

The Positive Impact of Medicare on the Nation's Health Care Systems

by WILLIAM H. STEWART, M.D.*

IN ITS FIRST YEAR of operation, the Medicare program has removed many of the financial barriers that prevented older people from seeking medical care and that narrowed the therapeutic alternatives available to them.

Through its standards for participation and its contributions to the surge of interest in the development of research and in the training and retraining of personnel, Medicare has provided a framework to help achieve improvements in the health care available to all Americans.

In November 1965, I described Medicare as "a door opened wide for us in the health professions to accomplish things we have talked about for years." Today, it can be shown that Medicare has indeed helped to accomplish things; it has had a substantial, positive impact on the health care systems of this Nation.

There are countless instances that could be cited that clearly show the influence of Medicare in the solving of individual problems—the return of physicians to an area where they could not have afforded to practice in recent years, for example, or the easing of recruitment of physicians for a rural community hospital.

But it is the story of the broader impact of Medicare that should be told here—what it has accomplished, the trends that are emerging and some new opportunities that exist today as a result of this program. It is a program that has stirred the imagination of people in the community—professional people and lay people. The Medicare experience has contributed a perspective for action to those who are planning for community health services.

QUALITY OF SERVICES

We saw Medicare, 18 months ago, as a program that would ultimately bring about an upgrading

* Surgeon General of the U.S. Public Health Service. The article is adapted from a paper presented to the State administrators of the Medicare program, April 7, at Social Security Headquarters, Baltimore.

of the quality of medical service available not only to older people but to all the people of the country. Today we can say with certainty that it has in fact helped to raise the standard of service offered by many health facilities in this Nation.

Channels of communication have been opened between the State health department and the medical society, between the hospital nurse and the extended-care facility nurse, between Federal agencies and the licensors and providers of care, and among the Federal agencies themselves; between voluntary organizations and the systems in which they operate, between buyers and providers, between trainees and trainers in the health care field.

The Conditions of Participation laid down for Medicare have helped administrators of nonaccredited hospitals to convince their boards and their communities to improve services. In particular, these standards have improved the physical environment of such hospitals and have enabled them to implement previously nebulous policies and procedures. The Medicare conditions have contributed to the contemplated actions of the Joint Commission on Accreditation of Hospitals to raise its standards. These conditions have also influenced new directions in the accreditation programs of the American Osteopathic Association. The standards for extended-care facilities have given us a new type of facility, a national resource that will grow. The standards for home health agencies are stimulating and supporting the effective development of home care services. Already three-fourths of the home health agencies offer physical therapists' services, and all offer at least one service in addition to the visiting nurse. Sixty-five percent of the 1,800 agencies offer three or more services.

The Conditions for Coverage of Services of Independent Laboratories set national minimums for these facilities. Examinations were conducted June 1-2 to help assure that the independent clinical laboratory is under the direction of a qualified person. The proficiency testing require-

ment also will further the goal of higher quality services.

MANPOWER AND RESOURCE DEVELOPMENT

Quality cannot survive unless manpower and resources are available in adequate quantity. Because it pays for services in a range of settings, Medicare has exerted a positive force and removed some obstacles to the availability of manpower and resources.

It has brought the pharmacist out of the corner pharmacy to his proper place on the community health team, as a medication expert and adviser on drug systems in institutions. Now the pharmacist may provide consultation to extended-care facilities, nursing homes, and small hospitals. Now we find extended-care facilities with formularies, pharmacy and therapeutic committees, dangerous drug procedures, and other elements that add up to higher quality pharmaceutical service.

We find the States becoming concerned, because of Medicare, with the quality of pharmacy services. A new regulation in one State requires that all pharmacy consultants in nursing homes or hospitals must be certified by the board of pharmaceutical examiners, if the institution does not have a full-time pharmacist. The consultant must be a pharmacist with experience as a staff or consulting pharmacist in a hospital or nursing home and must also have attended a training course in institutional pharmacy.

Training courses for other disciplines also have produced a high net gain in manpower. Medicare has brought nurses out of the kitchen, recapped them, and put them back in active service in hospitals, nursing homes, and home health agencies.

