

**Medical Peer Review and PSRO (1)**

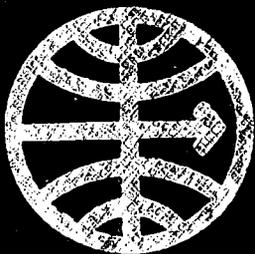
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# **MEDICAL PEER REVIEW AND PSRO**

An In-Depth Study of Opportunities in  
the Professional Standards Review Organizations (PSROs) Program



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the Professional Standards Review Organizations (PSROs) Program

A Status Report Prepared by:

IMS AMERICA, LTD.  
Maple Avenue and Butler Pike  
Ambler, Pennsylvania 19002  
Telephone: (215) 643-0400

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Comments and Questions May Be  
Directed to: Mr. David C. Olson

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## SECTION I. EXECUTIVE SUMMARY

### A. Definition of Peer Review and PSRO

Medical peer review is the process of physicians reviewing the professional work of physicians, using as a basis for judgement, a previously developed and agreed upon set of standards, criteria and norms. The professional Standards Review Organization (PSRO) program is one type of medical peer review program.

### B. Brief History

In the early 1970s, Congress became aware that the Medicare and Medical Assistance program (which became effective by passage of an amendment to the Social Security Act in 1954) would have a projected \$250 billion overrun in expenditures by 1995 if the current spending level continued. In addition to this severe financial condition, there was well documented evidence to suggest that Medicare and Medical Assistance beneficiaries were receiving very low quality medical care.

The American Medical Association proposed and the Congress passed an amendment to the Social Security Act in 1972, which required implementation of a peer review program for all claims under the following three Federal programs: Medicare (Title XVIII); Medical Assistance (Title XIX); and the Maternal and Child Health Program (Title V). This medical peer review program was known as the PSRO program. It basically required a series of local peer organizations to be established where doctors would be responsible for review of the medical care delivered by other doctors, to assure that this medical care was delivered: (a) on a necessity basis;

(b) in accordance with minimum standards of quality; and (c) in an appropriate setting.

C. Current Status

The PSRO program has been very slow in being implemented because of the lack of adequate funding, turnover in Federal personnel, and lack of physician acceptance. However, there have been PSROs established that are working within the spirit of the law. All of the PSROs face common problems such as: physician acceptance; confidentiality of data; adequate numbers and types of competent review personnel; lack of baseline data; lack of agreed upon standards, criteria, and norms of medical care. Various groups have responded to the program ranging from outright hostility to eager acceptance by consumer groups. There were numerous legal problems with utilization review regulations which appear to have been resolved.

D. Outlook

The outlook for the concept of peer review is very good, while the outlook, specifically for the PSRO program, is less favorable. Many astute observers view the PSRO program as a precursor, trial, experimental peer review program which will be tried and tested for applicability to the inevitable national health insurance program.

At any rate, the alert group will take advantage of the opportunities that have been presented by the PSRO program. These opportunities involve primarily the invitation to provide standards in the use of medical supplies and equipment. The other needs that organizations can capitalize upon include educational systems, data banks and data systems, claims review

processing, consumer education, government sponsored R and D projects, physician recruitment services, and a wide range of management consulting services to meet a wide spectrum of PSRO needs.

Additional information about proposed strategies may be obtained from the writer.



## SECTION II. INTRODUCTION

This section will detail the following aspects of the report:

(a) description of the reasons or stimulus for conducting the study; (b) outline of the goals and objectives of the study; (c) description of methods and procedures utilized; (d) a brief review of the literature related to PSRO; and (e) a listing of recommended uses for the study.

### A. Stimulus for Conducting The Study

This study was conducted with the intention of presenting valuable insights, information, and recommendations to our existing and future clients. IMS America, Ltd., is a medical marketing research company which gathers, processes and reports statistical information in the health care field. It produces: (a) syndicated ongoing statistical reports and (b) specially-designed custom research studies. The Company has provided these services for more than twenty years and is considered the country's leading supplier of health care and pharmaceutical market data. IMS syndicated reports and customized studies together monitor and provide current information about many aspects of health care, including: (a) the incidence and treatment of disease; (b) the extent and nature of drug abuse; (c) the prescribing habits of physicians; (d) the nature and extent of pharmaceutical promotion; (e) pharmaceutical markets by prescriber characteristics; (f) hospital diagnostic procedures and treatment; (g) effectiveness of pharmaceutical detailmen; (h) purchase patterns and

pricing trends for pharmaceuticals, toiletry and beauty aids, hospital supplies, veterinarian pharmaceuticals, and animal feed additives through retail outlets and end users; and (i) prescription sales by retail pharmacies.

Outside of the syndicated studies and the customized studies that are performed for specific clients, IMS has recently established the capability to perform special multiclient studies that relate to the major issues and the delivery of health care in the United States.

These issues include at least the following: (1) peer review and the PSRO program; (2) national health insurance; (3) health maintenance organizations; (4) comprehensive care organizations; (5) maximum allowable costs for pharmaceuticals; (6) comprehensive health planning; (7) medical malpractice insurance; (8) trend toward group practices and physician combines; (9) health data systems; (10) health manpower shortages and maldistribution of health manpower; (11) control mechanisms related to cost and quality; (12) consumer movement; (13) generic versus brand name prescribing; (14) pharmaceutical promotional practices; (15) drug use and quality controls; (16) medical device legislation; (17) criticism of clinical research; (18) third party reimbursement; (19) effects of a "downward" economy on the health care field; (20) the effects of product diversification on the health care field; (21) the implications of the need for continuing physician education; (22) the general politics of health and medical care at the Federal governmental level; (23) certificate of need legislation; (24)

shortage of funds for medical education; and (26) proliferation of foreign medical graduates (FMGs) in the United States.

PSRO and peer review (the major subject discussed in this paper) is certainly a key issue today in the delivery of health care services. The major stimulus for conducting a study of PSRO stems from the assumption believed to be true that PSRO will set the stage for assuring adequate controls over the cost, quantity and quality of health care under a national health insurance once it is established.

IMS clients need to be aware of the impact of the PSRO program. Such awareness will enable them to be in the best position to respond to the opportunities as well as the problems that exist in this area.

#### B. Goals and Objectives

The overall objectives of the study were to provide a state of the art report on the PSRO and peer review program, and to describe the implications of these programs for the various submarkets of the health care industry.

The sub-objectives of the study were developed to be as broad as possible to assist a maximum number of clients as possible and in as many ways and methods as possible. The sub-objectives are as follows:

1. Provide a means by which clients can receive a broad overview of the health care issues of 1975; and then to place the PSRO and peer review programs into perspective against the panel of overall health care issues.

2. The second major sub-objective is to indicate how and why the PSRO program was originally initiated, and how the PSRO program fits into the overall historical development of the peer review program for delivery of medical care in the United States.
3. The third major objective is to provide an analysis of the actual PSRO legislation. Although the verbatim legislation is included in the Appendices, a non-legal interpretation of the provisions of the law is included in Section VI.
4. The fourth major objective is to provide a brief but comprehensive status of the PSRO program and how it has affected the delivery of medical care in the United States. In addition, the report details the status of individual components of the PSRO program, such as statewide support centers; PSROs in the planning, conditional and operational stages; the attempts at establishing norms of care; and data collection requirements; and a number of other areas of significance. The status report also indicates the comparison on the projected timetable as established by the Department of Health, Education and Welfare with the actual progress made by mid-September, 1975.
5. The fifth major sub-objective is to indicate the probable future of PSRO in the total provision of medical peer review in this country. The implications of medical peer review for establishing a method for monitoring a national health insurance program is discussed.

6. The sixth major sub-objective is probably the most valuable aspect of this report for the client. This objective deals with how the PSRO program and the peer review activity can have: (1) both a negative and a positive affect upon the current operations and future growth of a client company; (2) how the program can be utilized to develop new products and services for the future; and (3) how the program can augment existing products that the company has developed.

C. Methods and Procedures

The study was conducted during the last half of 1974 and the first seven months of 1975. This was considered a key period for the growth and development of the PSRO program. The provisions of the law were just beginning to be implemented. Some of the Emergency Medical Care Review Organizations (precursor organizations to PSRO) were already in operation. There was peer review experience to evaluate. In addition, the many major aspects of the PSRO program (development of norms and criteria sets, data systems, physician reimbursement) were in progress.

The data collected originated from both primary and secondary sources. Every effort was made to review the complete history of the PSRO program utilizing a number of techniques. In addition, every effort was made to obtain as comprehensive a view and as many opinions as possible about: (a) the future for PSRO and peer review programs, and (b) opportunities and problems that could exist for IMS clients as a result of the program.

Table 1.

OTHER GOVERNMENTAL HEALTH - MEDICAL PROGRAMSIMS IS MONITORING

1. NATIONAL HEALTH INSURANCE
2. HEALTH MAINTENANCE ORGANIZATIONS
3. COMPREHENSIVE HEALTH PROGRAMMING
4. HEALTH - MEDICAL DATA SYSTEMS
5. MEDICAL MALPRACTICE INSURANCE
6. TREND TOWARD GROUP PRACTICES AND PHYSICIAN COMBINES
7. MANPOWER SHORTAGES AND MALDISTRIBUTION
8. PHARMACEUTICAL PROMOTIONAL PRACTICES
9. CRITICISM OF CLINICAL RESEARCH
10. POLITICS OF HEALTH - MEDICAL CARE
11. MEDICAL PEER REVIEW AND PSRO
12. MAXIMUM ALLOWABLE COSTS (MAC)

With this in mind, the following methods and procedures were utilized to conduct the study:

1. Interviews

Interview guidelines were prepared before the interviews were conducted. Professional persons conducted the interviewing in all cases. The types of interviewees were as follows: Federal Congressmen; trade association executives; insurance executives; medical directors of PSROs; executive directors of PSROs; Department of Health, Education and Welfare executives; pharmaceutical company executives; quasi-regulatory and accreditation agency individuals, such as the Joint Commission on Accreditation of Hospitals.

2. Review of Literature

All available written material available to IMS relating to the PSRO program and the history of peer review was reviewed. This material can be categorized as follows: (1) professional journal articles; (2) books; (3) minutes of Congressional committee hearings; (4) Department of Health, Education, and Welfare policy statements, memoranda, and other documents; (5) special research studies relating to PSRO and peer review; (6) trade association material related to official positions, instructions to membership, and informational pieces about the PSRO program; (7) Federal budget documents; (8) Federal rules and regulations; (9) opinion surveys; (10) newsletters; and (11) consulting reports.

Figure 1. is a general schematic describing the types of informational sources contacted for conducting the study.

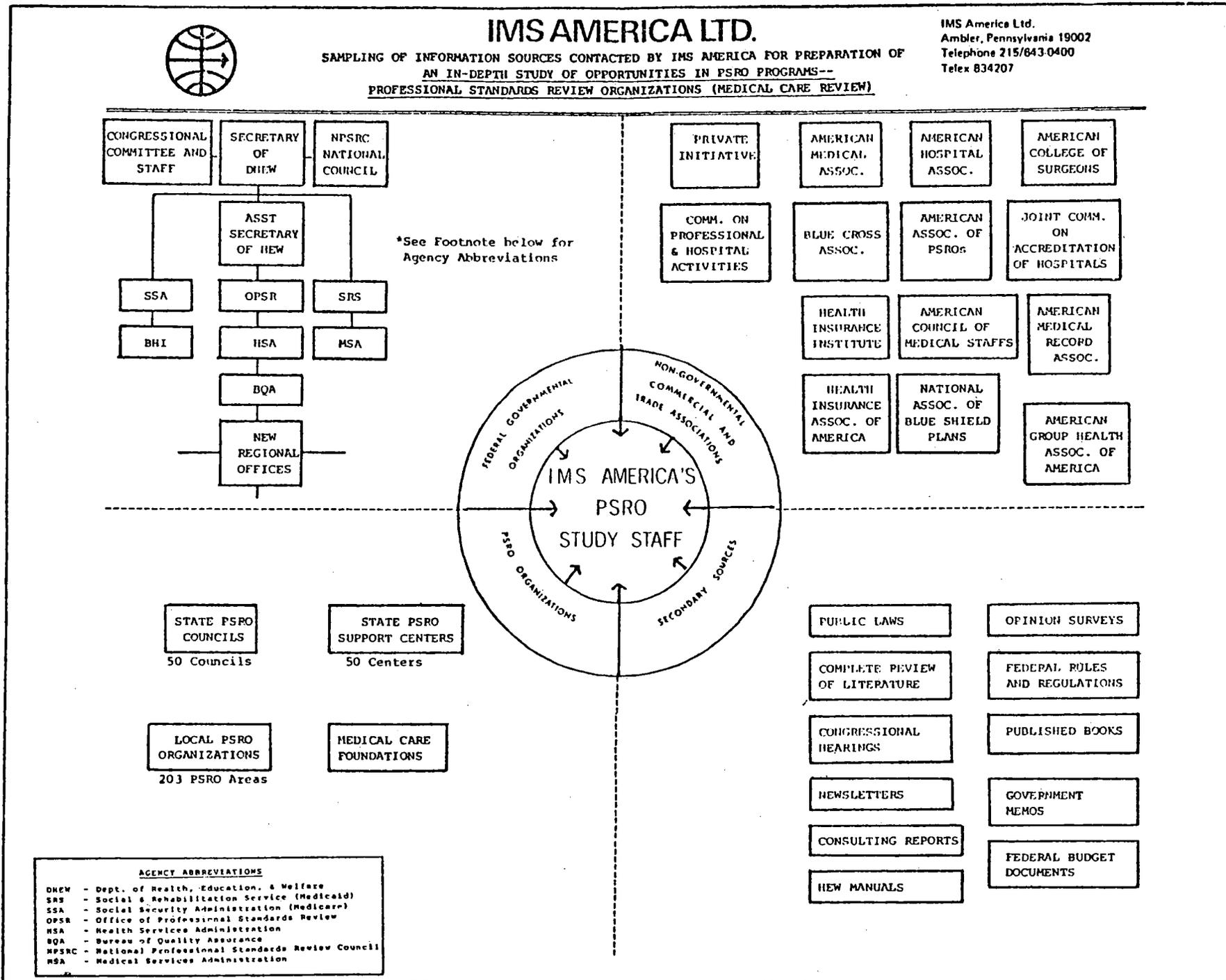
D. Recommended Uses of the Study

The recommended uses of the study by IMS clients are as follows:

1. Top level management will be interested from the standpoint of general information and to secure a general awareness of the trends in the medical care delivery as they relate to PSRO and peer review.
2. The corporate planner and marketing researcher will find the report a helpful tool to analyze the PSRO impact on the future for the company's product lines.
3. The report can be used as a base of knowledge from which to build a strategy for capturing specific opportunities in the PSRO program.
4. The reader will find that nowhere else does such a thorough list of reference sources and data exist on the PSRO program.
5. The client can determine which area of the PSRO program affects his business operation the most, and then choose to take immediate action or to simply monitor the program as it becomes further implemented.

The next two Sections (III and IV) of this report provide a macro-analysis of the history and projected growth of the health care industry and a description of some of the more crucial medical care issues as a

Figure 1



backdrop to the PSRO program. Sections V and VI provide a history of the development of peer review, culminating in the passage of the PSRO legislation. Sections VII and VIII describe the reactions of various interest groups to the PSRO program and the current status of program implementation. The last two major Sections describe the opportunities resulting from peer review and some recommended approaches for taking advantage of these opportunities.



