community, physicians, and other home health agencies. Recommended solutions include clarifying home health benefits, incorporating home health services into voluntary individual and group health insurance plans, and implementing a utilization review of home health agencies.

Witkin, Erwin, M.D. "Medicare and the Future of Health Services." Journal of the American Geriatrics Society, vol. 16, September 1968, pp. 999-1004.

Evaluates the program as it approaches the end of its second year. Medicare has provided the elderly with effective demand for health care; has produced a 15- to 20-percent increase in utilization of inpatient services by the elderly, and a 5-percent increase in total utilization; and has helped to secure adequate hospital financing and to develop progressive levels of care. A major problem in the delivery of health services cited by the author is the health manpower shortage, estimated at 1,000,000 persons.

Wolff, Howard. "What Home Care Means to Physicians." Medical Economics, April 17, 1967, pp. 76-80.

Describes the successful experiences of Kent County Memorial Hospital in Warwick, Rhode Island, in an experiment on providing extended care services in

the patient's own home. Doctors found that they are not unduly inconvenienced by the necessity of extra home calls and that their patients improved more rapidly than they did before the experiment was begun.

## 4. PHYSICIANS' SERVICES

"AMA Sticks to Its Reservations About Medicare at Clinical Meeting: A Special Report." Hospitals, vol. 41, January 1, 1967, pp. 21-23.

Reports on a clinical session of the AMA House of Delegates in November 1966, during which members voiced their resentment against Medicare and their concern over the hospital's role in the delivery of medical care. The agenda included a reiteration of the resolution to defend the private fee-for-service practice; an assertion that billing as a part of hospital costs, or billing by the hospital, is unethical; and a statement of legal complications of anti-trust action. The delegates also expressed their unhappiness over the requirement for certification and recertification of medical necessities, and the prohibition of direct billing for title XIX recipients.

Chase, Edward T. "The Doctor's Bonanza." The New Republic, vol. 157, April 15, 1967, pp. 15-17.

Discusses Medicare's impact on the nation's health care system, stating that the two largest changes are the increase in doctors' fees and the rise in hospital daily service charges. According to the author, Medicare highlights the need for group practice to overcome America's shortage of doctors, and for establishment of compulsory national health insurance to underwrite increasingly expensive health care.

Colombotos, John. "Physicians' Attitudes Toward Medicare." Medical Care, vol. 6, July-August 1968, pp. 320-331.

Examines the relationship between physicians' attitudes toward Medicare and their political ideology, geographic location, age, specialty, and religious affiliation, based on interviews with 1,205 private physicians in New York State in late 1964 and early 1965. At that time, Medicare (hospital insurance only) was favored most by political liberals, city practitioners, older physicians, psychiatrists, and Jewish doctors. The author concludes that other areas worthy of investigation are the relationship

of medical societies to the attitudes of their members, the possibility of predicting changes in attitude, and the effect of attitude on performance of the program.

Cox, C. Jeffrey. "Medicare Shakes Up the Outpatient M.D.'s." Medical Economics, vol. 44, July 10, 1967, pp. 111-115.

Discusses the collection of Medicare fees for outpatient visits. The author maintains that Medicare has not reduced hospital outpatient visits as expected because the physicians have been reluctant to relinquish the clinic's teaching cases, and because many elderly people continue to seek treatment at an outpatient clinic out of habit. The task of collecting fees is thought to be the main reason physicians forego payment. The author suggests one solution is for hospitals to collect, pool, and distribute fees among the doctors who work in the outpatient department.

"Doctors, Money, and Medicare." Medical Economics, October 16, 1967, pp. 237-246.

Summarizes the remarks of a physician (Dr. William Nolan, a Litchfield, Minn., surgeon) before a subcommittee of the Senate's Special Committee on Aging. According to Dr. Nolan, physicians treating welfare and Medicare patients tend to employ unnecessary procedures and treatments. He feels that the success of Government regulation hinges on a change in their view that "Government money is nobody's money."

Dwyer, William A., Jr., M.D. "The Assault on Your Medicare Fees." Medical Economics, March 6, 1967, pp. 109-111.

Refers to the reassignment of physicians' Medicare and Medicaid fees to the general funds of hospitals. The Social Security Administration allows reassignment only if the fees are earmarked for a specific purpose. Before reassigning fees, doctors should consider that they retain malpractice liability for patients and tax liability for fees. The author feels that while physicians should resist pressures for reassignment, they should not reject outright requests for their fees.

Goldberg, Joel. "How Staff Doctors Are Faring Under Medicare." Hospital Physicians, August 1966, pp. 81-89.

Discusses the operation of Medicare during the early months of the program. Hospital admissions were near normal; outpatient admissions rose; paper work was not a severe problem; radiologists and pathologists were able to work out billing agreements with their hospitals.

Kennedy, Alan. "Is Medicare Triggering Fee Revisions?" Medical Economics, vol. 43, May 30, 1967, pp. 42-51.

Cites the most common circumstances under which fee revisions occurred. Medicare prompted physicians who had not put their fee schedules in writing to do so, those charging substandard fees to revise them upward, and those concerned about future controls to raise fees lest they be unable to do so in the future. The author points out that the fee increases of 14-33 percent were not exorbitant, asserting that since physicians were slow to raise fees, they needed to make large increases to get in line with the economy.

Lea Associates, Inc. "The Current Impact of Medicare on U.S. Private Medical Practice." National Disease and Therapeutic Index, Medical Report No. 24, Ambler, Penna.: The Associates, January 1967, 5 pp.; and No. 25, May 1967, 5 pp.

Two reports that compare data on the number of patient visits to private practitioners during the first 6 and 9 months of the Medicare program, with those for the previous year. Although medical visits for patients aged 65 and over increased about 10 percent (from about 20 million to 22 million a month) between 1965 and 1966, total patient visits showed no increase. Office visits of the elderly did not increase, but institutional visits increased about 20 percent. Greatest increases occurred in urology, general practice, and otolaryngology, each averaging at least 3 additional visits per week per physician for patients aged 65 and over. Visits for many of the diagnoses relating to elderly patients also increased significantly.

-----. "The Impact of Medicare on Current Private Medical Practice." Ambler, Penna.: The Associates, October 1968. 8 pp.

Reports that visits by aged patients in the year ending June 30, 1968 were up 30 million over the number for the 12-month period prior to the implementation of Medicare, 2 years earlier. While practically all of the increase during the program's first year reflected visits in institutions, during the second year most of the increase represented visits outside the hospital. Statistics on the volume of visits by diagnosis show that some categories have continued to show an increase since June 30, 1968. Use of drugs by the aged has risen since Medicare benefits became available.

-----. "U.S. Private Medical Practice in 1970 and the Expected Impact of Medicare." National Disease and Therapeutic Index, Medical Report No. 23. Ambler, Penna.: The Associates, 1966. 27 pp.

Presents 1966 estimates of Medicare's impact on private practice by 1970 and its implications for medical education. The report predicts that aged-patient/physician contacts will be 20 percent above normally expected levels in institutions and 10 percent higher in offices; hence, 8,000 more general practitioners and 13,000 more internists will be needed, and significant personnel increases in opthalmology, urology, and osteopathy can be expected.

Marmor, Theodore R. "Why Medicare Helped Raise Doctors' Fees." Trans-Action, vol. 5, September 1968, pp. 14-19.

Contends that the Medicare formula itself and the laxity of its administration prompted physicians to raise fees. Some increased their fees in anticipation of Medicare because of the low level of their fees compared with those of other doctors in the area, and others out of concern that "customary" fees would be binding for years to come. Increasing prices and the question of medical-care quality will, in the author's opinion, continue to be problems for Medicare.

McClure, William. "Medicare Means $7,200 More For Me." Medical Economics, September 4, 1967, pp. 156-164.

Deals with the income of a physician whose case is representative of rural doctors. Prior to Medicare,

his practice netted $14,000 annually from a gross income of $40,000, due to an excess of elderly and poor patients and substantial traveling expenses. By 1967 Medicare had raised his net income 50 percent and enabled him to provide his patients with better care.