In some areas, licensed practical nurses with "waivered" certificates are taking refresher and training courses in order to achieve the status of graduate licensed practical nurses.

Some States have aimed their training programs both at developing new skills for practicing nurses, physical therapists, nutritionists, dietitians, and other health disciplines to enable them to serve as consultants and supervisors and at reactivating inactive professional personnel through refresher courses. Three States are showing strong current interest in establishing state-

wide manpower organizations that would address themselves, in the first instance, to collecting and analyzing the data required to act on needs for essential health manpower. Medicare has been instrumental in focusing attention on manpower needs in these States.

Applications are now being reviewed for training courses for professional nurses employed in extended-care facilities and for home health aides in many areas, and courses for nursing-home administrators are already under way in a few States.

In one State, the health department and the hospital association recently held four institutes for medical record librarian. This action was notable not only because it was motivated by Medicare but because it is supported entirely from non-Federal sources.

For the purpose of jointly sponsoring training courses, some States have established relationships between State agencies and nursing home associations, pharmacy associations, and dietary associations. Many hospitals are involving themselves in home care to a greater extent than ever before.

These manpower activities by no means include all the training, retraining, and educational efforts stimulated by Medicare that have resulted in a better-informed professional group and a better-cared-for patient. They are examples of how Medicare has helped the Nation to look seriously at the problem of manpower.

HOME HEALTH SERVICES

Medicare has similarly helped us make better use of our resources. Home-care services are a good illustration. Because of Medicare, home care may play a much more important role in the delivery of services in the future than it has in the past. A few years ago, probably no more than 250 agencies provided the services in addition to that of the visiting nurse (physical therapy, occupational therapy, speech therapy, medical social services, or home health aide services) that would meet the Conditions of Participation for home health agencies. Now there are some 1,800 home health agencies across the country. The following data, compiled in one State, illustrate how Medicare is stimulating the growth of comprehensive services through home health agencies.

Type of service	Number of agencies offering specified services	
	March 1966	March 1967
Physical therapy.....	7	45
Occupational therapy.....	2	8
Speech therapy.....	3	14
Medical social work.....	2	10
Home health aides.....	23	51

In its home health benefit, Medicare has fostered a concept of care that is patient-centered. From the physician's referral for home care, and the evaluation of the patient's needs to the development of a plan of treatment to meet those needs and the further review and revision of the plan, Medicare encourages a continuing focus on the patient and his requirements.

UTILIZATION REVIEW

It seems evident Medicare's most important contribution to effective resource development rests with the utilization review requirement. This requirement has provided communities with an opportunity to look at their hospitals or extended-care facilities or home health services, and better evaluate their place in meeting overall community needs.

In one State, for example, it has caused a county commission to consider the future community service roll of a 200-bed chronic disease hospital that really seems to be functioning as a long-term care facility or nursing home. In addition, Medicare has been used as a vehicle for countywide utilization review and has sparked interest in establishing regional or statewide programs.

More effective utilization practices are influencing more effective resource development in many States. An increasing number of relatively small rural hospitals that have historically experienced a low patient census are converting some of these empty beds to extended-care beds. Larger community hospitals are planning and constructing new units that will be used as extended-care facilities.

The public hospital system of one State is in the process of being reviewed and evaluated in the light of Medicare's provisions—a step that should prove beneficial to the entire medical care system of the State.

The type of cooperation and coordination occurring in Medicare is a starting point toward the goals that mean good care for all. Before Medicare, one State had six medical active audit committees; now there are 143 active committees working with encouragement from the Medical Society. Before Medicare, another State had no standards for medical audit of utilization review; now the Medical Society is developing a plan for setting what are in effect such standards. Before Medicare, there existed obstacles in State legislature or lethargy in the States to setting laws, regulations, and licensing at levels as high as they might be. These obstacles are being removed, State by State.

TITLE VI OF THE CIVIL RIGHTS ACT

Medicare is also playing a significant role in the area of human rights through its interaction with title VI of the Civil Rights Act, which concerns discrimination in facilities participating in Federal programs. During the past year, there has been a significant change in the way Negro Americans receive hospital care. In hundreds of hospitals in all parts of the Nation, but especially in the South, quality medical care is now being offered to every sick person, regardless of his race. Negroes are able to enter hospitals that were previously reserved for white patients only. Negro physicians are able to apply for hospital staff privileges with assurance that their applications will be considered on their merits.