### SECTION III. THE HEALTH CARE INDUSTRY--GROWTH PATTERNS AND PROJECTIONS

This Section of the report provides a brief description of the history of the growth patterns as well as projections for future growth of the health care industry. Specifically, this Section will analyze on a macro-basis, the growth of the health care industry from 1955 to the present and then make projections through 1985. The Section additionally presents special analyses for the following major components of the industry: pharmaceuticals and drugs; medical supplies and equipment; health manpower; physical facilities.

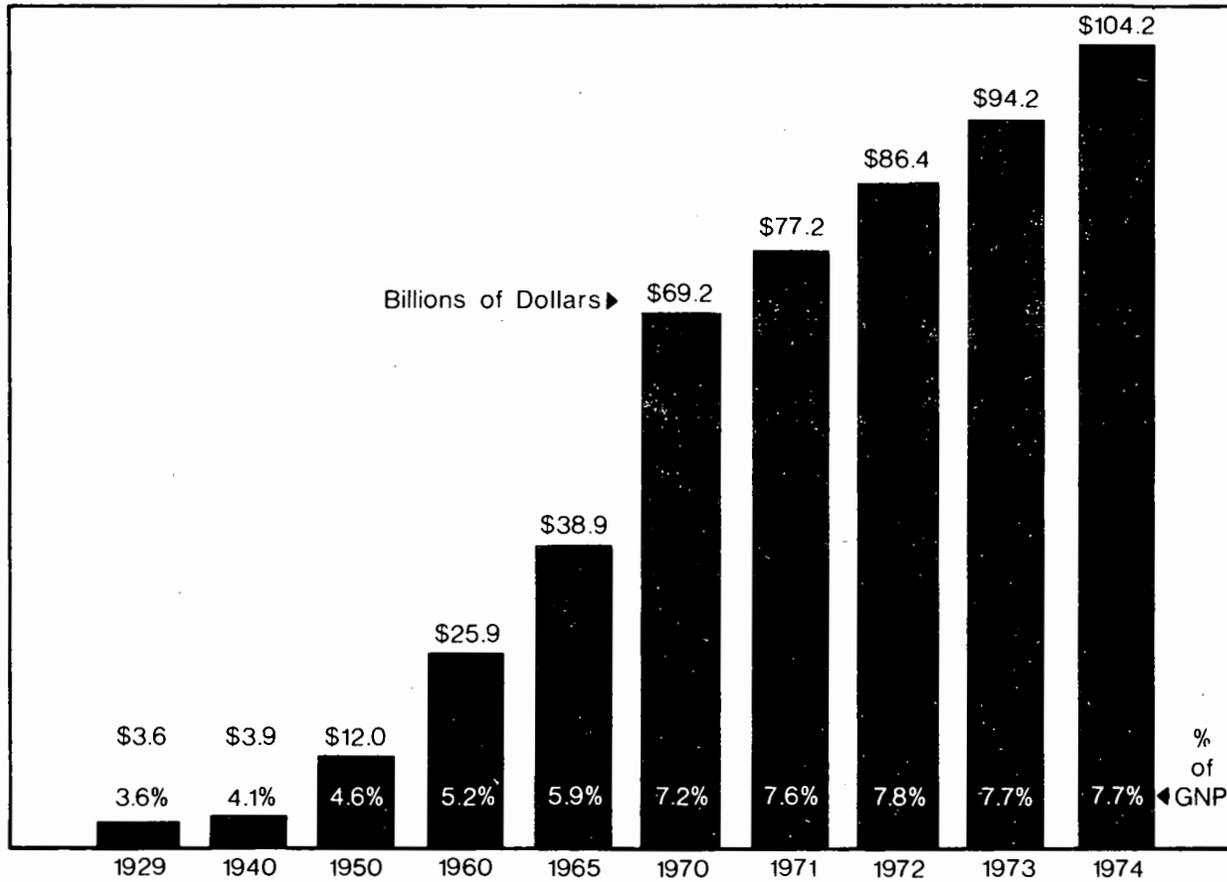
#### A. Analysis for Period 1955 to 1985

In 1974, Americans spent over \$104 billion for health care--more than an eight-fold increase from the \$12 billion spent in 1950. During the same period, the average per capita expenditure for health care rose from \$78 to \$485. From 1950 to 1970, the proportion of Gross National Product (GNP) spent for health care increased from 4.5% to 7.2%, but since 1972 the percent of the GNP spent on health has tapered off at about 7.7%. In fiscal year 1975 it is estimated to rise to about 8.3%.

Hospital expenditures accounted for \$40.9 billion of the total health expenditures in 1974. Doctors' bills accounted for \$19 billion. Since 1970, the hospital expenditures have increased 58%, while physician expenditures have gone up 41%. During the last ten years, except for the two and a half years of the Economic Stabilization Program, the medical care components of the Consumer Price Index (CPI) rose faster than did the total CPI.

Figure 2

**NATIONAL HEALTH EXPENDITURES AND PERCENT OF GROSS NATIONAL PRODUCT, SELECTED FISCAL YEARS, 1929 -1974**

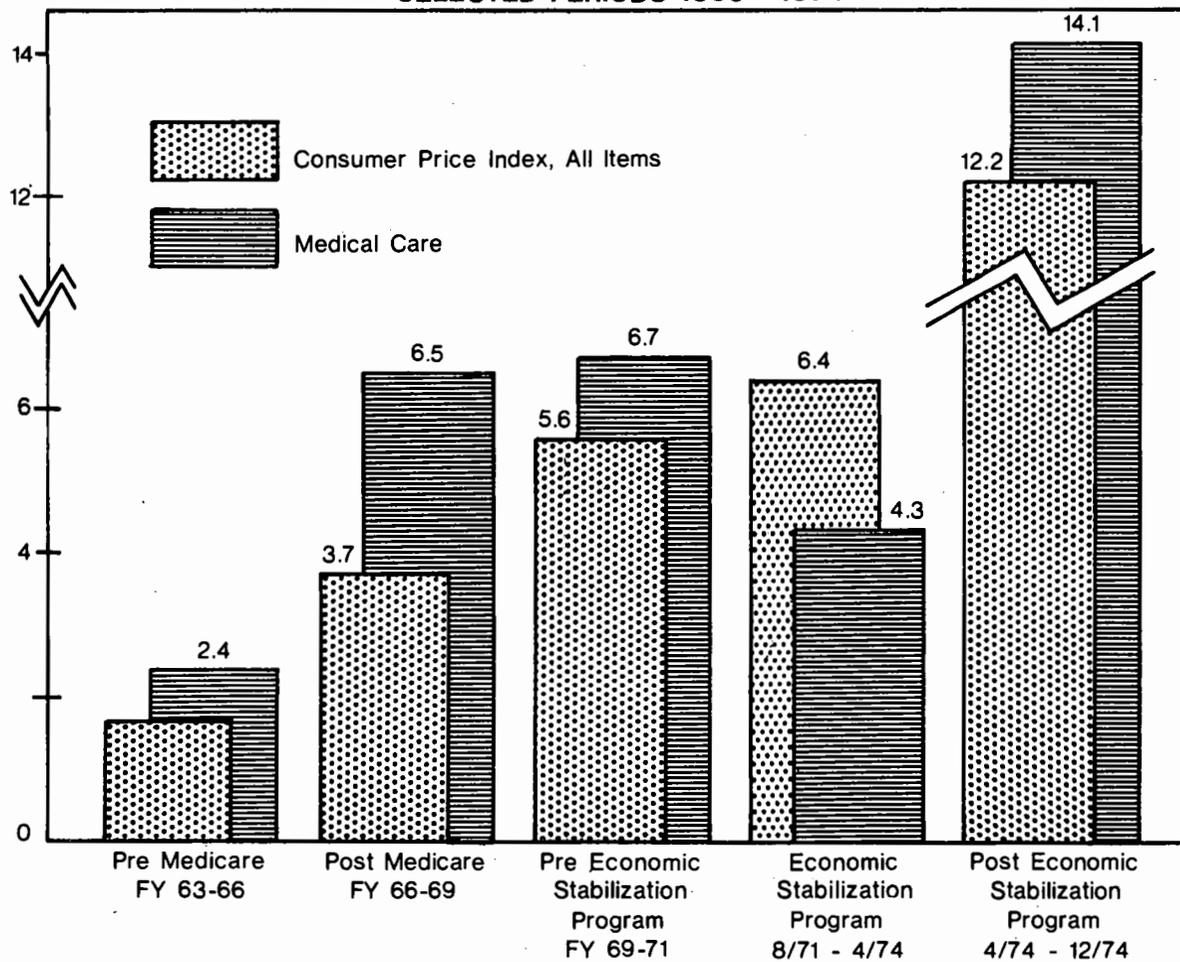


Source: Social Security Administration • Office of Research and Statistics

Percentage  
of Increase

Figure 3

**AVERAGE ANNUAL INCREASE IN THE CPI AND MEDICAL CARE PRICES  
SELECTED PERIODS 1963 - 1974**



Source: Social Security Administration • Office of Research and Statistics

The impact on individual families of the rising costs of medical care is reflected in the 16% of families in 1970 that had annual out-of-pocket medical expenses, including health insurance premiums, in excess of \$1,000. There were significant differences in the amount of out-of-pocket expenses by family income level, with 9% of the families with incomes of less than \$5,000 having expenses in excess of \$1,000, and 32% of the families with incomes over \$15,000 having expenses over \$1,000.

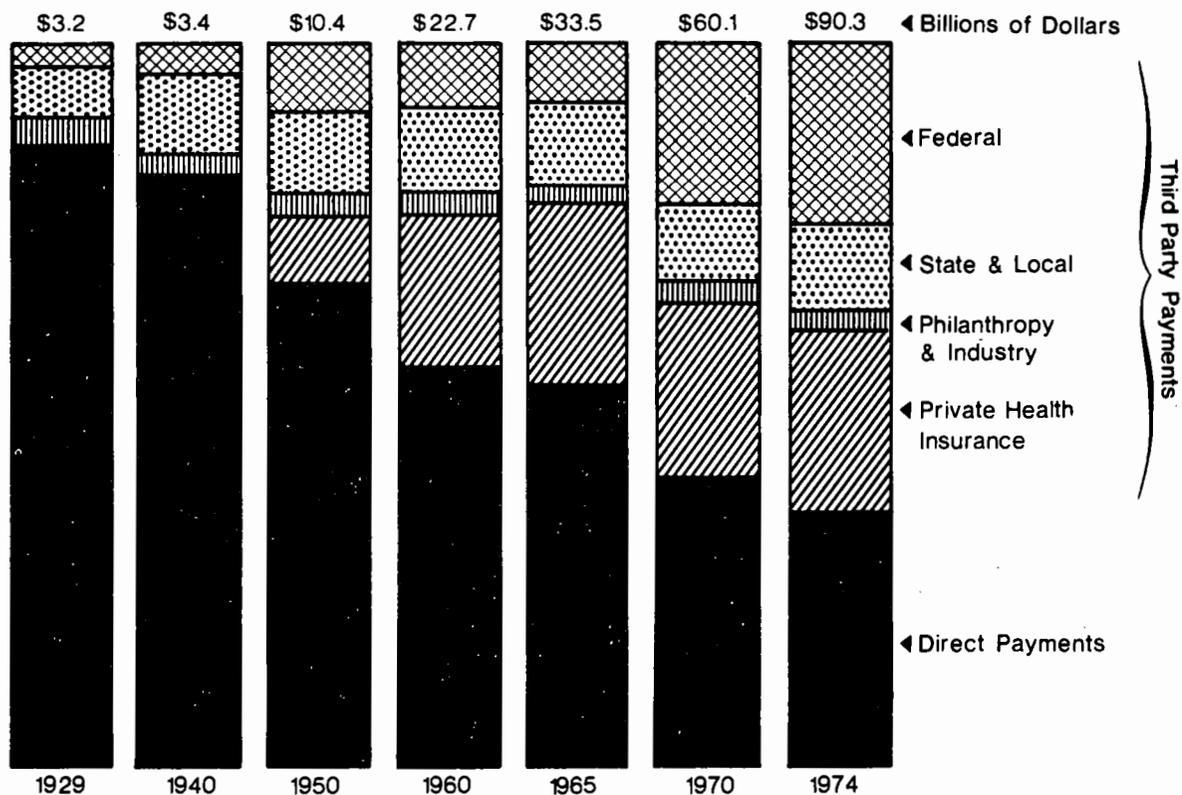
Gross expenditures in the health sector rose approximately 10% or more per year for each of the past eight years. This is not much different from other western industrial nations. In France, for instance, gross expenditures for health services at least tripled between 1965 and 1974--an annual growth rate of approximately 14%. Between 1965 and 1972, Sweden's aggregate expenditure increased by more than 150%--also an annual rate of 14%. Therefore, the experience of the United States during this period has not been much different from that of other nations.

Figure 2 presents the U.S. national health expenditures and percent of Gross National Product for selected years from 1929 through 1974. The level of aggregate expenditures for a year reflects billions of separate health care transactions--the payment made to a physician for a well-baby check-up; the purchase of an over-the-counter drug; the payment made for extensive orthodontic treatment; charges by the hospital, the surgeon, the anesthesiologist, and the special duty nurse in connection with open-heart surgery; the charges for an entire year's residence in a nursing home.

Therefore, a multitude of different forces can be involved in a change in the aggregate level. It has been estimated that approximately one-half of the increase in expenditures between 1965 and 1972 is due to price increases. However, description of price increases as a cause of

Figure 4

**DISTRIBUTION OF PERSONAL HEALTH CARE EXPENDITURES, BY SOURCE OF FUNDS  
SELECTED YEARS, 1929 - 1974**



Source: Social Security Administration • Office of Research and Statistics

Table 2

## FEDERAL OUTLAYS FOR MEDICAL AND HEALTH-RELATED ACTIVITIES BY AGENCY, 1974

(In millions of dollars)

	Func- tional code	Health research	Training and education	Construc- tion	Organiza- tion and delivery	Direct Federal hospital and medical services	Indirect Federal hospital and medical services	Preven- tion and control of health problems	Total
Department of Health, Education, and Welfare (total).....	550	(1,583)	(767)	(377)	(244)	(218)	(17,741)	(454)	(21,384)
Health Services Administration.....	551	5	33	38	-11	176	525	135	901
Health Resources Administration.....	550	2	452	277	182			17	929
Alcohol, Drug Abuse, and Mental Health Administration.....	550	128	106	15	33	38	256	56	632
Center for Disease Control.....	553	36	1					96	134
National Institutes of Health.....	550	1,386	145	28	26				1,584
Food and Drug Administration.....	553	20		1				144	165
Assistant Secretary for Health.....	550	4		1	12	4	11	8	38
Social Security Administration.....	551						11,348		11,348
Social and Rehabilitation Service.....	551/600	3			2		5,586		5,591
Other HEW.....	500	1	30	17			15	2	62
Department of Defense.....	051	107	191	86	1	2,062	474	13	2,934
Veterans Administration.....	703	78	167	107	18	2,488	148		3,006
Department of Housing and Urban Development.....	451			156	54				210
Department of Agriculture.....	350	45		1				244	290
Environmental Protection Agency.....	304	17						3	20
National Aeronautics and Space Administration.....	250	64							64
Energy Research and Development Administration.....	251	115		6					121
Department of Labor.....	553	1	4		4			61	69
Department of State.....	150		7		12		1	25	45
National Science Foundation.....	250	44	2						45
Other agencies.....		31	8	28	59	29	11	88	255
Agency contributions to employee health funds.....	551						745		745
<b>Total outlays for health, 1974.....</b>		<b>2,085</b>	<b>1,146</b>	<b>761</b>	<b>392</b>	<b>4,797</b>	<b>19,120</b>	<b>888</b>	<b>29,189</b>

Source: Bureau of the Budget, Executive Office of the President

increase may be based on questionable assumptions and measurements. In any case, only a relatively small part of the increase in expenditures since 1965 could have been due to increased purchases of a constant mixture of goods and services. For instance, while overall aggregate expenditures increased by 168% between 1965 and 1974, the number of patient days in community hospitals increased by only 20%. In fact, the only major category of goods and services where there has been a substantial increase in the volume of utilization was nursing home care, but the increment was not large enough to account for more than a small proportion of the overall aggregate increase. It appears that a significant proportion of the rise in expenditures has been due to changes in the kinds of services provided.