"Medicare and Medical Inflation." Hospital Practice, vol. 3, November 1968, pp. 23-25, 29, 32.
"Medical Inflation: Is Medicare Victim or Culprit?" Hospital Practice, vol. 3, December 1968, pp. 22, 24-26.

A two-part series. The first article deals with the history, concepts, and implementation of the supplementary medical insurance portion of Medicare. It asserts that Medicare may have contributed to the recent medical price inflation and that, administratively speaking, Part B was 2 years premature because customary prevailing payment mechanisms were not implemented by most carriers until the end of 1968. The second article consists of an interview with Senator Clinton Anderson, who favored limiting Part B payments, and HEW Secretary Wilbur Cohen, who called for voluntary restraint on the part of physicians.

"Medicare's Economic Impact on Doctors" (a symposium). Medical Economics, vol. 44, July 24, 1967, pp. 102-131.

Attributes to Medicare the accelerated increase in doctors' fees--7.8 percent in 1966. Physicians participating in this panel discussion believe that Medicare has made doctors more fee-conscious--many have raised their rates and many itemize more frequently, resulting in larger bills. Doctors' incomes increased by about 10 percent over the last half of 1966 due to higher fees, payments by patients who formerly were not billed, and increased use of medical services by the elderly.

"Medicare Fee Review Today." Medical Economics, December 25, 1967, pp. 53-59.

Presents highlights of a roundtable discussion among fee review experts, including representatives from Medicare intermediaries and physicians in private practice. It was revealed that nearly 90 percent of Medicare claims are settled without any review, 10 percent are reviewed by the carriers, and less than 1 percent are referred to medical society review committees. The need for review usually arises out

of the physician's failure to provide sufficient information regarding procedures. The director of SSA's Bureau of Health Insurance, Thomas Tierney, pointed to the guidelines for carriers that suggest how individual fee profiles can be drawn up to determine prevailing charges in the locality.

"Only 52% of MD's Approve Medicare, Poll Finds." Geriatric Times, vol. 2, November 1968, pp. 1 & 10.

Contains the results of a survey of physicians in which 52.6 percent approved of the Medicare program, 42.1 disapproved of it, and 5.3 percent were undecided. Changes recommended by those polled ranged from reform in the basic eligibility requirements to fees and accounting practices.

Paxton, Harry J. "A Rising Source of Funds for Training." Hospital Physician, November 1968, pp. 48-51.

Summarizes findings of the periodical's 1968 survey of teaching hospitals regarding the use of Medicare and Medicaid fees, indicating that 19 percent of such hospitals reassign fees to training programs. Reassignment is found mainly in university-affiliated hospitals and in local and State government hospitals. Mandatory reassignment systems provide a greater yield than voluntary arrangements, but total yield depends upon the hospital's private-patient population.

Perkins, Woodbury. "Effects of Medicare and Title XIX on House-Staff Training Programs." Journal of the American Medical Association, vol. 201, July 31, 1967, pp. 310-313.

Presents the results of a study conducted in 46 California hospitals. The author believes that the movement of patients from public to private hospitals under Medicare and Medicaid has adversely affected training programs for interns and residents, and the surgical and obstetrical-gynecological services provided by these institutions. To improve conditions in the hospitals that have been thus affected, he recommends expanding the techniques for incorporating private patients into training programs.

Roth, Russell B. "Medical Ethics vs. Medicare." Medical Economics, June 12, 1967, pp. 79-84.

Discusses numerous ethical decisions doctors must make involving Medicare payments. These include possible over-utilization; admitting a patient to a hospital in order to qualify him for extended-care benefits; billing patients under Part B for procedures that residents perform; and allowing residents and interns to order expensive diagnostic tests, even though the senior physician is experienced enough to do without them. As financing the Medicare program becomes a greater burden, the author maintains, increasing attention will be paid to these matters.

-----. "Medicare: Its Problems for Practicing Physicians." Journal of the American Medical Association, vol. 197, August 1, 1966, pp. 347-359.

Discusses the detailed mechanics of the Medicare program, pinpoints areas of concern for individual practitioners, and outlines approaches to resolving the difficulties. Among the problem areas covered are recertification requirements, utilization review, "reasonable charges" and "spell of illness" concepts, reimbursing physicians, covered services, the effect of fewer aged charity patients on postgraduate medical education, health insurance coverage for the total aged population, and the use of statistical data for regulatory purposes.

Scholten, James R.; Rubin, Ronald; and Lewis, Charles E. "Medicare and Medical Students." Journal of the American Medical Association, vol. 197, August 1, 1966, pp. 111-116.

Discusses a study of medical students' attitudes toward Medicare and their knowledge of the program. While 80 percent of the respondents possessed some knowledge of how the program operates, the majority of them were critical of it. The authors suggest that the universities provide more instruction about Medicare, thus enabling their students to make rational decisions based on factual data.

Scott, David G., M.D. "We Doctors Were Wrong About Medicare." The Saturday Evening Post, February 24, 1968, pp. 12 & 16.

A young doctor's defense of Medicare, in which he cites such positive contributions of the program as improvements in the U.S. health standard, a furthering

of the study of geriatrics, increasing physicians' incomes, and extending medical education. Among Medicare's deficiencies, he lists the threat of Government control and the possibility of patient abuse.

Walter, Charles. "Collect Medicare Fees for Service Work?" Medical Economics, February 6, 1967, pp. 25-33.

Discusses the question of whether service work covered under Medicare should be billed for or treated as conventional charity care. In some hospitals, physicians have formed corporations to collect such fees on assignment; in others, the individual physicians collect them. Many want their fees turned over to the hospitals. The author concludes that the concept of charity service will probably disappear within a generation.

"What Doctors Think of Medicare." U.S. News and World Report, vol. 65, July 22, 1968, pp. 34-36.

Summary based on interviews conducted at the American Medical Association's 1968 convention. The consensus was that the program is too costly, involves too much paper work, and adds substantially to hospital, physician, and nursing workloads.

## 5. PRIVATE HEALTH INSURANCE

Beier, Emerson. "Adapting Group Health Insurance to Medicare." Monthly Labor Review, vol. 89, May 1966, pp. 491-495.

Describes private health insurance approaches. The advantages and drawbacks of several plans, including supplemental, offset, and indemnity insurance are discussed. Problem areas are administrative complexity and cost, possible overutilization resulting from duplicate coverage, and questions in company plans, such as who pays the premiums and what to do with retired employees under age 65 and active employees over age 65.

Harmon, Edwin L. "Third-Party Payment Increases Utilization of Home Care Services." Hospitals, vol. 42, September 1, 1968, pp. 68-72.

Assesses the effect of third-party coverage, asserting that it has stimulated the growth of home care programs, that it will be the major source of payment for home care in the future, and that it should result in decreased cost of care. The author suggests that the Government encourage participating home care programs to broaden their services.

Jesmer, Shirley, and Scharfenberg, Robert J. "The Use of Hospitals by Blue Cross Members in 1967." Blue Cross Reports, vol. 6, December 1968, 11 pp.

Describes Medicare's effect on enrollment in and utilization under Blue Cross plans. By the end of 1967, 5.1 million aged had enrolled in Blue Cross' complementary coverage to Medicare. Between group and nongroup complementary coverage, there was no significant difference in the inpatient admission rate for the deductible and co-payment portion, nor in full-pay days covering stays beyond 90 days. The rate of inpatient days under nongroup was 13 percent higher than under group, while for outpatient visits the rate for group was 23 percent greater than for nongroup.

Kittner, Dorothy R. "Negotiated Health Benefits and Medicare." Monthly Labor Review, vol. 91, September 1968, pp. 29-34.

Discusses the benefits for active and retired workers available through 98 negotiated plans in 1968. Almost all plans for retirees have been adjusted in the light of Medicare. The different methods of providing health benefits, the benefits available, and the means of financing retirees' benefits are described.

"Medicare's Effect on Health Insurance." U.S. News and World Report, vol. 60, April 11, 1966, pp. 42-44.

Describes the new health insurance coverage provided by private insurance companies and by industrial firms to their workers, retired and active, after Medicare. Most insurance companies are offering policies that fill the gaps left by Medicare; in some cases they also extend hospital coverage past the 90th day. Some companies are dropping coverage for retired workers, others offer supplemental benefits, and still others are paying the $3 monthly premium for retired workers.