This is a truly significant step, but it is only a step. Despite the efforts of many courageous people, Negro and white, the sad truth is that discrimination continues to exist in many hospitals. Although the outward, more blatant signs of discrimination have been largely eliminated, in too many hospitals some subtle and ingenious devices to maintain discrimination are still in effect.

Discrimination in any form, overt or subtle, strikes doubly hard at the sick person, who in many cases has lost a measure of his self-respect or is frightened and uncertain because of his illness. If discrimination because of race is added to these factors of inadequacy, the best possible care is difficult to provide.

Recognizing this fact and reasserting the con-

stitutional right of every person to receive treatment without discrimination in any form, the Fourth Circuit Court of Appeals rendered a landmark decision in which the court upheld the firm enforcement of the Department's guidelines for ending hospital discrimination, particularly those relating to discrimination in room and ward assignments and in admission of physicians to hospital staffs.

In this case, a suit was brought against a hospital by a Negro physician and two of his patients. A lower court had ruled that the doctor and his patients did not have a case because the hospital had been declared eligible to receive Federal funds by meeting requirements of title VI. The Court of Appeals reversed the lower court, pointing out that certification of the hospital afforded no assurance of actual compliance, for "violations of constitutional rights often continue unabated" through the use of some sort of "contrivance" by which a hospital can still "evade the obligation of the law."

In other words, the fact that a hospital has been certified does not mean that an individual cannot sue for redress of his constitutional rights. The court upheld the legality and constitutionality of the Federal desegregation guidelines but noted that they may be difficult to enforce because of limited staff and budget. Thus, certification of eligibility is not a wall behind which a hospital can continue to act to deny a person his right.

With Medicare as an instrument, the overt forms of discrimination in hospital care are being brought to an end. But much remains to be done. With this court decision, the attack on the subtler forms of discrimination can go forward.

THE OPPORTUNITIES TODAY

Medicare is helping to create a new image of the State Health Departments and of the public health professions. It has helped us prepare for our responsibilities of planning under the Comprehensive Health Planning Act. If we will look at the opportunities we have today to strengthen Medicare in the service of the sick, we will continue to improve the potential for comprehensive health care for all of the American people. It is truly encouraging to detect the growing philoso-

phy that we should do not just what needs to be done to meet minimum standards but rather what needs to be done to improve the quality of patient care.

Now, specifically, to what type of new activities should we turn? What experiences in our involvement with Medicare provide food for thought—thought about how to achieve some other goals we have talked about for years?

The greatest problems we face today in the field of health care are the rising costs of care and the fragmentation of community and personal health services.

We must find ways to control costs, while recognizing that the delivery of quality care does not permit a full scale lowering of costs.

The problem of fragmentation must be approached through the development, demonstration, and evaluation of comprehensive health care systems. Medicare gives us a basis for encouraging alternatives to hospital care. It has the elements of one system of better coordinated health services: it provides insurance coverage for a range of services; it covers care in extended-care facilities, outpatient care, organized home health services, and professional review of utilization practices.

The time is at hand for the health department to interest itself, in a meaningful way, in this problem of encouraging greater comprehensiveness in health insurance, both private and public. Let the Medicare benefits set a standard—not a ceiling but a standard—for the whole population. And the health department should represent the health interests of the people of the State by encouraging the insurance department to require comprehensive coverages in the private plans and contracts approved in the State. Voluntary health insurance is one of the most important ways in which health services are financed in this country. To the extent that the health department can help to upgrade the quality of private health insurance coverages and policies, it will serve to upgrade the quality and increase the availability of health resources and assure that services reach the people. We need to strengthen the interagency cooperation begun with Medicare and extend it to include effective cooperation in the States between the health department and the insurance department.