After a number of years of relatively rapid increase, the percentage of Gross National Product devoted to health expenditures was rather stable for the four years between fiscal 1971 and 1974. During the period in which Gross National Product going for medical care was growing every year, medical care prices were increasing more rapidly than the Consumer Price Index as a whole. This is indicated by Figure 3. During the period of the Economic Stabilization Program--August 15, 1971 through April, 1974--however, medical prices were rising less rapidly than prices in general. Therefore, if the relative volume of output in the different sectors of the economy had remained constant during this latter period, aggregate health expenditures would have constituted a somewhat smaller percentage of Gross National Product than it had in prior years. It appears that the consumption of medical care has been growing at a slightly more rapid

Table 3

## FEDERAL OUTLAYS FOR MEDICAL AND HEALTH-RELATED ACTIVITIES BY AGENCY, 1975

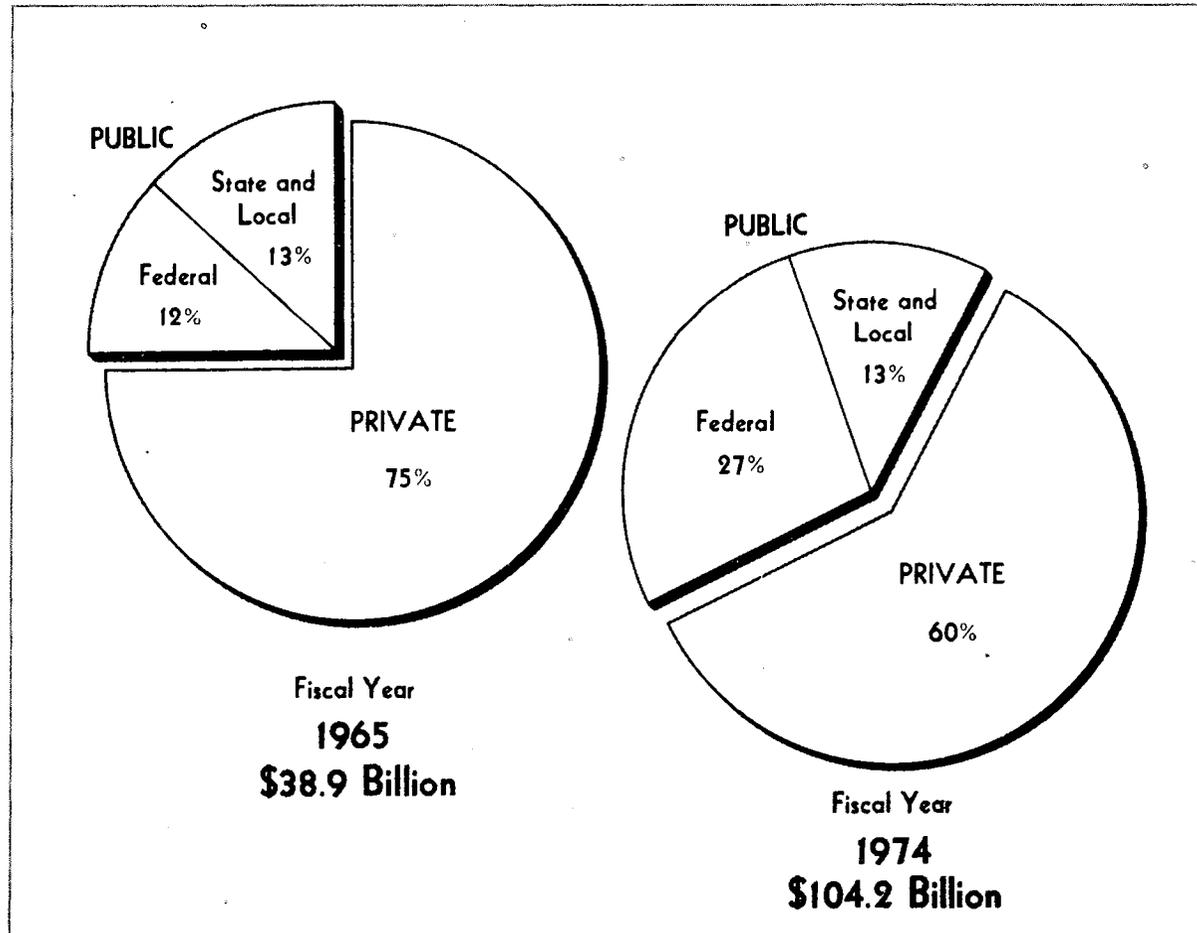
(In millions of dollars)

	Func- tional code	Health research	Training and education	Construc- tion	Organiza- tion and delivery	Direct Federal hospital and medical services	Indirect Federal hospital and medical services	Preven- tion and control of health problems	Total
Department of Health, Education, and Welfare (total).....	550	(1,845)	(860)	(476)	(363)	(260)	(21,473)	(504)	(25,781)
Health Services Administration.....	551	5	38	62	31	211	617	156	1,120
Health Resources Administration.....	550	2	490	325	221	-----	-----	18	1,056
Alcohol, Drug Abuse, and Mental Health Administration.....	556	136	132	25	65	45	407	56	866
Center for Disease Control.....	553	41	2	-----	-----	-----	-----	96	139
National Institutes of Health.....	550	1,633	165	43	27	-----	-----	-----	1,868
Food and Drug Administration.....	553	22	-----	2	-----	-----	-----	171	196
Assistant Secretary for Health.....	550	3	-----	1	13	3	-----	7	38
Social Security Administration.....	551	-----	-----	-----	-----	-----	13,903	-----	13,903
Social and Rehabilitation Service.....	551/600	3	-----	-----	4	1	6,517	-----	6,525
Other HEW.....	500	-----	33	9	2	-----	18	-----	61
Department of Defense.....	051	103	219	157	2	2,187	592	11	3,271
Veterans Administration.....	703	91	223	142	23	2,911	223	-----	3,613
Department of Housing and Urban Development.....	450	-----	-----	156	33	-----	-----	-----	189
Department of Agriculture.....	350	47	-----	8	-----	-----	-----	262	317
Environmental Protection Agency.....	304	29	-----	-----	-----	-----	-----	5	34
National Aeronautics and Space Administration.....	250	65	-----	-----	-----	-----	-----	-----	65
Energy Research and Development Administration.....	251	143	1	6	-----	-----	-----	-----	150
Department of Labor.....	553	2	5	-----	4	-----	-----	91	102
Department of State.....	150	-----	7	-----	12	-----	1	24	45
National Science Foundation.....	250	46	2	-----	-----	-----	-----	-----	48
Other agencies.....	-----	53	7	21	90	32	31	122	356
Agency contributions to employee health funds.....	551	-----	-----	-----	-----	-----	1,073	-----	1,073
<b>Total outlays for health, 1975.....</b>	-----	<b>2,424</b>	<b>1,324</b>	<b>966</b>	<b>527</b>	<b>5,390</b>	<b>23,393</b>	<b>1,019</b>	<b>35,044</b>

Source: Bureau of the Budget, Executive Office of the President

Figure 5

### Public and Private Health Expenditures



Source: Social Security Administration

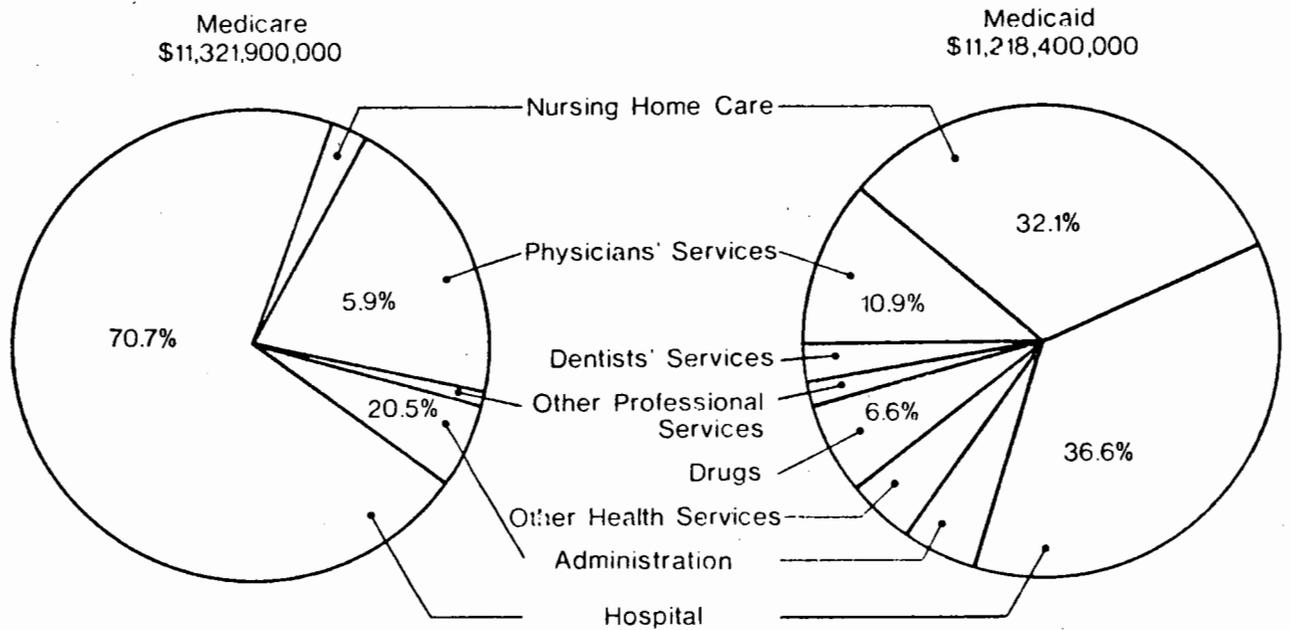
rate than has the output of the economy as a whole during the past several years. The increased utilization, however, was more in terms of the provision of more expensive care rather than increased volume.

Federal expenditures for personal health care have been growing more rapidly than private expenditures, as indicated by Figure 4. The share of aggregate personal health care expenditures paid for by the Federal Government has risen from 8.5% in fiscal 1965 to 25.5% in fiscal 1974. Much of this rise has been due to expenditures under the Medicare and Medicaid programs, which makes the PSRO program much more important. While state expenditures under the Medicaid program have also been rising very rapidly, the total state share of expenditures has remained rather level over a number of years. The rapid rise in state Medicaid payments has been offset by relative stability in other categories of state personal health care expenditures, resulting in a rise in the state total at approximately the same rate as personal health care expenditures from all sources combined.

As indicated by Figure 6, approximately 70% of the Medicare expenditures in fiscal 1974 went for hospital care and 20% for physician services. This distribution could be the result of the Medicare benefit structure, morbidity patterns, and the immunization pattern of the population aged 65 and older. Payments for care in long-term facilities and in short-term hospitals constitute the two largest categories of expenditures under Medicaid (32.1% and 36.6%, respectively). While nearly two-thirds of the individuals for whom Medicaid payments are made are children under 21 years of age, only about 15% of the aggregate expenditures are