Schwartz, Jerome L. Medical Plans and Health Care, Springfield, Illinois: Charles C. Thomas, 1968, 349 pp.

Contains a section devoted to Medicare's effect on group-practice prepayment plans, including those that deal directly with SSA and others that work through carriers, the benefits provided, difficulties encountered with reimbursement, and changes in regulations requested by group plans. The author recommends the appointment of a non-professional aged consumer to the Health Insurance Benefits Advisory Council, allowing group plans to be reimbursed on a capitation basis and to serve as carriers, and the elimination of Medicare deductibles.

Segal, Martin E. "Will Medicare Kill Off Private Insurance?" Medical Economics, vol. 45, April 15, 1968, pp. 225-231.

Foresees high insurance premiums for two reasons: protection is being broadened to compete with Medicare and Medicaid benefits, and the increases in medical care costs have been alarming. If Medicare were to be financed through general revenue taxes, the author feels, its real cost would be obscured, causing consumers to regard private insurance as the less desirable alternative.

Shinn, R. R. "The Impact of Federal Legislation on Private Health Insurance." Best's Insurance News, vol. 67, May 1967, pp. 38-42.

Discusses the effects of Medicare on the private insurance field. As carriers under the program, insurance companies have experienced administrative difficulties, especially with Part B, and these problems are likely to continue if Congress frequently changes the benefits. According to the author, the private health insurers have felt the pressure from better Medicare benefits and have had difficulty creating appropriate "tie-in" plans. On the other hand, they have profited from the movement to standardize billing procedures.

"The Day Medicare Stopped." The Spectator, vol. 175, April 1967, pp. 46-48.

Presents the findings of a survey to determine the types of additional hospital insurance elderly people would prefer to supplement Medicare benefits. Thirty-five percent preferred a $25,000 reserve plan to pay most hospital costs not covered by Medicare, and to pay after Medicare benefits stop on the 91st day; 23 percent preferred a cash indemnity plan; 21 percent desired a plan to cover out-of-hospital costs such as drugs; and 14 percent preferred a Blue Cross type "gap-filler." It was found that the desire to purchase additional coverage among the elderly is related to activity in organizations, family approval, and the sex of the individual.

"The Use of Hospitals by Blue Cross Members in 1966." Blue Cross Reports, vol. 6, March 1968, 11 pp.

Includes data for the last 6 months of 1966 on Blue Cross coverage sold to complement Medicare. Enrollment totaled 4.8 million, with 30 percent under group and 70 percent under nongroup coverage. The differences between group and nongroup as to rates of inpatient admissions and full-pay days for stays beyond 90 days are too small to be significant, according to the report. The rate of inpatient days was 16 percent greater and the rate of outpatient visits 19 percent greater under group than under nongroup contracts.

Walter, Charles. "Thank Medicare: Better Blue Shield Fees." Medical Economics, January 9, 1967, pp. 17, 20-23, 26-27.

Asserts that Blue Shield plans have clung to outdated fees and unrealistic full-service income levels for the past 20 years. Realizing the superiority of the Medicare benefit package, the under-age-65 population and big purchasers of group contracts are applying pressure to Blue Shield, according to the author. Some of the demands include the elimination of fee schedules and income limits for paid-in-full-benefits, and the coverage of office and house calls.

Weeks, David A. "The Effect of Medicare on Retiree Health Insurance." Conference Board Record, vol. 4, January 1967, pp. 13-24.

Discusses the effect of Medicare on the health insurance benefits provided to retired workers by their former employers. The analysis includes the number of companies that provided insurance benefits before and after the implementation of Medicare; the types of benefits; and the influence of previous company benefits, type and size of company, type of insurance carrier, and union demands on the type of new benefit.

## 6. PUBLIC POLICY AND ISSUES

Advisory Council on Health Insurance for the Disabled. Health Insurance for the Disabled Under Social Security: Report of the Advisory Council on Health Insurance for the Disabled. Washington: U.S. Govt. Print. Off., 1969. 44 pp.

Recommends extending Medicare to disabled beneficiaries because of their high health costs and low incomes, and their inability to secure private insurance. It favors reducing the waiting period to 3 months, lowering the eligibility age to 55 years, and broadening the definition of disability. The cost is estimated at $1,520 million for hospital insurance and $780 million for medical insurance. Appendixes contain the actuarial report on cost estimates and the 1966 social security survey of disabled adults.

Chase, Edward T. "Crises in Medicine." Commonwealth, vol. 85, March 10, 1967, pp. 650-653.

Cites Medicare and Medicaid as responses to the need for better health care in the United States, stating that, while Medicaid has begun slowly, Medicare in 1 year of existence revolutionized health care for the aged. The major problem now is a shortage of personnel, especially doctors. According to the author, the American Medical Association has sought to deny this need but will be unable to do so in the future as increasing Government programs and demands for services bring the failures of the health-care system into focus.

Cohen, Wilbur J. "The Impact of Medicare." Geriatrics, vol. 21, July 1966, pp. 149-154.

States that Medicare will have an impact not only on the elderly, but on all segments of the Nation. The author, who later served as HEW Secretary, predicted that the program would contribute to increases in health expenditures; change concepts in private health insurance, utilization, and community planning; affect the structures of hospitals, nursing homes, and home health services; emphasize the need for more health manpower and for improved medical care; involve

physicians more actively in health planning, increase their incomes, and probably make geriatrics a recognized field; and make possible extensive research into health resources and utilization of services.

Dearing, W. P. "Medicare--Its Meaning to the Consumer." Journal of the American Geriatrics Society, vol. 14, November 1966, pp. 1087-1094.

Predicts that Medicare will have an enormous and varied impact on the consumer of health care. Care will be more comprehensive, with greater emphasis put on preventive measures. The author maintains that, in view of this, the deductible feature should be reconsidered since it is designed to protect against loss and therefore does not fit in with the concept of prevention. He also feels that prepaid group-practice plans should be extended in the future.

"Dimensions and Determinants of Health Policy." The Milbank Memorial Fund Quarterly, vol. 46, January 1968, Part 2. 272 pp.

A series of papers presented at a health policy seminar sponsored by the Institute for Policy Studies. Topics discussed were basic determinants of medical care, hospital costs, health manpower, health planning, the power structure in health, the medical school's role, the public-private expenditure mix in health, the Municipal Hospital Affiliation Plan in New York City, the delivery of personal health and medical services for the poor, public policy issues concerning the organization and delivery of personal health services, and the health agenda for the future.

Egeberg, Roger O., M.D. "The Effect of the Changing Environment of Health Care on Educational Programs." Journal of Medical Education, vol. 42, October 1967, pp. 971-973.

Speculates on the future of hospital care and medical education in relation to titles XVIII and XIX, based on the author's personal experience of conditions in Los Angeles. In his view, the decline of charity patients may result in fewer cases for medical training. He predicts the outflow of patients from public hospitals to be only temporary. The author also describes the Los Angeles County Hospital's experience in establishing a simplified billing procedure for services under titles XVIII and XIX.

Feingold, Eugene. Medicare: Policy and Politics. San Francisco: Chandler Publishing Company, 1966. 310 pp.

A study of the evolution of Medicare and the major philosophical issues involved. The author presents background essays, supplemented by original source material written by the participants in the Medicare debate. These include excerpts from testimony by representatives of the American Medical Association before the House Ways and Means Committee in 1961 and 1962 on the King-Anderson bill, and a rebuttal by Congressman King; attacks by various individuals on the social security method of financing health care and on Government financing, and responses by Wilbur Cohen; sections on the special problems of the aged, various solutions to the aged's health needs, the legislative history of Medicare, the financing of Medicare, and the role of Government. Also included is a summary of most of the health care bills brought before Congress since the Forand bill was introduced in 1957.

Greenfield, Margaret. Medicare and Medicaid: The 1965 and 1967 Social Security Amendments. Berkeley: Institute of Governmental Studies, 1968. 143 pp.