By no means can all the positive accomplish-

(Continued on page 50)

TABLE M-18.—OASDHI hospital insurance: Monthly number of claims for inpatient care approved for payment, covered days, total charges and reimbursed amount, by type of hospital, as of April 22, 1967¹

Month claim approved ²	Approved claims			Hospital charges				
	Number	Covered days of care ³		Total (in thousands)	Per claim	Per day	Amount reimbursed ⁴	
		Total	Average per claim				Total (in thousands)	Percent of total
All hospitals ⁵								
Cumulative, July 1, 1966-March 31, 1967.....	2,921,174	38,179,957	13.1	\$1,675,395	\$574	\$44	\$1,339,758	80.0
1966								
July.....	41,493	294,873	7.1	11,711	282	40	8,699	74.3
August.....	274,119	2,837,257	10.4	118,767	433	42	92,984	78.3
September.....	327,242	4,081,177	12.5	172,010	526	42	136,899	79.6
October.....	381,194	5,079,655	13.3	215,160	564	42	172,388	80.1
November.....	391,052	5,273,050	13.5	230,085	588	44	184,482	80.2
December.....	375,032	5,174,692	13.8	229,392	612	44	183,587	80.0
1967								
January.....	398,058	5,457,770	13.7	244,771	615	45	196,300	80.2
February.....	388,297	5,219,525	13.4	235,743	607	45	188,998	80.2
March.....	344,687	4,761,958	13.8	217,756	632	46	175,421	80.6
Short-stay hospitals ⁶								
Cumulative, July 1, 1966-March 31, 1967.....	2,868,437	36,504,569	12.7	\$1,640,737	\$572	\$45	\$1,310,410	80.0
1966								
July.....	41,336	292,641	7.1	11,656	282	40	8,653	74.2
August.....	271,019	2,769,566	10.2	116,932	431	42	91,349	78.1
September.....	322,569	3,945,389	12.2	168,555	523	43	133,857	79.4
October.....	372,984	4,823,000	12.9	209,766	562	43	167,851	80.0
November.....	384,082	5,049,127	13.1	225,195	586	45	180,540	80.2
December.....	366,991	4,872,126	13.3	223,401	609	46	178,578	79.9
1967								
January.....	390,186	5,186,532	13.3	239,711	614	46	191,896	80.1
February.....	380,801	4,988,759	13.1	231,423	608	46	185,234	80.0
March.....	338,469	4,577,429	13.5	214,098	633	47	172,452	80.5
Long-stay hospitals ⁷								
Cumulative, July 1, 1966-March 31, 1967.....	43,197	1,566,441	36.3	\$30,618	\$709	\$20	\$26,489	86.5
1966								
July.....	148	2,054	13.9	49	331	24	42	85.6
August.....	3,096	66,670	21.5	1,834	592	28	1,635	89.1
September.....	4,234	131,741	31.1	3,294	778	25	2,927	88.9
October.....	6,825	241,835	35.4	4,842	709	20	4,143	85.6
November.....	5,469	207,079	37.9	4,235	774	20	3,471	82.0
December.....	6,622	285,625	43.1	5,374	812	19	4,576	85.2
1967								
January.....	6,540	255,787	39.1	4,472	684	17	3,989	89.2
February.....	5,660	209,755	37.1	3,550	627	17	3,213	90.5
March.....	4,603	165,895	36.0	2,968	645	18	2,493	84.0

¹ Includes only those claims approved and recorded in the Social Security Administration central records before April 22, 1967.

² Month in which the intermediary approved the claim for payment.

³ Includes covered days of care after June 30, 1966, but not more than 90 days in a spell of illness.

⁴ See footnote 3, table M-17.

⁵ Includes 9,343 claims with type of hospital unknown.

⁶ General and special hospitals reporting average stays of less than 30 days.

⁷ General and special hospitals reporting average stays of 30 days or more; tuberculosis, psychiatric, and chronic disease hospitals, and Christian Science sanatoria.

POSITIVE IMPACT OF MEDICARE

(Continued from page 12)

ments in the field of health today be directly or entirely attributed to implementation of the Medicare program. Similarly, many problems have been brought to the surface by Medicare that have existed, unresolved and almost unnoticed, for many years.

We have many serious problems squarely before us. But we feel that we are well on our way toward meeting these challenges. Medicare has reduced the dimensions of some of the problems along the lines indicated here. Now, in the coordination role of the State agencies, Medicare offers an opportunity to continue and expand the positive impact of this program.