Figure 6

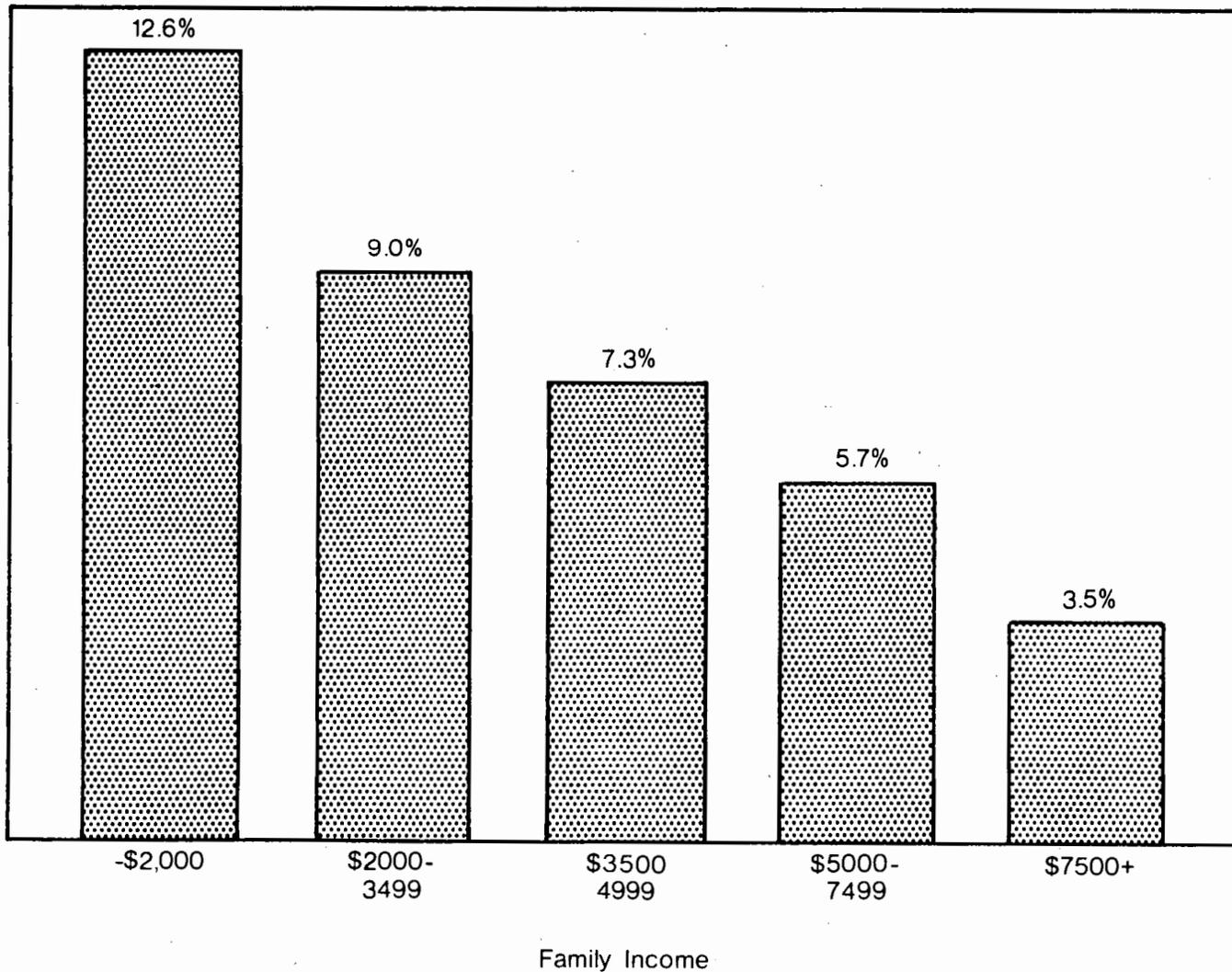
**MEDICARE AND MEDICAID PAYMENTS BY TYPE OF SERVICE, 1974**



Source: Social Security Administration • Office of Research and Statistics

Figure 7

**PERCENT OF FAMILY INCOME PAID OUT-OF-POCKET  
MEDICAL EXPENSES BY FAMILY INCOME, 1970**



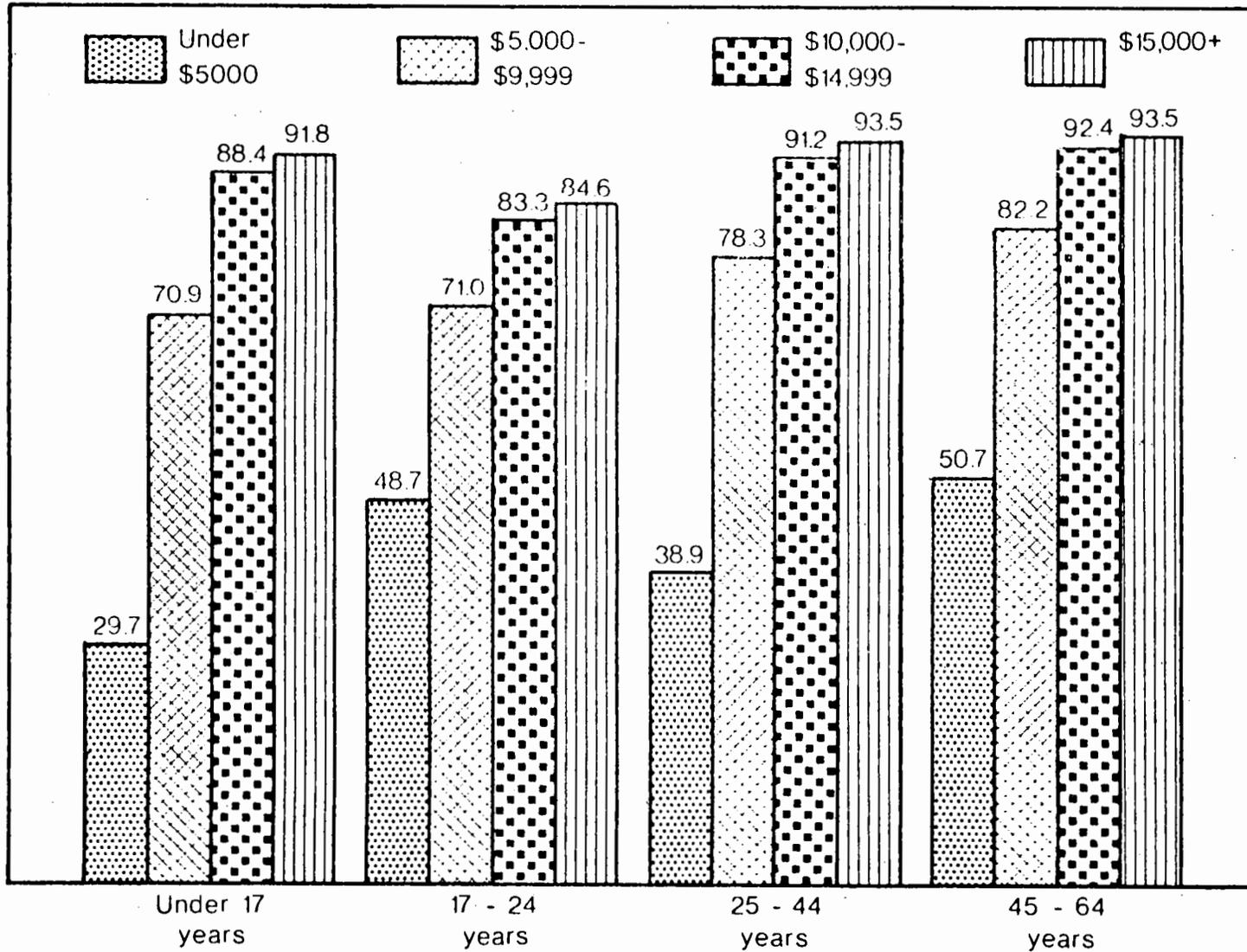
Source: Center for Health Administration Studies

for that age group. Payments for children are usually for ambulatory care and relatively short hospital stays, while payments for older individuals--particularly for the aged--are for stays in long-term care institutions and for long stays in hospitals.

The percentage of the aggregate expenditures paid for out-of-pocket by families has been steadily decreasing for at least the last four decades. This is due both to the increase in the Federal share and the increase in the coverage by private insurance. While the proportion of aggregate expenditures paid for directly by families has dropped from approximately two-thirds in 1950 to approximately one-third in 1974, total expenditures have been rising so rapidly that the average direct payment by families was approximately three times as great in 1974 as in 1950. Spreading the risk of large expenditures over the population has been viewed as one of the functions of private medical care insurance. As an example, prepayment can protect the individual family against having to make exceptionally large outlays during a relatively short period. This has been accomplished to a certain extent by the current array of payment mechanisms. However, there is still an appreciable risk for many families of incurring responsibility for substantial payments for medical care. This is why so many of the legislators have been pushing the concept of catastrophic health insurance to allow for emergencies of this nature. Figure 7 indicates that in 1970, it appeared that at least one of every twelve American families paid more than \$1,000 out-of-pocket for a combination of medical and dental care and related private insurance premiums. While out-of-pocket payments rise--on the average--with family

Figure 8

PERCENT OF PERSONS WITH HOSPITAL INSURANCE  
COVERAGE BY FAMILY INCOME AND AGE 1972



Source: Health Interview Survey • National Center for Health Statistics

Table 4.

## MEDICAL SERVICES: TRENDS AND PROJECTIONS, 1965-75

(In Billions of Dollars Except as Noted)

Type of Expenditure	1965	1970	Per- cent in- crease 1965- 70*	1971	Per- cent in- crease 1970- 71	1972	Per- cent in- crease 1971- 72	1973 <sup>1</sup>	Per- cent in- crease 1972- 73	1974 <sup>1</sup>	Per- cent in- crease 1973- 74	1975 <sup>1</sup>	Per- cent in- crease 1974- 75
TOTAL	40.5	71.6	12.1	79.6	11	89.5	12	98.7	10	112.0	14	125.9	12
Health Services and Supplies	37.1	66.4	12.3	73.9	11	83.2	13	91.8	10	104.5	14	117.7	13
Hospital care	13.6	27.5	15.2	30.8	12	34.2	11	38.0	11	43.5	14	49.6	14
Physicians' services	8.7	14.3	10.3	15.8	11	17.3	11	19.1	9	21.5	13	24.0	12
Dentists' services	2.8	4.4	9.5	4.9	10	5.2	7	5.6	7	6.0	8	6.5	9
Other professional services	1.0	1.5	7.1	1.6	6	1.6	5	1.7	5	1.8	6	2.0	7
Drugs and drug sundries	4.9	7.4	8.8	7.8	5	8.5	9	9.1	8	10.1	9	10.9	9
Eyeglasses and appliances	1.2	1.9	8.7	2.0	6	2.1	4	2.2	4	2.3	6	2.5	7
Nursing home care	1.3	3.1	18.1	3.4	9	3.6	8	3.9	7	4.3	10	4.7	9
Expenses for prepay- ment and administra- tion	1.3	2.1	10.3	2.6	26	3.7	39	4.6	25	5.8	26	6.9	19
Government public health activities	.7	1.6	17.6	2.0	27	2.5	27	2.6	25	3.2	25	4.0	25
Other health services	1.5	2.7	12.5	3.0	12	<sup>3</sup> 4.4	47	5.1	15	5.9	15	6.7	15
Research and Medical Facilities Construc- tion	3.4	5.2	8.6	5.8	11	6.4	9	6.9	9	7.5	9	8.2	9
Research <sup>2</sup>	1.5	1.8	4.7	2.0	5	2.2	11	2.4	9	2.6	9	2.8	9
Construction	1.9	3.4	12.0	3.8	14	4.2	9	4.5	9	4.9	9	5.4	7
Percent of GNP	5.9	7.3	--	7.5	--	7.7	--	7.7	--	7.7	--	--	--
Medical care--Consumer price index (1967 = 100)	89.5	120.6	--	128.4	--	132.5	--	137.7	--	150.0	--	--	--

Source: Office of Research and Statistics, Social Security Administration, Bureau of Labor Statistics and BDC

<sup>1</sup> Estimated by BDC.

<sup>2</sup> Research expenditures of drug companies included in expenditures for drug sundries and excluded from research expenditures.

<sup>3</sup> A new expenditure category "Medical payments to immediate health care facilities" was included in "other health services" beginning in 1972.

\* Compound annual rate of growth

Note: Totals do not always equal sum of components because of rounding.

Source: Office of Research and Statistics, Social Security Administration, Bureau of Labor Statistics and BDC.

income, these payments constitute a considerably larger percentage of income among poor than among wealthier families.

In 1972, it is estimated that approximately 76.7% of the population under 65 years of age had private health insurance of some type. However, there are marked differences by income level in the proportion of the population with insurance. For example, among persons 45 to 64 years of age, only one-half of those in families with less than \$5,000 have health insurance, while over 90% of those in families with incomes over \$15,000 have insurance. The percentage of persons with hospital insurance coverage by family income and age in 1972 is indicated by Figure 8.

It is very difficult to obtain information on the kinds of coverage people have under the health insurance plans; in other words, whether in addition to hospital bills, insurance pays for outpatient services, prescription medicines, nursing home care, and what proportion of these bills are paid by insurance (some data is included in next Section).

While there is a general concensus regarding the desirability of risk-sharing functions of insurance, there is less agreement regarding the desirability of total coverage for various categories of medical care charges.

The continued high levels of spending on medical care services reflect several persistent trends:

- (a) the changing composition of the population resulting from increased longevity and a declining birth rate;
- (b) rising prices per unit of service;

- (c) increases in the level and scope of services due to new drugs and treatment procedures;
- (d) the rapid expansion of private and public health insurance coverage, making medical care financially accessible to increasing numbers of Americans.

A large share of the medical dollar is spent on such manufactured goods as drugs, linens and furniture for hospitals and nursing homes; food servicing carts; computers which allegedly speed hospital record keeping; high volume and increasingly sophisticated laboratory equipment; and prefabricated patient service walls with monitoring devices. Other innovative equipment and new treatment techniques being used more frequently in hospitals include radiographs which can process X-rays in 90 seconds, kidney dialysis units, operating room instruments capable of broadcasting a patient's heart rate and blood pressure, and single-use packs of disinfectants which reduce infection hazards caused by the use of stock bottles. The trends and projections for medical care expenditures for the period through 1975 are presented in Table 4.

Medical spending varies considerably according to age group. One out of every ten Americans is 65 years of age or older. However, only about \$3 out of every \$10 spent on personal health care is for an aged person. The average medical bill for a person 65 years of age and over was \$1,052 in fiscal 1973, compared with \$384 for the 19 to 64-year group, and \$167 for those under 19. The average hospital bill for an aged person was ten times that of a youth and nearly triple that of persons in the intermediate age group.

With the shift of medical care financing from the private to the

Table 5.

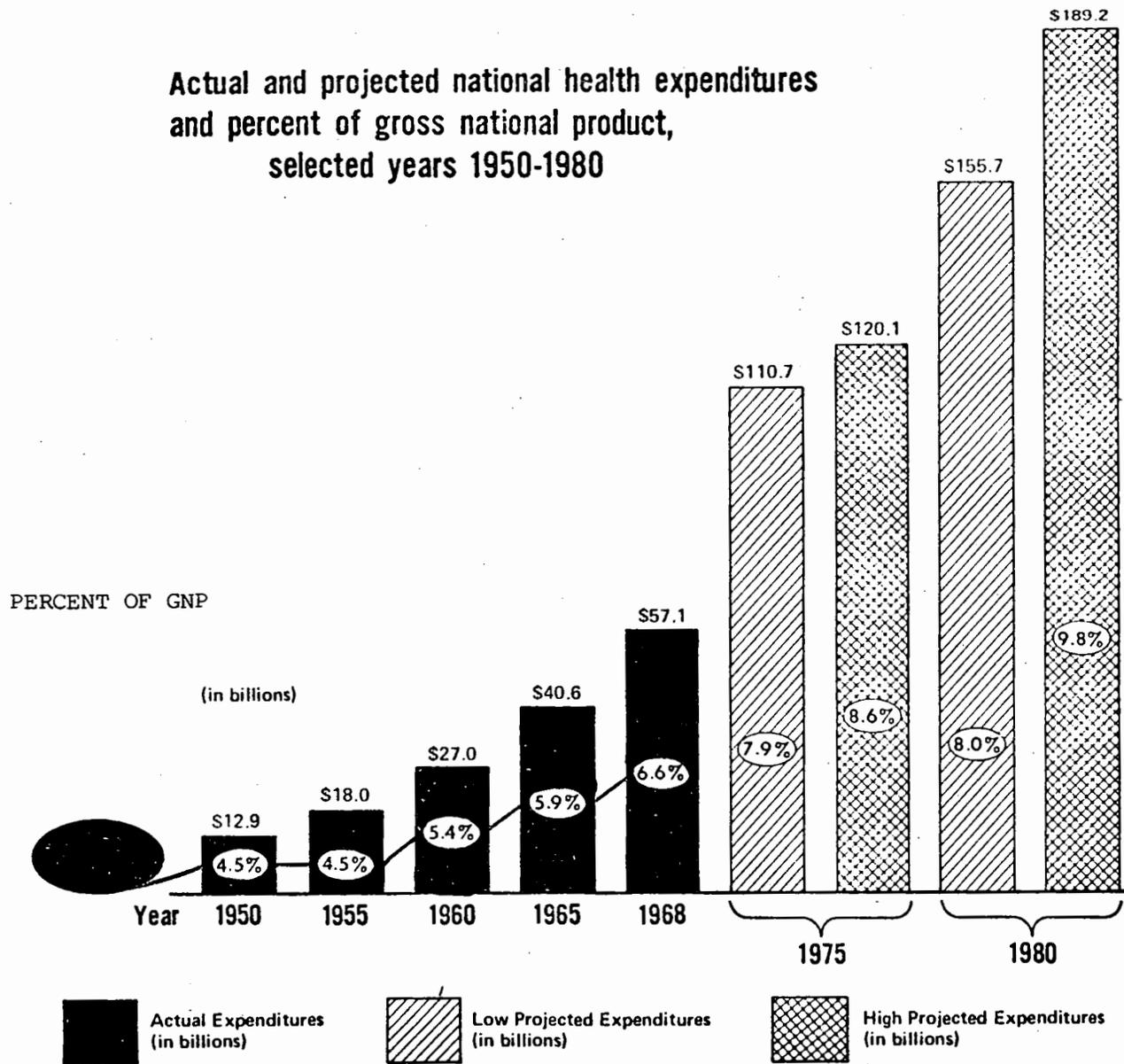
CONSUMER PRICE INDEX OF SELECTED MEDICAL CARE  
 COMPONENT PRICE CHANGES FOR SELECTED PERIODS

	Average Annual Percent Increase					
	All Items	Medical Care Total	Physician Fees	Dentist Fees	Semi- Private Room	Drugs and Prescriptions
1965-70	4.2	6.1	6.6	5.3	13.9	.7
Impact of Economic Stabilization						
7/69 - 7/71	5.6	6.7	7.4	6.4	13.3	2.0
8/71 - 11/71 (Phase 1)	1.6	-.8	2.4	6.1	2.8	.4
11/71 - 1/73 (Phase 2)	3.6	3.4	2.4	3.0	5.4	0
1/73 - 6/73 (Phase 3)	9.1	3.8	4.1	3.2	5.2	.5
6/73 - 4/74 (Phase 4)	10.4	7.6	6.8	6.0	7.1	1.9
Post Controls Period - 4/74 - 5/74	14.0	14.0	16.8	7.4	16.8	4.9

Source: Consumer Price Index, Bureau of Labor Statistics

Figure 9.