Section treating various aspects of the Medicare program discusses hospital and medical insurance benefits; program financing and administration; the program's effects on expenditures for health care, other Federal health programs, and the insurance and health industries; and Medicare's shortcomings in the areas of outpatient drugs, routine physical examinations, deductibles and coinsurance, and post-hospital extended care. The author discusses factors underlying the need for a Federal program--mainly the inadequacy of voluntary insurance and public assistance to provide medical cost coverage. Descriptions of the various health insurance proposals preceding the implementation of title XVIII are also given.

Harris, Richard. A Sacred Trust. New York: New American Library, Inc., 1966. 218 pp.

Traces the political and legislative history of Medicare from Louis Brandeis' introduction of the health insurance concept prior to World War I, through its progress during the Roosevelt, Truman, Eisenhower and Kennedy administrations, to its acceptance as incorporated in the King-Anderson bill. Throughout the book, special emphasis is placed on the role played by the American Medical Association.

"Hospital, Medical Costs and Crises." Public Health and Public Responsibility: The Task Before Us, Report of the New York State Joint Legislative Committee on the Problems of Public Health and Medicare, March 1967, pp. 55-80.

A chapter on the hearings on rising hospital and medical costs, conducted by the committee. Data on non-Government general hospitals in 17 counties of Southeastern New York showed that per-diem cost of patient care increased 12 percent in 1966, and that 49 percent of the increase in hospital expense between 1960-65 can be attributed to salaries. Possible effects of Medicare cited in the report are leveling of variations in hospital occupancy and reduction of per-diem costs, while increasing the public's total hospital-care expenditures; moving toward one level and system of care by eliminating the difference between the private and public patient.

Hudson, Charles L. "Looking Ahead in Medicare and Business." Vital Speeches, vol. 33, May 15, 1967, pp. 465-468.

Sets forth the basis of the American Medical Association's opposition to Government-financed health care for the aged and for the total population. The author maintains that preservation of the individualistic ethos is necessary to medicine's progress and that doctors have a moral obligation to provide better health care in areas where it is now lacking.

"Impact of Governmental Programs on Public Hospitals: A Conference Report." Public Health Reports, vol. 82, January 1968, pp. 53-60.

Discusses the public's images of hospitals, what goals should be set to alter these images, and how these goals can most effectively be achieved. Now that the medically needy are offered a choice between the public and private hospitals through Medicare and Medicaid, hospitals must strive to eliminate the stereotype of a double standard of care.

"An Interview with Robert M. Ball." Hospitals, vol. 41, January 1, 1967, pp. 46-52.

Reports on Medicare's first 6 months touching upon a general evaluation, public attitudes, reimbursement problems, compliance with title VI of the Civil Rights Act, and the Miller amendment. The following

were cited as factors in keeping Medicare financially sound: anticipation of higher than average increases in hospital costs being calculated into the payroll tax; the natural increase in Medicare's funds with each rise in wages; an expected congressional action to increase the wage base; and shorter hospital stays, on the average, resulting from increased utilization of extended care facilities.

Jacks, Margaret H. "Impact of the Social Security Medical Amendments at State and Local Levels." Economic Leaflets, vol. 26, July 1967, Part I. 4 pp.

Discusses title XVIII provisions in relation to State and local programs. According to the author, Medicare provisions for use of extended care facilities have failed to relieve States and counties of the financial responsibility for long-term institutional care of the chronically ill aged; the payment differential between long-term institutional care and post-hospital (convalescent) care may lead to a deterioration of standards in long-term facilities; the deductible and coinsurance features of both Parts A & B constitute real hardships for the indigent aged.

Liberman, Aaron. A National Study of the Opinions of Hospital Administrators about the Medicare Program. Health Care Research Series, No. 6. Iowa City: University of Iowa, 1968. 51 pp.

Explores extent to which a hospital administrator's conservatism, age, political affiliation, geographical location, economic attainment, educational level, length of time as an administrator, and size of hospital influence his opinions on Medicare. A significant relationship was found except in regard to party affiliation, level of education and position tenure. Details on the study's limitations, the sample size and selection, and the method of collecting and collating the sample data are provided.

Peterson, Paul Q., M.D. "The Impact of Recent Federal Legislation on Personal Health Services." American Journal of Public Health and the Nation's Health, vol. 57, July 1967, pp. 1091-93.

Discusses the necessity of providing quantity and quality medical resources in order to implement the 1965 Social Security Amendments. Medicare has

provided an impetus to the upgrading of health care. The author states that cooperation among the Public Health Service, the Social Security Administration and the Welfare Administration is required for efficient delivery of health services. Surveys in Pennsylvania and Illinois are cited as indicating good working relations.

"Protecting Care Quality, Finding Manpower Seen as Highest Hurdles in Medicare Era." Hospitals, vol. 40, December 16, 1966, pp. 121-124.

Highlights views on Medicare's potential and problems that were presented at the American Public Health Association's 1966 meeting. Anticipated difficulties related to increasing and reallocating manpower, assuring high laboratory standards, and assessing the quality of medical care. Developing a comprehensive program for accrediting all types of community health services and raising health care standards were cited as opportunities afforded by Medicare.

Radovsky, Saul S., M.D. "The Advent of Medicare." The New England Journal of Medicine, vol. 278, February 1, 1968, pp. 249-252.

Considers the history and consequences of Medicare, expressing the view that, while organized medicine's resistance prevented a less sensible program, it also diminished the profession's capacity to influence the course of events. Medicare, according to the author, has resulted in better and more frequent medical care for the elderly, but in doing so has made more acute the shortage of doctors and overcrowding of hospitals.

Roemer, Milton I., M.D., and Anzel, Daniel M. "Health Needs and Services of the Rural Poor." Medical Care Review, vol. 25, May 1968, pp. 371-390; and June 1968, pp. 461-491.

Examines the rural poor's health needs and the programs serving them, and provides some recommendations. Medicare is expected to have less impact on rural than on urban aged. Limiting factors are lower enrollment in Part B, failure of rural hospitals to comply with the Civil Rights Law, and Medicare's deductible and coinsurance features. Despite implementation problems, the authors advocate extending Medicare's principle to cover all age groups, as one solution to the rural population's health care problems.

U.S. Congress. Senate. Committee on Finance. Social Security Amendments of 1967. Hearings, 90th Cong., 1st sess. Washington: U.S. Govt. Print. Off., 1967. 3 parts.

Interspersed with testimony on the Medicare program by Administration spokesmen and representatives of interest groups. Among the changes proposed were coverage of the disabled, broadening of hospital benefits, inclusion of more services, experimenting with reimbursement methods, dropping of inpatient X-ray coinsurance, consolidation of hospital outpatient visits under Part B, and changing the contribution rate for hospital insurance.

----- ----- -----. Social Security Amendments of 1967: Comparison of H.R. 12080 As Passed by the House of Representatives, With Existing Law. (90th Cong., 1st sess.) Washington: U.S. Govt. Print. Off., 1967, pp. 3-5, 24-29.

Contains the committee's final recommendations, a summary of the changes in the legislation, and a discussion of the factors behind them. Recommended modifications (which numbered over 25) relate to Medicare's benefits, administration, operation, and possible extension. Committee recommendations for a higher contribution rate and taxable base, as well as estimates of the trust funds' future actuarial position, are presented.

----- -----. Special Committee on Aging. "Impact of Medicare." Chapter 3, Part I, of Developments in Aging, 1967. (S. Rept. No. 1098, 90th Cong., 2d sess.) Washington: U.S. Govt. Print. Off., 1968, pp. 39-48.

Discusses Medicare's achievements, shortcomings, and impact on the Nation's health care system. On the positive side, the report asserts, Medicare has raised the quality of care, generated an awareness of the need for areawide planning of health resources, and encouraged physicians to specialize in geriatrics. On the negative side, the report focused on excluded services, deductible and coinsurance features, physician reimbursement, and on the 3-day hospitalization requirement for extended care and home health benefits which the committee recommended be suspended.

U.S. Department of Health, Education, and Welfare. Feasibility Study on Preventive Services and Health Education

for Medicare Recipients: A Report to the Congress, December 1968. 31 pp.