**Actual and projected national health expenditures  
and percent of gross national product,  
selected years 1950-1980**



Source: Social Security Administration

public sectors since the advent of Medicare/Medicaid, public funds cover more than 4/5's of the aged's hospital bills and about 3/5's of their physician fees. In contrast, public funds pay for only 2/5's of the hospital expenditures for persons under 65 and less than 13% of their doctor bills. This is described graphically by Figure 8, entitled "Medical Insurance Benefits Vary Among Age Groups."

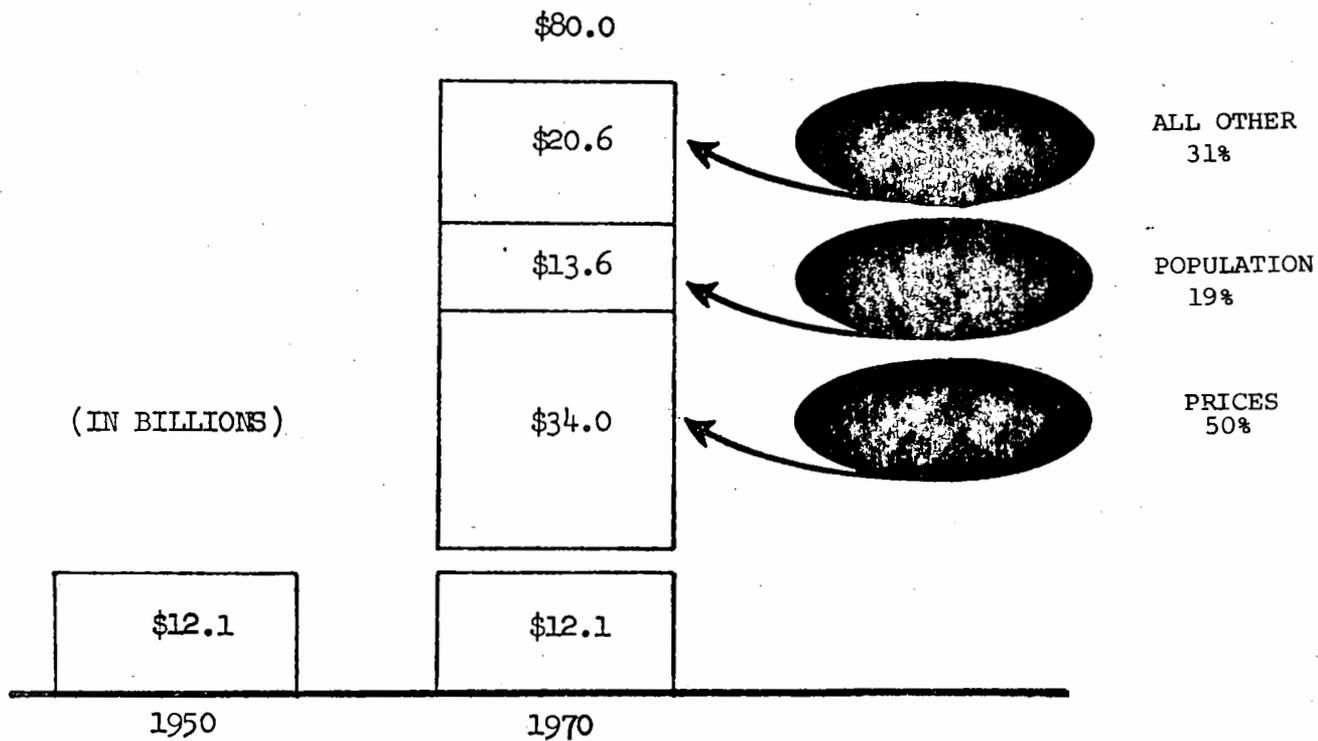
In 1964, approximately \$50 billion was spent on hospital care--the largest item in the nation's health bill. Spending on hospital care has more than tripled since 1965, increasing at a 13.8% annual rate. The average daily hospital charge, not including physicians' fees, grew from \$44 in 1965 to more than \$100 in 1974.

Under the Economic Stabilization Program, strict controls were imposed on the health care industry which limited price increases for unit charges to 6%. Largely because of wage-price controls, consumer prices for medical care in 1972 and 1973 rose at an annual rate of only about one-half of that reported during the pre-freeze. Average daily hospital rate increases have slowed significantly.

However, hospital expenses per patient-day continue to rise rapidly--largely reflecting sharp increases in such non-payroll expenses as rent, interest, equipment and supplies. According to the American Hospital Association, non-payroll expenses now account for 45% of all hospital expenses, compared with 37% in 1968. With the ending of price and wage controls on April 30, 1974, hospital expenses were expected to continue to rise, reflecting higher prices for purchased goods and services.

Table 5 indicates the Consumer Price Index of selected medical care.

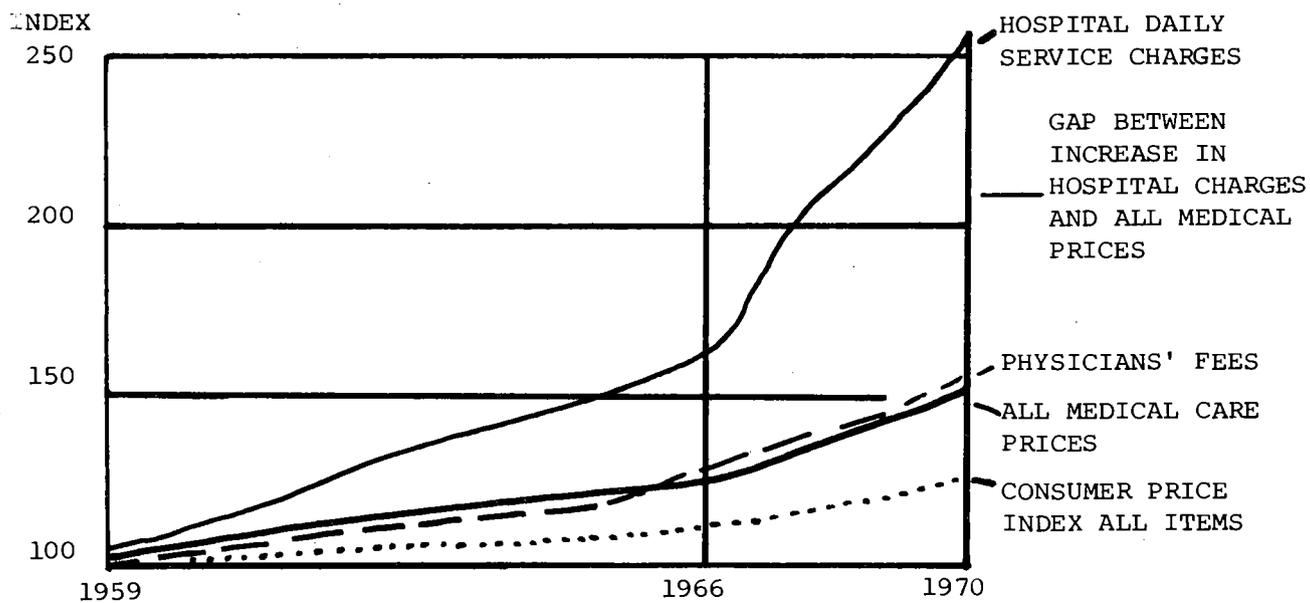
Figure 10.  
CAUSES OF THE GROWTH IN MEDICAL EXPENDITURES FROM 1950 - 1970



Source: United States Department of Commerce

Figure 11.

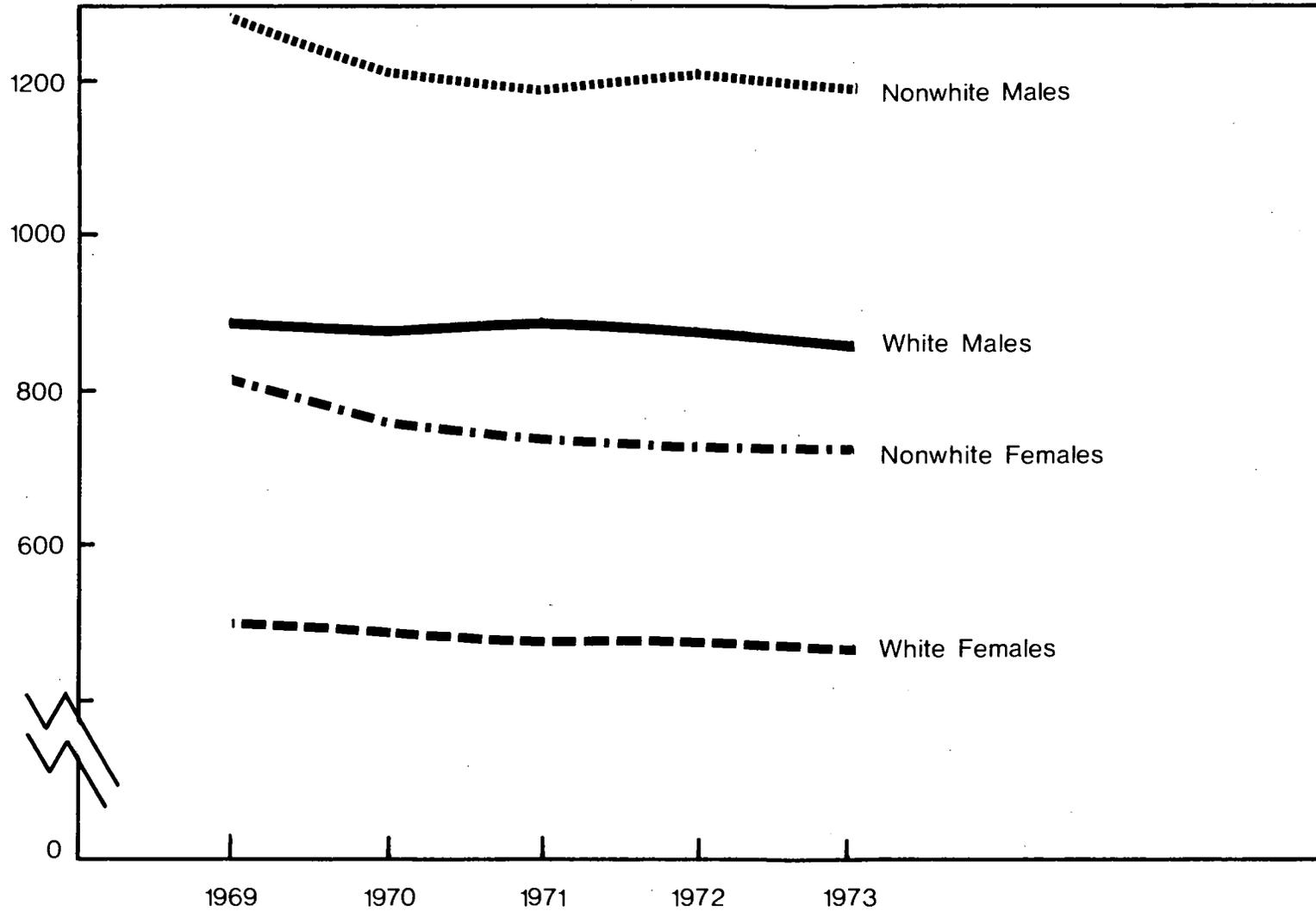
THE RISE IN MEDICAL CARE PRICES: GAP BETWEEN INCREASE  
IN HOSPITAL CHARGES AND ALL MEDICAL PRICES 1959 - 1970



Source: Social Security Administration

Figure 12

**AGE-ADJUSTED DEATH RATES, ALL CAUSES  
BY COLOR AND SEX, U.S., 1969-1973**  
(DEATHS PER 100,000 POPULATION)



Source: National Center for Health Statistics

component price changes for select periods before, during, and after the Economic Stabilization Program.

Figure 9 indicates the actual and projected national health expenditures and percentage of Gross National Product for the period 1950 through 1980. It should be noted that the high projected expenditures for 1980 are approximately 9.8% of Gross National Product.

Figure 10 indicates the causes of the growth in medical expenditures during the period 1950 through 1970. Fifty percent of the increase is accounted for by general price increases and inflation; 19% is caused by population increases; and 81% of the increase is caused by all other factors. In addition, Figure 11 indicates the rise in various medical care prices for the period 1959 through 1970, and illustrates the wide gap between the increase in hospital charges and other medical services for physicians' fees and other medical care prices, and the Consumer Price Index for all items.

A word about the general health status of the Nation is appropriate here. After a decade of stable mortality rates in the United States, the age-adjusted mortality rates have again shown a steady decline of approximately 2% per year since 1968. This is indicated by Figure 12. The causes of the leveling off during the preceding decade and the recent downturn are not clear or well understood. The recent decline in mortality is particularly marked among selected diseases and within certain age and sex groups. For example, for each ten-year age group among males aged 25 through 74, the death rate from eschemic heart disease dropped nearly 10% or more between 1968 and 1973 (for males aged 55

through 64, the drop was 961 to 870 per 100,000 population).

Wide differences in mortality still remain among various subgroups of the population. For instance, the age-adjusted death rate for non-white males was more than one-third greater than the rate for white males; the rate for non-white females was half again as great as the rate for white females.

Infant mortality rates have shown a pattern of decline similar to the mortality rates of the total population. Subsequent to an appreciable slowing of the rate beginning in the mid-fifties, a relatively rapid downward trend began in the mid-sixties. During the most recent decade, infant mortality has been declining at a rate of about 4% per year. The rate in 1974 was 16.5 deaths per 1,000 live births. However, there are very large differentials in infant mortality between various segments of the population.

In summary, it can be said that the health of the nation is certainly not improving as fast as the expenditures for health care are increasing. The PSRO program is an attempt to hold down some of the costs, while increasing the quality and, hopefully, the health of the nation. This is the primary reason why the above analysis has been included in this report in a discussion of PSRO.

#### B. Pharmaceuticals

It is estimated that over 2.25 billion prescriptions were written in 1974. Drugs have become an intrinsic part of disease management. The average practicing physician is known to prescribe some pharmacological

Figure 13.

DRUGS AND PHARMACEUTICALS: PROJECTIONS 1974-80<sup>1</sup>

(Value of Shipments in Millions of Dollars Except as Noted)

SIC Code	Industry	1974	Percent Increase 1973-74	1975	Percent Increase 1974-75	1980	Percent Increase 1974-80 <sup>2</sup>
283	Drugs and Pharmaceuticals	9,554	9	10,395	9	15,990	9.0
2834	Pharmaceutical Preparations	8,470	9	9,215	9	14,180	9.0

<sup>1</sup> Estimated by Bureau of Domestic Commerce

<sup>2</sup> Compound annual rate of growth

Source: United States Department of Commerce

agent for 75% of his patients.

In 1975, the drug and pharmaceutical shipments should increase to a record high of \$10.4 billion. This is an increase of almost 9% over estimated shipments of \$9.6 billion in 1974. Projections for the period 1974 through 1980 are contained in Figure 13.