Concludes that coverage of comprehensive health screening and other preventive services would be infeasible at present due to administrative constraints, inability to estimate costs, limited experience with automated multiphasic health screening, and an inadequate supply of health professionals. Some of the recommendations were to allow reimbursement for tests that are part of good patient-care management; to consider further the inclusion of comprehensive health screening; for the Department to initiate a health education program for the aged; and for SSA to expand its information activities. The report includes a bibliography on preventive services, and health education and information.

-----. Independent Practitioners Under Medicare: A Report to Congress. December 28, 1968. 308 pp.

Concerns inclusion under Medicare of the services of additional types of independent licensed practitioners. It recommends that coverage of occupational therapists, clinical psychologists, social workers and speech pathologists (working within organized settings certified for participation) be expanded; that coverage not be extended to include physical therapists practicing independently; that coverage of optometrists, audiologists and corrective therapists not be expanded at this time; and that coverage not be extended for naturopathic and chiropractic services.

-----. Relating Social Security Protection to the Federal Civil Service: A Report Requested by the Committee on Ways and Means, U.S. House of Representatives, and the Committee on Finance, U.S. Senate. January 1969. 76 pp.

Deals with the problems precluding social security coverage of most Federal Government employees. The following recommendations were made: where no benefit eligibility has been established, credits would be transferred from the staff-retirement system to social security; where benefit eligibility has been established, the staff-retirement benefits would be as high as social security benefits; Federal employees would contribute toward health insurance protection during their working years and the Government would make available complementary health insurance that, together with Medicare, would provide protection at the level of the present Government-wide high-option plans.

-----. A Report to the President on Medical Care Prices. Washington: U.S. Govt. Print. Off., 1967. 38 pp.

Discusses factors contributing to sharp increases in medical care prices in 1966 and recommends various Government actions to moderate the price rise and to increase efficiency in medical care delivery. The report examines the long- and short-run factors influencing hospital daily service charges and physicians' fees. Some suggestions for Government action involve developing comprehensive community health care systems, encouraging prepaid group practice, developing cost-reducing methods of delivering hospital services, and using Federal funds to effect innovations in education for the health professions.

-----. Task Force on Prescription Drugs. Approaches to Drug Insurance Design. Washington: U.S. Govt. Print. Off., February 1969. 95 pp.

Reviews the major considerations in designing a Government insurance program to cover outpatient prescriptions for Medicare beneficiaries. Primary areas include the scope of benefits, program financing, reimbursement methods, program administration and data requirements, drug classification and coding, utilization review, and cost estimates. Alternate proposals are presented with their advantages and disadvantages.

----- -----. Current American and Foreign Programs. Washington: U.S. Govt. Print. Off., 1968. 205 pp.

Investigates selected characteristics of current drug programs of the Federal Government, 12 State governments, 6 private programs, and 13 foreign governments. The characteristics include general program features, determination of beneficiary eligibility, drug benefits provided, program size, method of reimbursement, cost control, agreement of participation, audit and review procedures, drug lists and drug pricing, claim processing, use of electronic data processing or manual procedures, and administrative costs.

----- -----. The Drug Makers and the Drug Distributors. Washington: U.S. Govt. Print. Off., December 1968. 85 pp.

Surveys the pharmaceutical industry, and the retail and wholesale distribution system for prescription

drugs. The areas scrutinized are industry concentration and market structure, research and development, production and quality control, marketing, pricing systems, patents and trademarks, and profitability. The report discusses the cost components of the industry sales volume of $5.1 billion in 1967, the complex price-discounting system and the effect of time on price, reasons why the CPI may not accurately reflect drug price trends, alternatives to patent and trademark protection, operating costs and capital investment, and pricing practices of the community pharmacy.

----- -----. The Drug Prescribers. Washington: U.S. Govt. Print. Off., December 1968. 50 pp.

Surveys three major factors involved in the selection of the appropriate drug: the physician's knowledge of drugs, the availability of safe and efficacious products, and the use of drug formularies. The Task Force noted that increasing the amount of pharmacology in the medical curriculum could enable physicians to prescribe more rationally, and that drug standards in the official compendia are being reappraised.

----- -----. The Drug Users. Washington: U.S. Govt. Print. Off., December 1968. 145 pp.

Presents data on the elderly's use of and expenditures for prescription drugs. The five major considerations dealt with are the demographic distribution of the elderly, financial resources, health needs, health expenditures, and patterns of drug use. Some findings are as follows: in 1966, half the families headed by an aged individual had incomes of less than $3,645; 80 percent of the elderly suffer from one or more chronic diseases; the elderly use 23 percent of the prescription drugs. A master drug list was developed to include the 409 most frequently used drugs, broken down by therapeutic category, diagnostic category, and products used in treatment of chronic illnesses.

----- -----. Final Report. Washington: U.S. Govt. Print. Off., February 1969. 86 pp.

Primarily concerns the alternative proposals for placing outpatient prescription drugs under Medicare. The report recommends that coverage be less than comprehensive, that a coinsurance and annual deduct-

ible program be utilized, and that reimbursement be based on the cost of the least expensive chemical equivalent. It examines the effectiveness of cost controls in on-going Government drug programs and the adequacy of information provided to physicians on drug dosage, side effects, toxicity, and cost. It identifies problems in developing quality and cost standards for drugs, and considerations underlying the establishment of reasonable cost and charge ranges for prescriptions.

## 7. STANDARDS

Bierman, Pearl; Myers, Beverlee; Rodak, John; and Reibel, Jay. "Certifying Independent Laboratories Under Medicare." Public Health Reports, vol. 83, September 1968, pp. 731-39.

Describes the regulations governing the participation of independent laboratories in Medicare, and presents data on the number and characteristics of participating laboratories and on the qualifications of their directors. According to the authors, because of the widespread lack of licensure laws, there is a nationwide shortage of skilled laboratory personnel and a lack of incentive for improvement of laboratory performance. To assure quality performance of participating laboratories, Federal guidelines for evaluation are being developed and States are establishing proficiency testing programs.

Cashman, John W., M.D., and Myers, Beverlee A. "Medicare: Standards of Service in a New Program--Licensure, Certification, Accreditation." American Journal of Public Health, vol. 57, July 1967, pp. 1107-1117.

Examines the progress made toward defining realistic standards in Medicare, the effectiveness of their application, and the degree to which they have given support to licensure and accreditation activities. Other issues discussed are the fragmented approach to standards, voluntary professional regulation, and the quality-availability dichotomy.

-----; Bierman, Pearl; and Myers, Beverlee. "The 'Why' of Conditions of Participation in the Medicare Program." Public Health Reports, vol. 83, September 1968, pp. 714-718.

Treats various aspects of standards for health facilities participating in Medicare--their history and justification, the agents responsible for establishing standards, the problems involved in setting national standards, and the balancing of quality and availability. The authors conclude that Medicare standards have had an upgrading effect, though many will require future evaluation and revision.

"'Emergency' Medicare and Desegregation: A Special Report." Hospital Practice, vol. 3, July 1968, pp. 14-19.

Asserts that statistics on length of stay, cost, etc., for emergency and non-emergency Medicare payments in the South indicate that utilization is very similar, pointing to the reporting of non-emergency cases as emergencies. Administration of the emergency provision is complicated by limited staff, lack of a clear definition of "emergency," and failure of physicians to provide adequate information on claim forms. According to the report, the Federal Government hopes to solve this problem by increasing the number of participating hospitals in these areas.

McClure, William. "The City Without Medicare." Medical Economics, September 19, 1966, pp. 204-206.

Describes a situation in which the only hospital in a town of 52,000 was denied participation in Medicare because of its failure to comply with title VI of the Civil Rights Act. One consequence was an increase in the number of emergencies reported. The author concludes that community sentiment would probably lead the hospital to change its policy in order to gain certification.

"Medicare and Desegregation." Hospital Practice, vol. 2, January 1967, pp. 14-18.

Discusses civil rights compliance under Medicare. An estimated 3,000 hospitals made some changes in 1966 to comply with the Medicare conditions for participation. Of the 900 cases documented, 22 percent admitted Negro patients for the first time and 13 percent accepted Negro physicians for the first time. Compliance in the South varied from 97 percent in Texas to 49 percent in Mississippi.

Nash, Robert. "Compliance of Hospitals and Health Agencies with Title VI of the Civil Rights Act." American Journal of Public Health, vol. 58, February 1968, pp. 246-251.

Discusses progress towards compliance with title VI of the Civil Rights Act on the part of hospitals and nursing homes. Two requirements for lasting change, cited by the author, are skilled full-time personnel working in the area of equal health opportunity, and on-site visits. Of the 3,000 hospitals visited by the end of 1966, 2,000 had abandoned

discriminatory practices. The author asserts that nursing homes present more of a problem than hospitals since they have less control over sources of patient referral, and turnover is slower.

Porterfield, John D., M.D. "Attaining Medicare and Pursuing Higher Standards." Medical Record News, vol. 37, October 1966, pp. 295-298.

Discusses Medicare's effect on standards established by the Joint Commission on Accreditation of Hospitals. Medicare appears to be leading the commission to believe its function may best be performed through instituting standards at the optimum achievable. The author suggests a six-step appraisal program for use by the commission, as follows: the recording of diagnosis by the physician; assembly of data from individual charts by the medical record department; sampling of the data by the hospital's utilization review committee; use of the review committee's findings for medical staff education, for administrative action, and for demonstrating quality care to those who pay the bills; a review of this process with outside consultants; and an evaluation of the appraisal program's efficiency by the commission.

"A Second Battle of Mobile." Hospital Practice, vol. 2, June 1967, pp. 61-62.

Describes two cases of hospital noncompliance with title VI of the Civil Rights Act. In Mobile, a hospital containing 40 percent of the city's beds was denied Medicare certification for 8 months, until it demonstrated progress toward compliance. The article states further that a Newport News hospital was found guilty in court of discriminatory practices in admitting and staffing, despite its certification by HEW to participate in Medicare.

U.S. Department of Health, Education, and Welfare. Personnel Qualifications for Medicare Personnel: A Report to Congress. Washington: U.S. Govt. Print. Off., December 1968. 66 pp.

Relates to five major categories of health services personnel and is based on data derived from questionnaires directed to qualified personnel under Medicare and to disqualified personnel. The conclusions were that no changes be made in the requirements for three categories--independent laboratory personnel, corrective therapists, and charge nurses

in extended care facilities. The report recommends that efforts be made to qualify the currently disqualified physical therapists, and that accredited record technicians and registered record librarians be allowed to function as hospital medical record department heads. The use of proficiency testing and educational equivalency as qualifying devices and Federal support of upgrading of health personnel are also discussed.

"What's Wrong with Medicare?" Health Insurance Review, vol. 59, September 1966, pp. 2-3.

Discusses the desegregation of nine Atlanta hospitals during the first several months of Medicare. Of 135 white physicians who had Negro patients admitted to hospitals during a 3-week period, 78 (many for the first time) referred most of these patients to previously white hospitals. Four hospitals accepted Negro staff members, although only on a courtesy basis. The article concludes that Medicare and the need for qualified personnel have substantially reduced race barriers in the hospital-training programs of these nine institutions.

## 8. USE AND FINANCING OF MEDICAL CARE SERVICES

Ahmed, Paul I. "Current Estimates from the Health Interview Survey--United States, July 1966-June 1967." Vital and Health Statistics. (Public Health Service Publication 1000, Series 10, No. 43--National Center for Health Statistics.) Washington: U.S. Govt. Print. Off., 1968. 51 pp.

Includes data reflecting the influence of the Medicare program. Among the aged, there was an 11.3 percent increase over the previous year in discharges from short-stay hospitals, and a 20.3 percent increase in hospital days of care. Physician visits of the aged decreased from 6.7 visits per person for the period July 1963-June 1964, to 6.0 for the period July 1966-June 1967. This lower volume of physician visits was characteristic of all age groups and the author concludes it was undoubtedly associated with the low incidence of acute conditions during the period.

Ament, Richard P. "Medicare Boosts Bed Usage by Elderly." Modern Hospital, vol. 108, February 1967, pp. 81-82.

Based on a sample of 100 hospitals participating in the Professional Activity Study of the Commission on Professional and Hospital Activities. This study indicates that for the first 3 months of Medicare there was a 19-percent increase in bed-use by the aged, and also a greater increase in patient-days for nonteaching than for teaching hospitals. There appears to be no consistent relationship between a hospital's size and its increase in patient-days; but, on the whole, hospitals showed a 9 percent greater increase in patient-days for the aged than for the non-aged.

-----, and Luttman, Roger. "P.A.S. Finds the Elderly Are Staying Longer in Smaller Hospitals." Modern Hospital, vol. 109, August 1967, pp. 106-107.

Relates to the Professional Activity Study, involving 100 hospitals. The 19 smallest hospitals (99 beds or less) had the largest increase--31 percent--in the percent of total stay used by aged patients during the first three calendar quarters

of the Medicare program. The study also showed that the expected rise in brief hospitalizations for patients transferred to extended care facilities did not occur.

Berry, William F., and Daugherty, James C. "A Closer Look at Rising Medical Costs." Monthly Labor Review, vol. 91, November 1968, pp. 1-8.

Reviews medical care price trends for the past 21 years and discusses concepts and procedures relating to the medical care price index. While prices for all services at least doubled, prices for medical care services increased nearly 2½ times. A major factor in the upward price trend has been increased demand for medical care services in the face of continuing shortages of skilled manpower. The article indicates that the fastest rising component of the medical care price index has been hospital daily service charges.

Coe, Rodney M., et al. "The Impact of Medicare on the Utilization and Provision of Health Care Facilities: A Sociological Interpretation." Inquiry, vol. 4, December 1967, pp. 42-46.

Presents testable hypotheses concerning the elderly's utilization of community health resources and the community's provision of them. These are that Medicare may alter the norms defining the appropriateness of seeking professional care; stimulate a reorganization and higher coordination of resources; increase the level of health care; reorient the objectives of long-term care from custodial to therapeutic; and result in the extension of subsidized care to all population groups, and an increased demand for preventive medical care.

-----. "The Response to Medicare." Public Health Reports, vol. 83, April 1968, pp. 271-276.

Reports on a survey of 2,622 respondents aged 60 years and over, living in five Midwestern urban communities, to determine their knowledge about and attitudes toward Medicare. It was found that most of them were aware of Medicare; that knowledge about Medicare varied according to marital, social and health status; and correlations of the opinions ex-

pressed showed that the 60-64 age group, the men, married couples, and the lower economic class responded more favorably toward Medicare.

Commission on Professional and Hospital Activities. "Patients 65 Years or Older: Days of Care." PAS Reporter, vol. 6, August 26, 1968, 4 pp.

Describes a study of 300 PAS short-term general hospitals for two 6-month periods in 1965 and 1967, showing Medicare's effect on hospital care of the aged. Since the beginning of Medicare, admissions of the aged have increased 17 percent; total days of care, 23 percent; and average length of stay, 6 percent. According to the study, smaller PAS hospitals care for more aged patients, proportionately, than larger hospitals--in half of the small hospitals, patients eligible for Medicare used 48 percent of the total days of care.

Furstenberg, Frank F. "A Hospital-Based Program of Specialized Care for the Aged." Hospitals, vol. 40, September 1, 1966, pp. 61-64.

Describes the development by Baltimore's Sinai Hospital of a center for the elderly needy patient. Medicare provides to the needy aged dignity and independence; however, the center offers additional services. The author suggests that Medicare provide the center with more funds, thus enabling it to expand.

-----. "The Impact of Title XVIII on Outpatient Departments." Journal of the American Geriatric Society, vol. 15, November 1967, pp. 991-994.

Based on personal observations, concludes that there is no sharp trend indicating an increase or decrease in clinic use by aged patients, and that Medicare has not resulted in a substantial change in type, quality, or organization of care.

"The Future of Tax-Financed Medicine--An interview with Professor Herman M. Somers." Medical Economics, vol. 44, December 11, 1967, pp. 25-37.

Expresses views that the Government's entrance into the health field has increased the demand for medical services, and that increasing costs are forcing medical care to become more hospital-centered--which,

in turn, is leading hospitals to demand more Government support. The author does not believe that Government's expanding role will lead to control of physicians nor that Government will move much further into the medical care field unless voluntary insurance fails to offer adequate coverage.