There is a continuing healthy demand for drug products. There is also increased government funding of health care services at the Federal and state levels. In addition, there is an ever-expanding overseas market which will contribute to industry growth. However, some of the negative influences on industry growth are:

1. a lethargic tendency in the introduction of new drugs and chemicals;
2. price pressures are already arising from regulations under government-funded health programs; and
3. wider use and popularity of generic drugs.

The share of industry sales of prescriptions in generic form continues to rise. This reflects the expiration of patent protection on large numbers of drugs, and the lower prices of generic drugs made possible by the lower introductory marketing costs of generic drug manufacturers. The price gap between generic and brand name drugs is expected to narrow as producers of generics increase their outlays to improve their quality control systems. In addition, generic producers will probably shift sales promotion expenses from brand name to generic products.

Because of the impact of generic prescribing, many major drug companies are proceeding to diversify their product line into many non-drug

health-related areas. In addition, these companies are increasing overseas expansion in order to keep pace with expanding market prospects abroad.

Post-tax profits for drug and pharmaceuticals averaged 10.2% on sales in 1973--a figure slightly below the 1972 average. This is compared with 4.7% for all manufacturing industries.

After-tax profits, as a percentage of net worth in 1973, averaged 18.1%. This represented an improvement over 17.6% average of a year earlier. Profit margins could well be affected by the multitude of government programs which are being proposed and implemented. Table 6 illustrates the trends and projections in various parameters of measurement of drug activity for the period 1967 through 1975.

Research and development continues to be a major aspect of a pharmaceutical company's concern. In 1973, research and development expenditures totaled \$719 million, and outlays budgeted for 1974 amount to \$749 million. It is estimated that research and development spending will reach a record high of \$850 million in 1975, or more than 8% of estimated shipments. Research efforts probably will continue to focus on the discovery of anti-cancer, cardiovascular, central nervous system, and antiviral agents.

Drug exports in 1975 should total about \$697 million, or \$40 million above estimated 1974 exports. This increase is primarily due to rising demand in most major drug markets. In addition, developing countries, where expanding health programs are providing health care to more people, will require increasing amounts of drug products. Industry export growth

Table 6.

DRUGS AND PHARMACEUTICALS:  
TRENDS AND PROJECTIONS 1967-75

(In Millions of Dollars Except as Noted)

	1967	1970	1971	1972	1973 <sup>1</sup>	1974 <sup>1</sup>	Percent Increase 1973-74	1975 <sup>1</sup>	Percent Increase 1974-75
Industry:									
Value of shipments	5,302	6,778	7,261	8,071	8,781	9,554	9	10,395	9
Pharmaceutical preps <sup>3</sup>	4,696	5,994	6,393	7,155	7,785	8,470	9	9,215	9
Total employment (000)	118	131	135	129	132	n.a.	--	--	--
Production workers (000)	66	72	70	67	69	--	--	--	--
Value added per produc- tion worker man-hour (\$)	31.77	35.41	39.88	46.45	n.a.	--	--	--	--
Value of imports	72	87	119	149	163	179	10	190	6
Value of exports	288	420	396	474	626	655	5	686	5
Wholesale price index (1967 = 100)	100.0	101.1	102.4	103.0	104.3	--	--	--	--

<sup>1</sup> Estimated by BDC

n.a. = Not available

<sup>2</sup> Value of all products and services sold by the  
Drugs and Pharmaceuticals Industry (SIC 283)

Source: Bureau of the Census, Bureau of Labor  
Statistics, BDC

<sup>3</sup> Value of shipments of pharmaceutical preparations  
only (SIC 2834)

is expected to increase at an average of 9% per year during the seventies. Shipments should reach \$16 billion by 1980.

Increases in international markets are also forecast through increased exports, as well as investments in overseas facilities. While the availability of new capacities in the customer countries may limit drug exports to some countries, there will probably be increased exports to developing countries whose mounting health care requirements will generate a strong demand for drug products.

Exports should reach \$890 million by 1980, with Canada, Western European countries, Latin America, and Japan ranking high as prospective markets. The Soviet Union, the People's Republic of China, and many of the Soviet satellite countries are expected to emerge as important markets for U.S. products.

Imports are expected to total about \$250 million by 1980, with West Germany serving as the major supplier, followed by the United Kingdom, Switzerland, and probably Japan.

#### C. Supplies and Equipment

It appears very evident that the whole area of medical supplies and equipment is one of the fastest growing aspects of the health care industry. It is also characterized by rapid technological development. Much of the attention given to the lack of efficiency in the present delivery of health care services and the present trend toward preventive medicine will definitely open opportunities for many new products to gain ready market access.

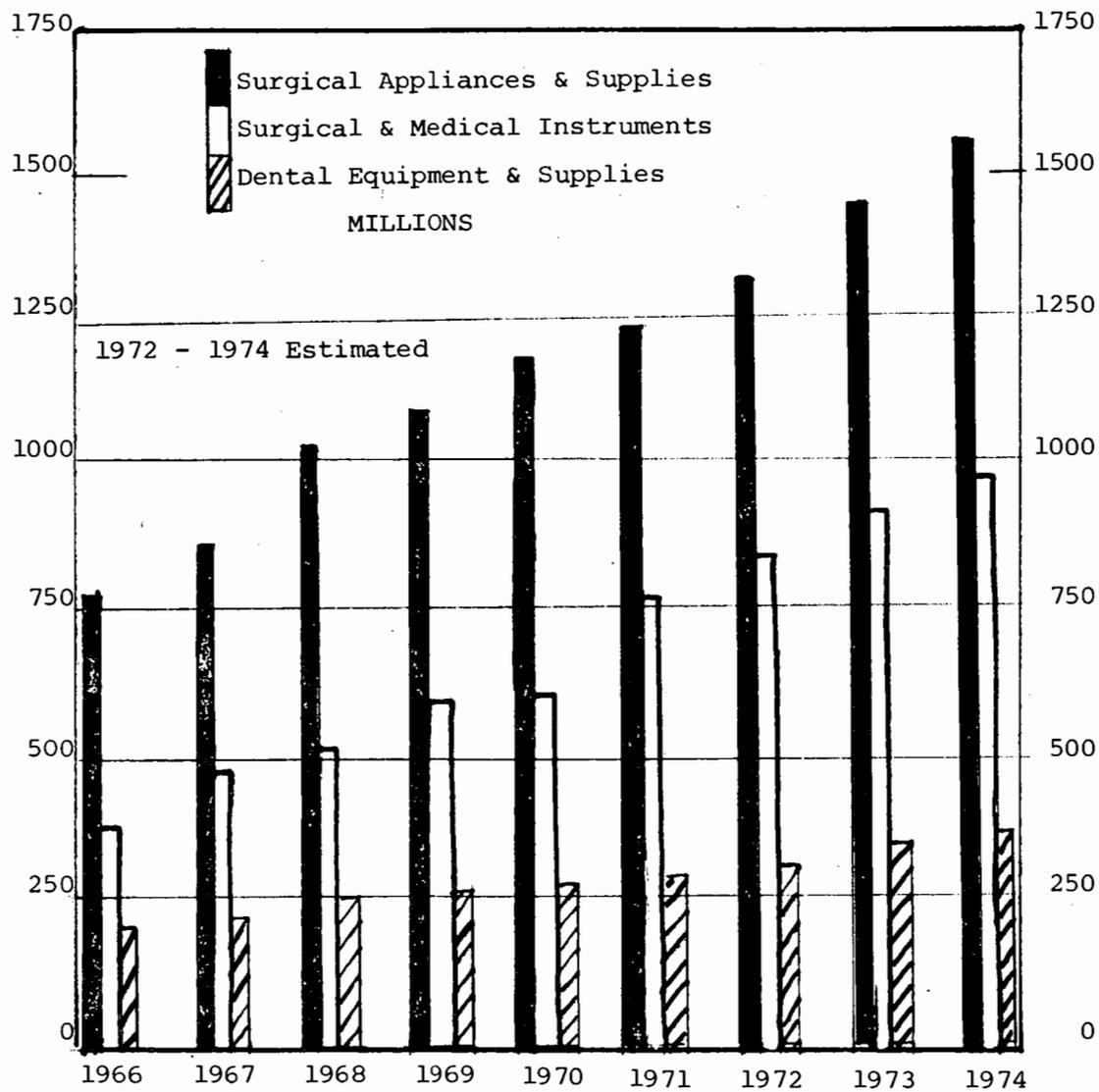
According to actual figures and estimates of the Department of Commerce, total value of shipments for medical and dental supplies and equipment in 1974 rose to \$2.9 billion, which is up approximately 8% from 1973. Shipments for 1975 are expected to rise to \$3.2 billion. Of overall shipments in 1974, surgical appliances and supplies accounted for 5% of the total; surgical and medical instruments, 3%; and dental equipment and supplies, 11%.

A need for new instrumentation and techniques is evident to help spiraling of labor costs in medical institutions. In 1974, shipments of surgical and medical instruments advanced about 8% to \$988 million, and another advance of about 10% to equal a total of \$109 billion is projected for 1975.

Surgical and medical instruments are also a rapidly growing market. This is due primarily to obsolescence. Further rapid gains will also be evident in use of lasers for medical procedures, fibroptics, cryogenics, and radiopharmaceuticals. Figure 14 details the production of medical and dental equipment and supplies for the period 1966 through 1974.

The 1974 shipments of surgical appliances and supplies increased by about 7% to \$1.6 billion. The 1975 gain is expected to be 8%. Within this category, medical disposable products are expected to grow approximately 14%. Medical institutions are turning increasingly to disposables to offset spiraling labor costs and to eliminate costly sterilization processes. In addition, there is a need to reduce the dangers of contamination.

Figure 14.

PRODUCTION OF MEDICAL & DENTAL EQUIPMENT & SUPPLIES

Source: U. S. Department of Commerce

#### D. Health Manpower

Figure 15 indicates the supply of active health professionals for the period 1960 through 1990. The number of active physicians in the United States has been growing faster than the population as a whole; therefore, the physician-to-population ratio has been increasing. This increase is due in part to the formation of new medical schools and an increase in the number of admissions by some of the older medical schools. It is due also to an appreciable increase in the number of foreign-trained physicians practicing in the United States. At the same time, there has been a decline in the rate of growth of the total population.

Figure 16 illustrates the projected supply of active physicians per 1,000 population for the period 1970 to 1990.

The geographic distribution of physicians is weighted heavily toward metropolitan areas. In 1973, there were approximately 196 non-federal physicians providing patient care for approximately every 100,000 individuals living in the largest metropolitan areas. The comparable ratio for small, non-metropolitan counties was 40 physicians for every 100,000 residents. This comparison is illustrated in Figure 17.

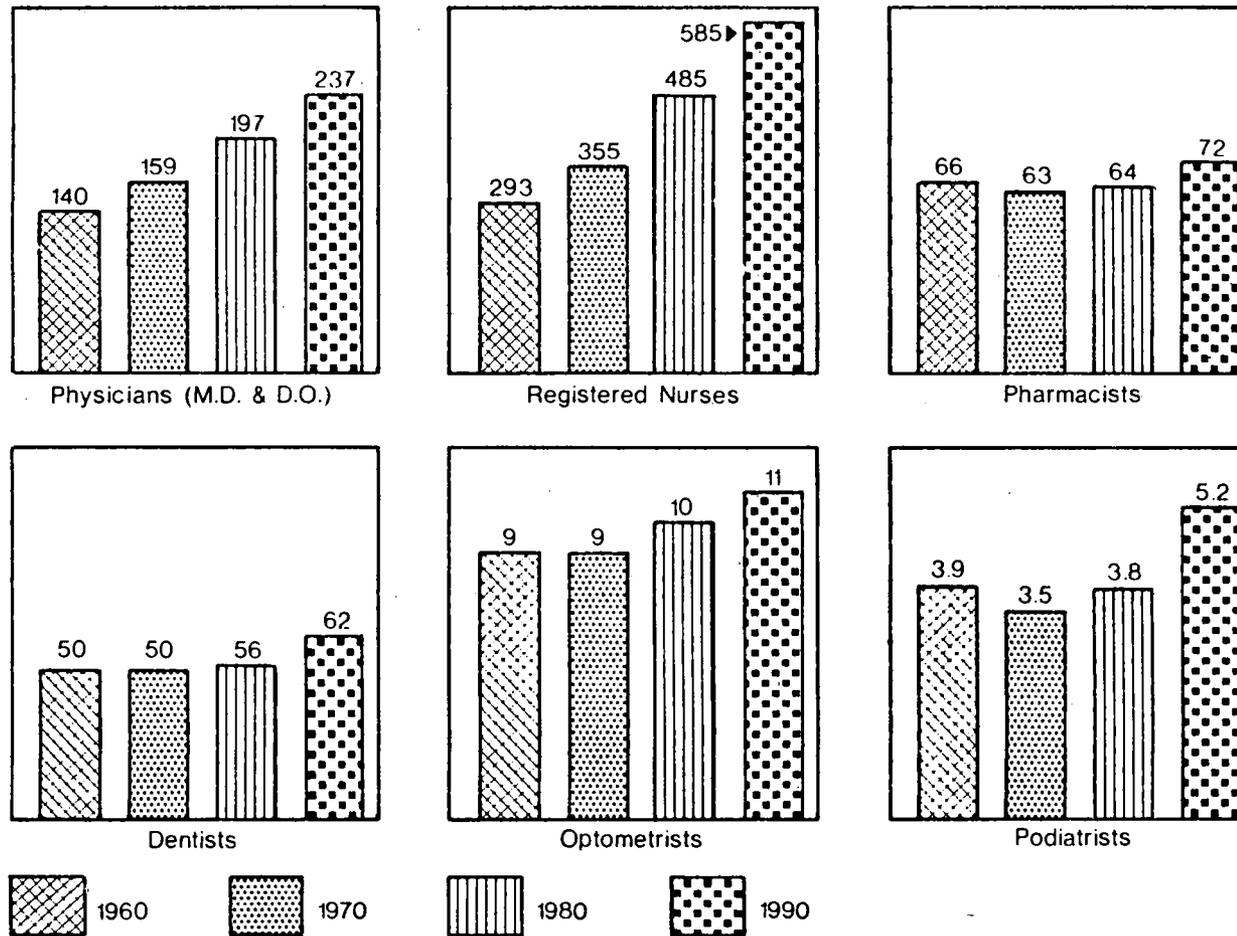
With respect to medical specialists, the geographic distribution is based even more towards the large metropolitan areas.

Registered nurses comprise more than one-half of all health professionals and are the largest single group of health workers. The number of registered nurses is expected to double between 1970 and 1990. While there are projected increases in the number and rate per 100,000 population of dentists, pharmacists, and optometrists, they are not as large

Figure 15

**SUPPLY OF ACTIVE HEALTH PROFESSIONALS, 1960 - 1990**

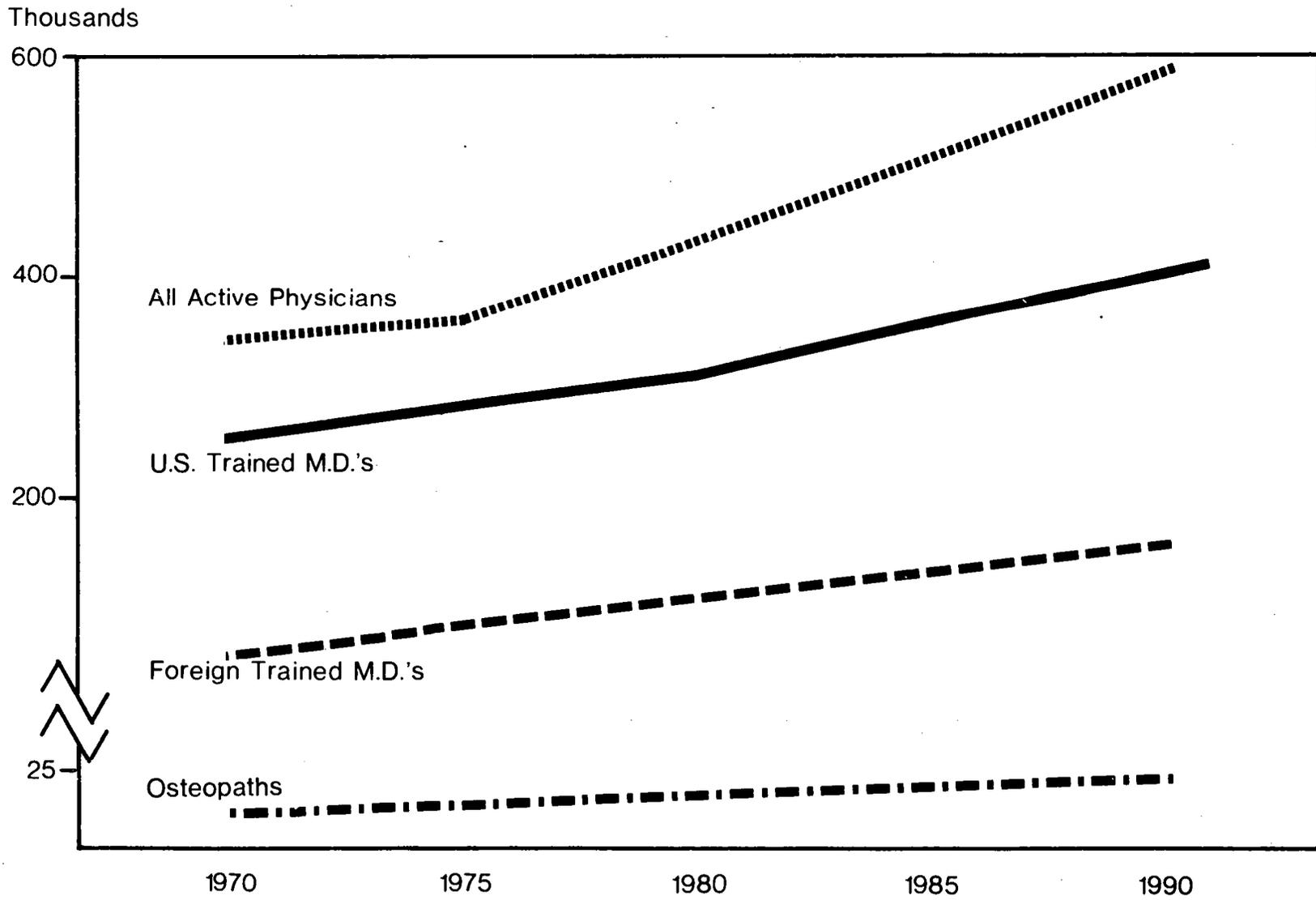
(Rate per 100,000 population)



Source: Bureau of Health Manpower - PHS

Figure 16

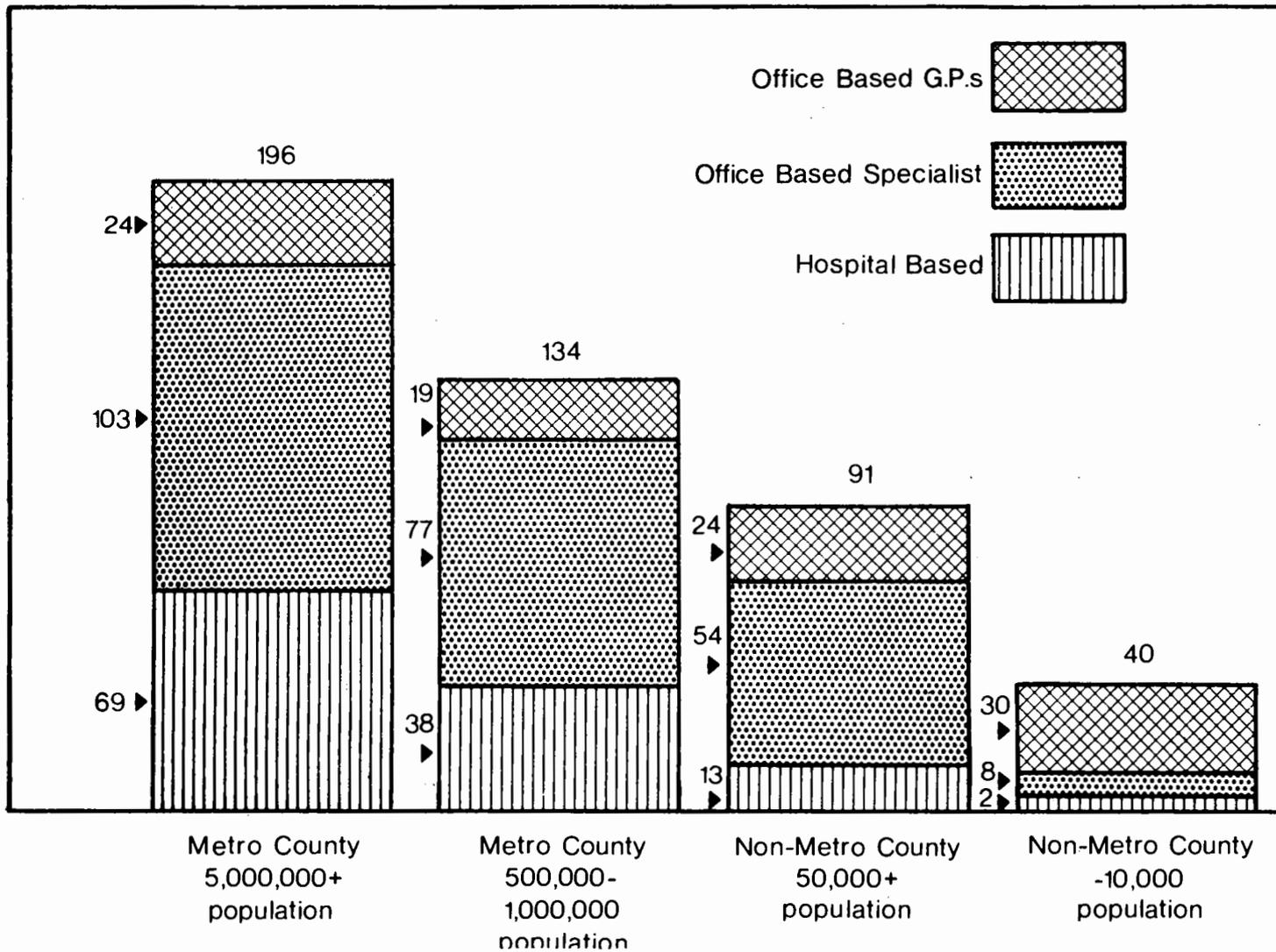
### PROJECTED SUPPLY OF ACTIVE PHYSICIANS, 1970-1990



Source: Health Resources Administration, PHS

Figure 17

**NUMBER OF NON-FEDERAL PHYSICIANS PER 100,000 POPULATION  
BY COUNTY SIZE AND TYPE OF PHYSICIAN, 1973**



Source: AMA

as for physicians and nurses.

There has been a significant shift in the utilization of physician services by the poor. In 1964, prior to Medicare and Medicaid, the poor of all ages had fewer physician visits per year than did the non-poor; but by 1973, the poor were using physician services at a somewhat higher rate than the rest of the population. They also had more dental visits in 1973 than in 1964, but the rate still does not equal that of the rest of the population.

During the period 1971 to 1974, the aggregate number of physician contacts--excluding those with hospital inpatients--has remained almost constant at about 1 billion contacts each year. Since the number of practicing physicians increased between 5 and 10% during this period, it appears that the average number of patient contacts per physician providing primary care has declined somewhat since 1971. Part of the decline could be due to an increase in the average duration of physician contacts, or to a shortening by physicians of the average number of hours devoted to ambulatory patient contacts.

#### E. Physician Facilities

In 1948 there were approximately 3.4 non-federal general medical and surgical beds per 1,000 civilian population. However, some areas of the country had as few as 2 beds per 1,000 population. During the next 30 years, when the Hill-Burton program was implemented, the rate rose to its present level of about 8 beds per 1,000 population. However, some states with particularly high bed to population ratios in 1948 have

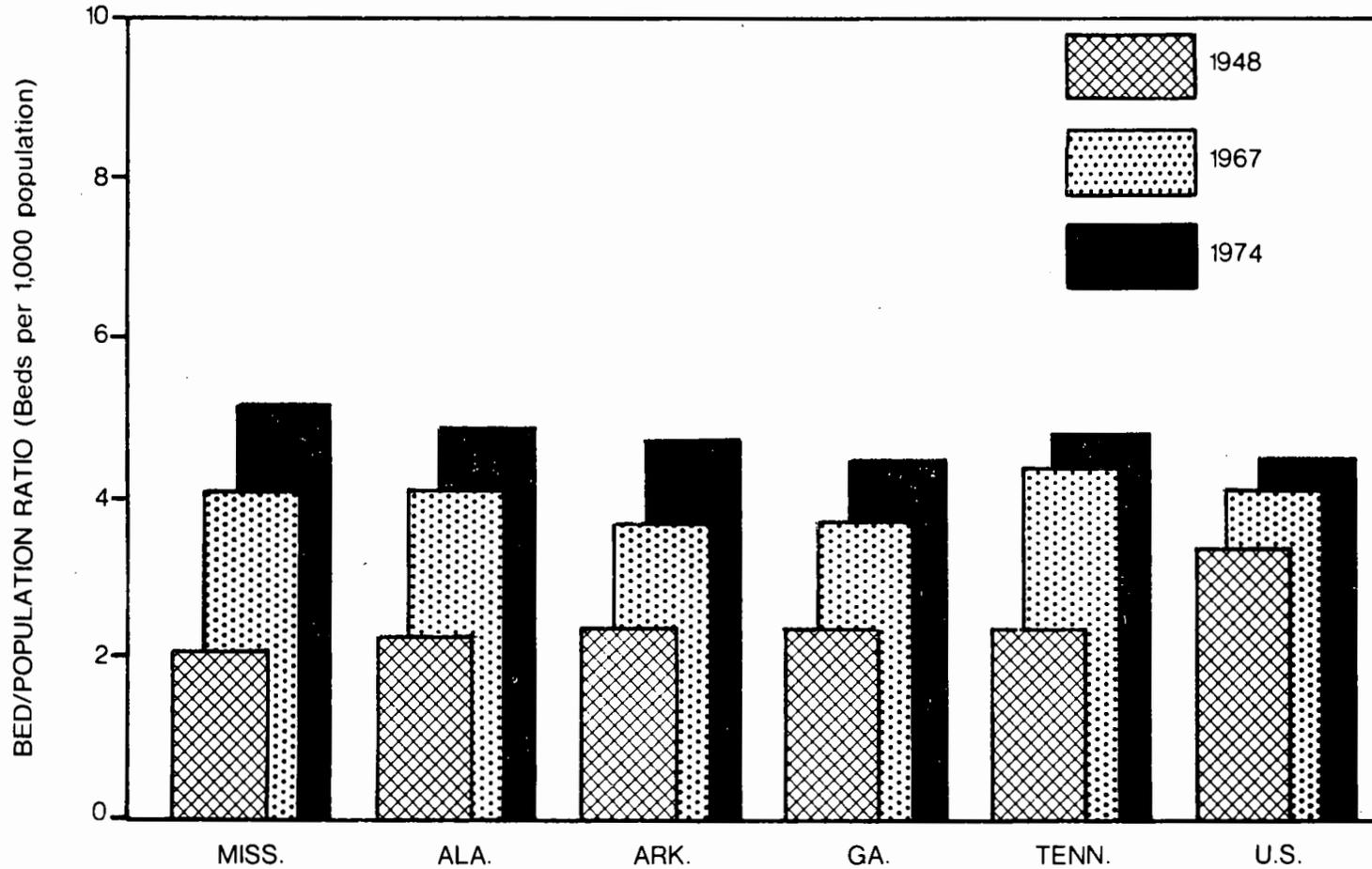
Table 7

### ANNUAL U.S. DOCTOR VISITS PER PERSON, 1964 AND 1973

	1964		1973	
	Poor	Nonpoor	Poor	Nonpoor
All ages.....	4.3	4.6	5.6	4.9
Under 17 years.....	2.3	4.0	3.8	4.3
17 to 44 years.....	4.1	4.7	5.7	5.0
45 to 64 years.....	5.1	5.1	6.3	5.4
65 years and over.....	6.0	7.3	6.5	6.9

Figure 18

**BED/POPULATION RATIOS IN GENERAL HOSPITALS**  
**SELECTED STATES, 1948, 1967 AND 1974**  
5 STATES WITH LOWEST BED/POP. RATIO, 1948



Source: Health Care Facilities--Existing and Needed Hill-Burton State Plan Data

actually experienced a decrease in the ratio. Within states there is also evidence of an improved balance in hospital facilities between the less affluent and more affluent areas. There has been a shift in concern in recent years from construction and expansion to modernization of existing facilities.

Non-profit hospitals are still a minority factor in the industry in comparison to proprietary hospitals. The American Hospital Association indicated in 1972 that the "for-profit" hospitals accounted for about 10% of the total U.S. hospitals and only 4% of the total beds. In addition, multi-facility hospital management companies account for one-third of all "for-profit" hospitals and one-half of all "for-profit" hospital beds. Although the "for-profit" share should increase in the future, it should still only represent a small portion of the industry. The primary reasons for the minority position are as follows:

- (a) some states forbid "for-profit" hospitals;
- (b) many areas are considered undesirable for expansion, such as large metropolitan areas; and
- (c) a large number of sponsored institutions, such as university hospitals, exist.

Nursing homes have been accused of overbuilding. In addition, one of the most controversial factors about them is that their patient care patterns and procedures have been highly criticized. Much of the criticism has stopped as a result of stricter regulation of the industry, sharp cut-backs in construction, and the elimination of a number of unqualified institutions.