"Hospital Indicators." Hospitals, vol. 42, December 16, 1968, pp. 21-23.

Presents statistics on total admissions, the admissions and length of stay for the aged, total births, total outpatient visits, occupancy rate, and total expenses, based on a sample of 656 short-term general and special hospitals. September 1968 data show that aged admissions were 6.6 percent higher in 1968 than in 1967, and length of stay for the elderly increased from 13 to 13.3 days. The percent of total inpatient days attributed to the elderly increased from 32 percent in 1967 to 34 percent in 1968. Monthly statistics.

Hospital Review and Planning Council of Southern New York, Inc. Impact of Medicare on the Demand for and Financing of Health Facilities and Services in Southern New York. August 1965. 15 pp.

Presents data on hospital utilization in Southern New York by the aged and recommends to the Planning Council policies to be followed in regard to Medicare. The major conclusions are that State resources will be redirected to improve health care for the under-age-65 population; the availability of alternate treatment facilities will reduce the demand for any great increase in hospital utilization; and treatment of patients in public hospitals by private physicians and the conversion of wards into semiprivate rooms will become necessary.

"Hospital Rx's Jump 16% in 1967." American Druggist, vol. 157, June 3, 1968, pp. 17-18.

Discusses the periodical's study to determine Medicare's effect on hospital pharmacy activity. The total number of prescriptions filled increased 16 percent from 1966 to 1967 (Medicare's first year), compared with a 14-percent increase the year before and a 10-percent rise in 1965. The number filled in non-Government hospitals rose 18 percent in 1967, compared to an 11-percent increase in the Government

hospitals. The study found that to meet the increase prescription demand of Medicare patients, hospitals had to employ more pharmacists.

Kerr, John R. "Income and Expenditures: the Over-65 Age Group." Journal of Gerontology, vol. 23, January 1968, pp. 79-81.

Provides estimates of the number of families, income structure, and the price levels for different categories of goods and services for the over-65 age group in 1970, 1975, and 1980. By 1980, there will be approximately 21 percent more families in the over-65 age group than in 1965; their average disposable incomes will increase faster than projected price level changes. The author concludes that, while their dollar outlays for medical care in 1980 will nearly equal that for apparel, personal care, and recreation, the proposed increases in Medicare allotments will lessen the burden of increasing medical care expenditures.

Krute, Aaron; Dikoff, Newton; and Scharff, Jack. "Statistical Elements of Medicare." Public Health Reports, vol. 83, May 1968, pp. 352-358.

Describes Medicare's data collection system for measuring and evaluating the program's operations and effectiveness. The authors explain how program statistics are derived from the four separate but related computer-tape records--the master eligibility record, the provider record, the hospital insurance utilization record, and the medical insurance bills sample. The Current Medicare Survey, which provides up-to-date information on medical services utilization, is also described.

Latiolais, Clifton. "Influence of Medicare on Pharmacy Service in Small Hospital and Extended Care Facility." American Journal of Hospital Pharmacy, vol. 23, April 1966, pp. 195-200.

Cites probable effects on pharmacy service as more hospital and nursing homes having pharmacists, the hospital pharmacist competing with community pharmacists, a shift to the professional fee system in hospital pharmacies, more hospitals adopting formulary systems, and nurses spending less time on pharmaceutical tasks.

Lonni, Louis J., and Bradley, Iver E. "Medicare: A Statistical Study on Utilization." Hospital Management, May 1966, vol. 101, pp. 29-33.

Predicts a 30-percent increase in demand for health services as a result of Medicare, based on a regression equation using hospital admissions of aged persons and admissions of aged persons on welfare. Other findings include the following: balancing of the cost structure is a major administrative problem, the ratio of ancillary to total charges varies inversely with length of stay, shortage of covered services will be in extended and home care rather than short-term hospital care.

"Medical Bills Still Worry the Elderly Despite Medicare, Survey Discovers." Geriatric Times, vol. 2, October 1968, pp. 1 & 4.

Discusses the newspaper's survey of a random sampling of retired persons concerning their satisfaction with Medicare. The survey results showed that only 33 percent were relieved of worries about medical bills, most elderly persons do not understand Medicare coverage, and some of them feel it is too limited. A simultaneous survey of physicians showed that practically all objected to the paper work involved.

Medical Care Facilities Utilization: Pre- and Post-Medicare. Menlo Park: Stanford Research Institute, December 1968. 212 pp.

Data from hospitals, extended care facilities and nursing homes in four counties, showing the demographic and economic characteristics of the counties and patients, and the type, size and utilization of each of the facilities. In the post-Medicare period there was a significant increase in the length of stay in extended care facilities and nursing homes for both the control group (aged 60-64) and the study group (aged 65 or over); the source of payment for the study group shifted uniformly in all regions from patient resources, insurance, and public assistance to Medicare.

"Medicare Assessment at Two-Year Mark: Economic Security." Geriatrics, vol. 23, August 1968, pp. 52, 56, 60.

Cites on Medicare's positive side the extent of utilization of covered services by the aged; on the

negative side, the threat to the program's financial soundness posed by increases in hospital use and hospital costs.

Myers, Robert J. "Comparison of Actual Experience Under Medicare with Original Estimates, 1966-67" (Actuarial Note No. 44). Washington: Social Security Administration, July 1968. 3 pp.

Compares Medicare costs with estimates made in 1965. For the hospital insurance program, income in 1966-67 was about 15 percent higher and benefit payments 21 percent higher than anticipated. Administrative expenses for Medicare in 1966 were double the estimate; for 1967, they were almost as estimated. Transfers from general revenues to the trust fund were lower than estimated for 1966 and higher for 1967. The trust fund's interest income was double the estimate and its balance at the end of 1966 was about 50 percent higher (and at the end of 1967, 4 percent lower) than originally estimated.

-----, and Baughman, Charles B. "History of Cost Estimates for Hospital Insurance." Washington: Social Security Administration, 1966. 57 pp.

Traces the development of cost estimates for the various Federal legislative proposals providing hospital insurance benefits to the aged, beginning with the 1962 proposals and culminating with the Medicare legislation. The report discusses basic assumptions about the earnings base and the trends of hospitalization costs and earnings that underlie cost estimates of various legislative proposals; it also takes up the reasons for changing them at different stages.

-----, and Sanders, Barkev. "What Would 'Medicare' Cost?: Comment and Author's Reply." Journal of Risk and Insurance, vol. 34, March 1967, pp. 141-147.

Mr. Myers' response to an earlier item that charged the actuaries with grossly underestimating the cost of Medicare. The article asserts that the author of the charges used inaccurate statistics in many places, and that the cost estimates being compared were not truly analagous because they employed different models. Following Mr. Myers' article, there is a point-by-point rebuttal by Dr. Sanders in which he defends his original charges.

"The Nation's Hospitals: A Statistical Profile." Hospitals, vol. 42, Part 2, August 1, 1968. pp. 440-446.

Compares hospital data for pre- and post-Medicare periods (1965 and 1967), analyzing changes in in-patient, outpatient, personnel, and payroll data in relation to hospital size and control. The statistics show a small increase in number of inpatients, a significant increase in outpatients, increased hospital staff, a 10-percent rise in hospital wages, a 22-percent rise in total expense per patient-day, and an 18-percent increase in payroll expense per patient-day.

The 1969 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund and The 1969 Annual Report of the Board of Trustees of the Supplementary Medical Insurance Trust Fund, Referred to the Committee on Ways and Means. House Document Nos. 91-45 and 91-47. Washington: U.S. Govt. Print. Off., January 1969. 28 pp. and 30 pp.

Summarize the highlights of fiscal year 1968; describe the changes due to the 1967 amendments that are significant from an actuarial standpoint; provide detailed statements of income, disbursements, and assets; compare figures for fiscal year 1968 with the estimates presented in the 1968 reports; and estimate the operations and status of the trust funds for the period July 1, 1968-June 30, 1971. The conclusions were that the earnings base must be updated or the contribution schedule speeded up to maintain the actuarial soundness of the hospital insurance trust fund, and that a $4 premium rate provides the medical insurance program with sufficient funds on a cash basis.

Rice, Dorothy P. "Current Data from the Medicare Program." Public Health Reports, vol. 83, September 1968, pp. 719-730.

Presents utilization data for the period, July 1966-June 1967. Includes annual per-capita benefit payments; admission rates for hospital and extended care facilities, and rates for starting home health care services; number of approved claims and amounts reimbursed, and use of covered medical services.

Sanders, Barkev. "What Would 'Medicare' Cost?" Journal of Risk and Insurance, vol. 32, December 1965, pp. 579-594.

Charges that the Government underestimated the cost of the King-Anderson Bill, contending that the method of estimating the days of hospital care per aged patient failed to take into account the increased utilization. The author maintains that the per-diem hospital cost estimate of $37 for 1966 is too low, and estimates the amount to be $46.

Shain, Max. "Hospital Admission Rates Under Medicare and the Former OAA Medical Program." Inquiry, vol. 5, March 1968, pp. 65-67.

Compares hospital admission rates in 19 States under the old-age assistance medical program in fiscal year 1962 and under Medicare in fiscal year 1967. Under Medicare, the mean of the States' hospitalization rates was slightly lower because the median age of OAA recipients is higher than that of the total aged population and the incidence of sickness is greater among OAA recipients. Under Medicare, there was less variation in number of admissions among the States, reflecting the program's uniform conditions of eligibility and methods of administration.

Snoke, A. W. "Medicare Year One: A Critical Appraisal." Hospitals, vol. 41, November 1, 1967, pp. 49-53.

Identifies problems involving adequate and equitable hospital reimbursement, dealing with two independent trust funds, and complexity of administrative detail. Some achievements cited by the author are progress toward proper utilization, higher quality of care, and promotion of the concept of a continuum of care.

Snook, I. Donald, Jr. "Hospital Program Fills Medicare Information Need." Hospitals, vol. 42, January 16, 1968, pp. 61-64.

Describes a program at the author's hospital to inform patients about Medicare. According to a survey reported by the author, most beneficiaries do not understand Medicare but want to learn more about it. The basis for the informational program is telephone and personal contact between a hospital-based Medicare specialist and the beneficiary.

Somers, Herman M., and Somers, Anne R. Medicare and the Hospitals: Issues and Prospects. Washington, D.C.: The Brookings Institute, 1967. 303 pp.

Examines aspects of the Medicare program, concentrating on the hospital in its role as the central institution in modern medical care. The major questions discussed are the adequacy of present facilities, the quality of care, the health manpower crisis, hospital reimbursement, hospital planning, utilization and costs. The authors conclude with speculations on the program's future operation and a discussion of hospital trends--fewer but larger institutions, more comprehensive integrated services, quality improvements, and community and regional health resources planning.

## 9. UTILIZATION REVIEW

Arts, Sister M. Vivian, and Klauck, Sister M. Patrick. "Utilization Review in Action." Hospital Progress, December 1966, pp. 65-72.

> Describes the detailed procedures and forms used in a program at a Minnesota hospital. A committee of medical staff members reviews the medical records supplied by the hospital medical librarian and recommends removal of patients who no longer require care. The supervising physician is given 48 hours to justify extending the stay if he disagrees. There is a monthly review of randomly selected cases by the committee to provide a further check on utilization of hospital facilities.

Donabedian, Avedis, M.D. "Promoting Quality through Evaluating the Process of Patient Care." Medical Care, vol. 6, May-June 1968, pp. 181-202.

> Cites Medicare's utilization review as a positive contribution to the creation of formal review mechanisms, predicting it will strongly influence other private and public programs. The author questions the separation from the hospital structure of the pathologist who is one of the most important participants in any quality review mechanism.

Kolb, Jonathan. "Influence of Utilization Review on Hospital Length of Stay." JAMA, vol. 203, January 8, 1968, pp. 117-119.

> Compares data on length of stay for patients aged 65 and over at Massachusetts General Hospital in periods before and after Medicare--the third quarter of 1964 and of 1966. Stays were somewhat longer in 1966, but significantly more patients were being discharged between the 18th and 21st days. Two interpretations are possible, according to the author: either the patients were being hospitalized longer than necessary under Medicare, or patients who would have been hospitalized for a few more than 21 days were being discharged in advance of the necessity for recertification.

Lewis, Paul. "Hospital Utilization Project of Pennsylvania." Public Health Reports, vol. 83, September 1968, pp. 743-750.

Describes a project, begun in 1963, which abstracts records for 75 hospitals, prepares comparative statistics, and develops hospital profiles. Monthly listings of diagnoses, operations, discharges and deaths and semiannual indexes of diagnoses and operations are prepared. Such an abstract is being used by 26 extended care facilities participating in a central review plan. Data on these facilities are being compared with those of 12 facilities using other utilization review methods.

Maki, Nancy; Walden, Daniel; and Cohen, Lawrence. "Issues and Outlook." Public Health Reports, vol. 83, September 1968, pp. 708-713.

Discusses the concept of utilization review--its history, its importance for quality medical care, the obstacles to its effective use, and its operation under Medicare. Preliminary Medicare data show great variations in approaches to, and competence in carrying out, the review process. Of the 6,738 hospitals certified at the beginning of Medicare, 97 percent have an institution-based review program. The authors favor community-based plans, for they are more effective in maintaining uniformly high standards and in assuring the greatest use of the community's health resources.

Salmon, Pierre, M.D. "Medical Care Appraisal." Hospitals, vol. 41, April 1, 1967, pp. 127-130.

Deals with the general principles and specific applications of utilization review, and with Medicare's probable effect on hospital accreditation standards. The author cites the Hibbing Minnesota General Hospital's utilization review as a useful prototype. He foresees standards of the Joint Commission on the Accreditation of Hospitals being raised to identify excellence in performance, and the development of different measures to be applied to different types of institutional health care.

Sharpe, George, and Youngquist, Lila. "Medical Society-Sponsored Review in Montgomery County, Maryland." Public Health Reports, vol. 83, September 1968, pp. 751-756.

Discusses a utilization review plan for extended care facilities. Two-man teams of physicians review cases having a stay longer than 30 days. Some of the needs uncovered were for additional beds in both extended care facilities and chronic disease hospitals, transfer agreements with long-term care facilities, a greatly expanded home health care program, and better physician cooperation in the recertification process. The authors state the program's benefits include educational advantages for staffs and physicians, increased cooperation among all agencies participating in patient care, and improved quality of patient care.

"Viewpoint--The Implication of Utilization Review. An interview with Arthur E. Hess." Geriatrics, vol. 22, March 1967, pp. 82, 86, 88.

Discloses opinions on the progress of utilization review in nursing homes and extended care facilities. Due to the limited size of their medical staffs, many extended care facilities were unable to form review committees. Some have solicited the aid of their medical societies to sponsor a community or Statewide utilization review program. The article urges that physicians organize the review mechanism as a professional tool and use it to develop a picture of widespread practices and to create better geriatric care.

Wallace, J. Douglas. "Developing an Effective Utilization Review Program." Hospitals, vol. 41, November 16, 1967, pp. 70-73.

Urges tailoring utilization review to the needs of the individual hospital. The author asserts that basic utilization controls include deciding, on the basis of scientific study, the number and departmental distribution of beds; providing adequate service departments; taking advantage of organized management training programs; and establishing good communications at all levels in the hospital.

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Cites proposals advanced by the project's committee, which include evolving an automated utilization-review screening-procedure that uses material extracted from patient records by clerical employees; extracting data on hospital utilization and treatment procedures during the screening; developing performance profiles for the providers of health care and fiscal intermediaries. The article reports that physicians and administrators reacted favorably, for the use of record-room personnel would reduce the physicians' burden in reviewing small, isolated facilities.

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Discusses a screening procedure for utilization review that uses regression equations to predict length of stay. The advantages of this screening technique are that it eliminates those cases for which certain characteristics of the individual account for overstay or understay, and it permits a cursory review of every case. According to the author, Medicare has stimulated research into the development of criteria and techniques for utilization review.

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