Table 8

## HOSPITAL AND HEALTH FACILITY CONSTRUCTION

(In millions of dollars)

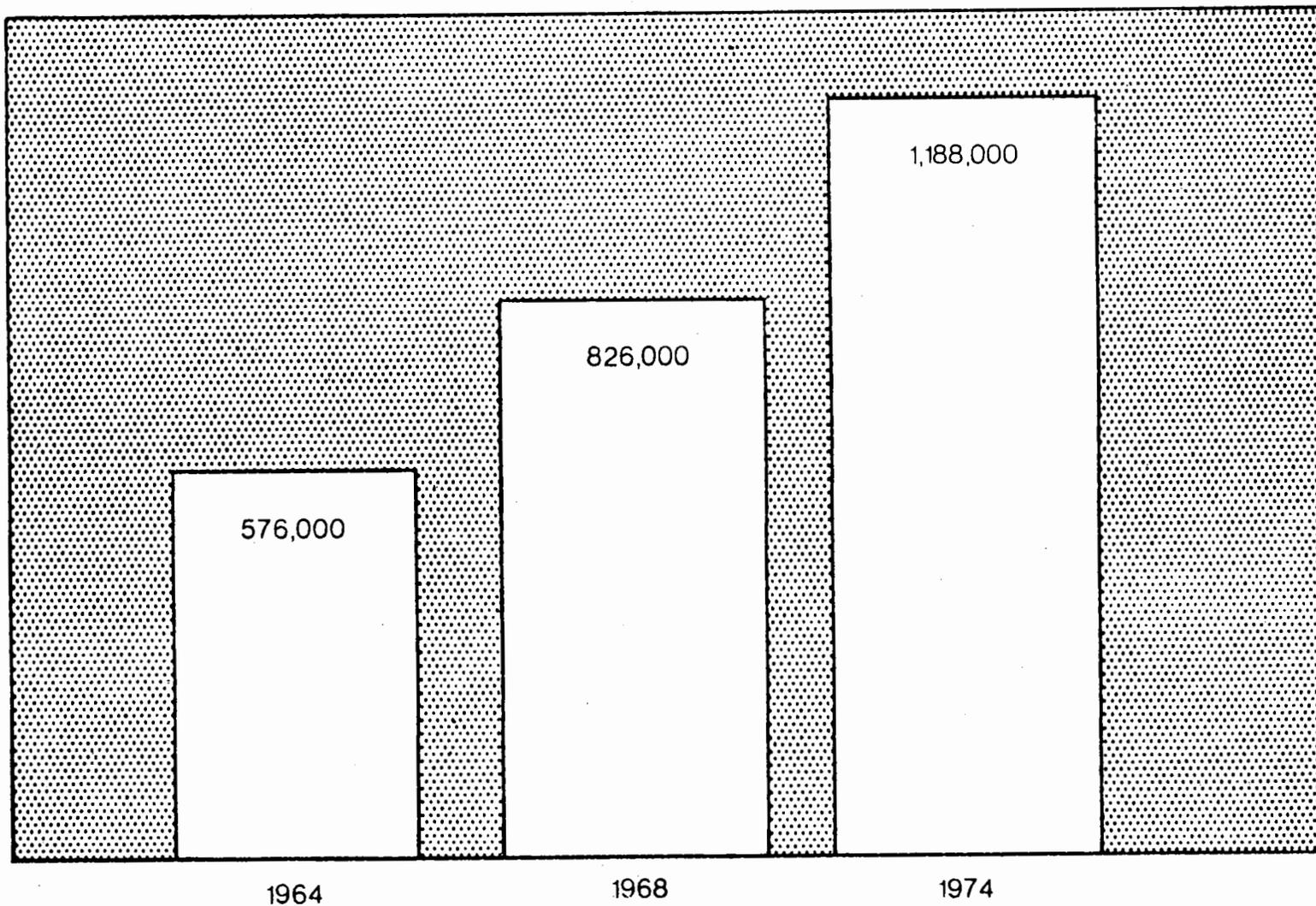
	Outlays		
	1974 actual	1975 estimate	1976 estimate
<b>Federally supported construction:</b>			
Hospitals, new .....	60	51	41
Hospitals, modernized and replaced .....	75	64	51
Long-term care facilities .....	22	25	23
Research facilities .....	27	37	33
Environmental health facilities .....	150	153	143
Ambulatory care facilities .....	42	72	62
Health professions educational facilities .....	123	153	169
Other facilities .....	17	24	19
<b>Total, federally supported</b> .....	<b>516</b>	<b>579</b>	<b>541</b>
<b>Federal hospitals and health facilities:</b>			
Hospitals, new .....	38	96	58
Hospitals, modernized and replaced .....	141	185	325
Long-term care facilities .....	5	8	9
Research facilities .....	18	26	25
Environmental health facilities .....	31	44	44
Ambulatory care facilities .....	5	8	27
Other facilities .....	7	21	79
<b>Total, Federal</b> .....	<b>245</b>	<b>388</b>	<b>567</b>
<b>Total, construction</b> .....	<b>761</b>	<b>967</b>	<b>1,108</b>

The actual number of beds in nursing homes providing nursing care doubled between 1964 and 1974, and the ratio of beds to population 65 and over increased more than 70%. This is indicated by Figure 19. The increase probably was due in part to the coverage of charges for certain types of nursing home care under Medicare and Medicaid programs, as well as changes in family living arrangements, and advances in medical technology. There are wide differences, however, in nursing home bed to population ratios in different areas of the country. For instance, in 1973, in the census divisions of New England and the West North Central, all had ratios of nursing home beds to population 65 and over of greater than 70 per 1,000, while the South Atlantic and East Southern Central Divisions had ratios of approximately 40 per 1,000. The causes and consequence of this variation are not all clear.

In summary, this Section has illustrated the rapid growth and projected future growth of the health care industry.

Figure 19

**NUMBER OF NURSING HOME BEDS, 1964, 1968, 1974**



Source: National Center for Health Statistics



#### SECTION IV. THE HEALTH CARE INDUSTRY - MAJOR ISSUES IN 1975 AND 1976

This Section of the report will detail the major issues involved in the delivery of health care services in 1975. Many of them have been alluded to in the previous section and will be detailed more thoroughly in the discussion of the PSRO Peer Review Programs. However, this Section describes these issues in general terms and relates each of them to the PSRO program.

##### A. National Health Insurance

There appears to be no question that the United States will eventually have a national health insurance program. Three primary questions present themselves:

1. What will the format be for the national health insurance program?
2. When will Congress actually pass the law?
3. When will the national health insurance program be implemented?

Enactment of a national health insurance program is likely to impose more regulation on the health care industry as part of the effort to protect what will be an even greater Federal investment of funds in health care. The final format of the national health insurance program, in terms of whether it is administered by the Federal Government or by private insurance carriers, probably will not influence the degree of Federal regulation initially--only the location of the bureaucratic structure of it. The area of most prevalent agreement when there is debate between the Administration and liberal Democrats over the health insurance

issue is that of cost control. Senator Kennedy and the Administration have no problem in getting together against the providers on the major issue. This really makes the PSRO program and peer review that much more significant in light of the attempt to establish controls prior to enactment of a national health insurance program.

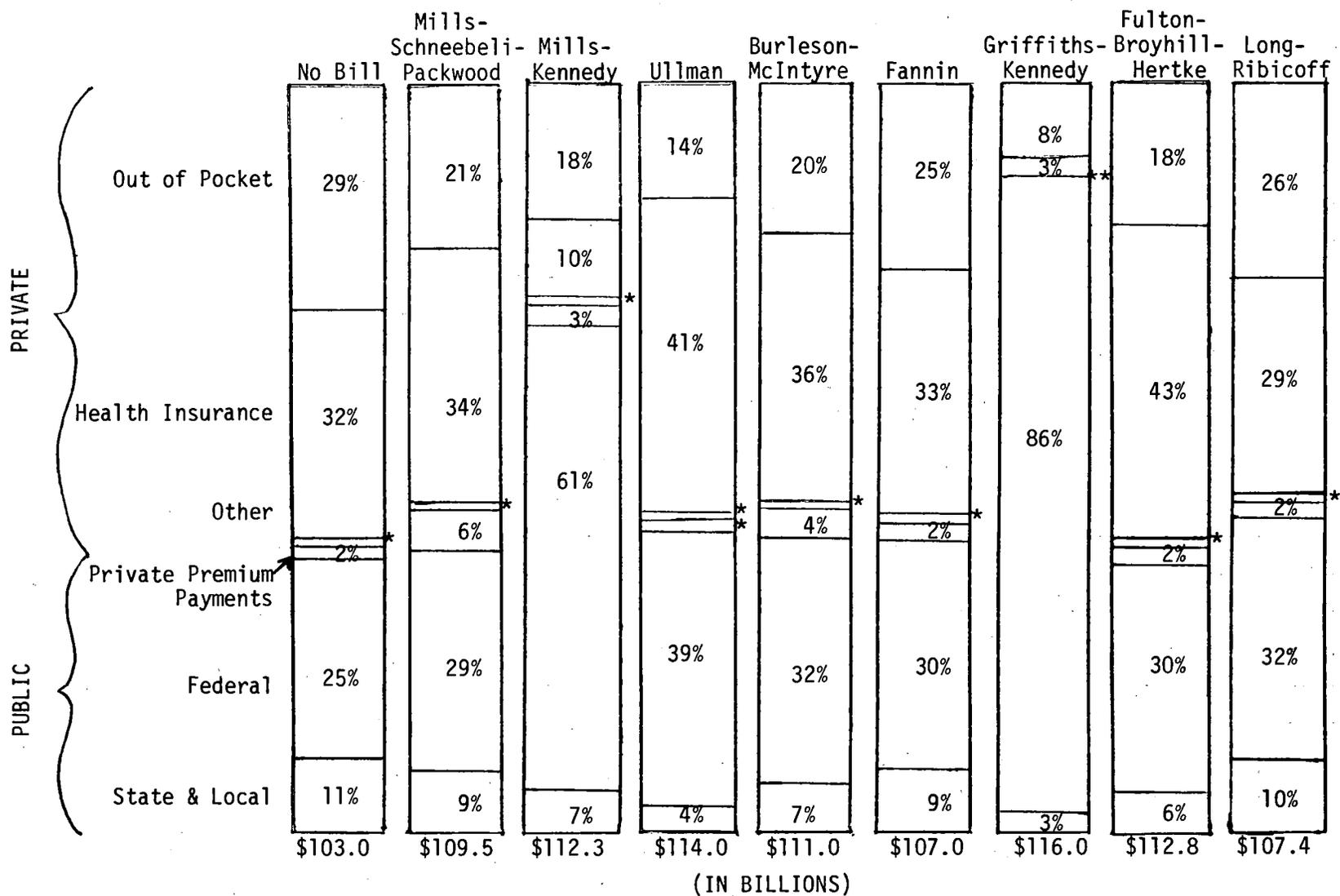
Figure 20 describes the various health insurance proposals submitted during fiscal 1965, and describes also the source of financing for each of them. As far as passage and implementation of a national health insurance program is concerned, it appears realistic to expect that if the 94th Congress passes legislation on national health insurance, the likelihood is--even though it is likely to be introduced in 1975--that final resolution will not evolve until 1976. The House Ways and Means Committee has put it on "top priority" lists. However, the President has decided not to propose his bill in 1975; he prefers to place national health insurance into a pending state because of the possible inflationary effects. In summary, if Congress passes national health insurance in 1975 or 1976, implementation of such a program would take approximately two to three years. A number of structural changes would need to be made to the delivery system in order for it to accept national health insurance.

#### B. Health Maintenance Organizations

The health maintenance organization concept was favored by the Nixon Administration as a method for reducing costs and improving the quality of medical care. The Federal Government is still interested in

Figure 20.

ESTIMATED PERSONAL HEALTH CARE EXPENDITURES UNDER ALTERNATIVE NATIONAL HEALTH INSURANCE PROPOSALS, BY SOURCE OF FUNDS, FISCAL YEAR 1975



\*One(1) Percent  
\*\*Less Than One(1) Percent

this method of delivery. However, the budgetary amounts for HMO have been reduced substantially and HMOs that have been developed are finding it very difficult to survive financially.

The health maintenance organization budget for F.Y. 1976 will probably be about \$19 million, which is a reduction from prior years. The actual core budget to compare that with was \$16 million in 1975. There is a \$35 million loan-revolving fund which is established from 1974 funds, which would enable the Department of HEW to make loans to HMOs to assist them in meeting their operating deficits in the first three years of operation. The Department feels that this plan will support the continuation of 42 planning and development awards for HMOs and will enable it to increase the Department's efforts on existing HMOs to increase enrollment of patients and improve their financial stability.

C. Movement Toward Cost and Quality Controls

The Federal Government is strongly favoring the placement of controls over the cost and quality of medical care in the United States. The Federal Government needs a system that produces one major result: economically improving the health status of the American people. The Department of HEW has posed the following basic goals for improving quality during fiscal years 1977 to 1981:

1. Develop a formalized approach to increase and disseminate clinical knowledge regarding efficacy of medical practices and to weigh the health benefits they produce against their risk and cost.

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**KEY HEALTH INSURANCE STATISTICS**

	1968	1972	1973	% CHANGE	
				1972-73	1968-73
<b>NUMBER OF PERSONS UNDER 65 WITH HEALTH INSURANCE PROTECTION IN THE UNITED STATES*</b> (000 omitted)					
Hospital expense .....	156,952	167,019	170,256	1.9	8.5
Surgical expense .....	145,867	155,173	159,462	2.8	9.3
Regular medical expense ..	126,675	139,704	143,155	2.5	13.0
Major medical expense† ...	55,298	78,154	81,170	3.9	46.8
Disability Income					
Short-term .....	55,013	60,396	61,894	2.5	12.5
Long-term .....	7,718	14,130	15,332	8.5	98.7
<b>HEALTH INSURANCE BENEFITS PAID TO PERSONS UNDER 65 IN THE UNITED STATES</b> (000,000 omitted)					
Insurance Companies ....	\$ 6,354	\$10,152	\$10,809	6.5	70.1
Hospital expense .....	3,078	4,871	5,115	5.0	66.2
Surgical, medical and dental expense .....	1,942	3,419	3,672	7.4	89.1
Disability income .....	1,334	1,862	2,022	8.6	51.6
Blue Cross, Blue Shield and other hospital-medical plans	5,159	9,604	10,761	12.0	108.6
Hospital expense .....	3,560	6,484	7,123	9.9	100.1
Surgical, medical and dental expense .....	1,599	3,120	3,638	16.6	127.5
Total .....	\$11,513	\$19,756	\$21,570	9.2	87.4
<b>HEALTH INSURANCE PREMIUMS IN THE UNITED STATES††</b> (000,000 omitted)					
Insurance companies .....	\$ 9,082	\$14,315	\$16,042	12.1	76.6
Group .....	6,088	10,245	11,788	15.1	93.6
Individual .....	2,994	4,070	4,254	4.5	42.1
Blue Cross, Blue Shield and other hospital-medical plans	5,903	11,422	12,791	12.0	116.7
Total .....	\$14,985	\$25,737	\$28,833	12.0	92.4
<b>COMMUNITY HOSPITAL STATISTICS IN THE UNITED STATES</b>					
Average length of hospital stay (days) .....	8.4	7.9	7.8	-1.3	-7.1
Average cost to hospital per patient day .....	\$ 61.38	\$105.40	\$114.56	8.7	86.6
Average cost to hospital per patient stay .....	\$515.59	\$832.66	\$893.57	7.3	73.3

\*Data have been revised due to a change in methodology of data collection.

†Insurance companies only.

††Data for "Insurance companies" prior to 1973 refer to written premiums and data for 1973 refer to earned premiums. Data for "Blue Cross, Blue Shield and other hospital-medical plans" refer to earned income.

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2. Implement operational quality assurance programs sponsored by the Department, including PSRO, utilization review, and the quality assurance components ESRD and HMO.
3. Complete and implement the PSRO evaluation plan.
4. Develop improved methods of assessing and improving quality. Research in this area will include the development of strategies for expanding participation in quality assurance activities beyond the confines of the health professional establishment.
5. Educate health professionals in quality assurance methodologies to enable them to participate fully in quality assurance programs.
6. Strengthen HEW's ability to manage quality assurance activities. DHEW feels that direction and guidance must be provided to develop a sound bridge between operational quality assurance programs and the Department of Health, Education, and Welfare health agencies responsible for developing information about health care quality.

On the cost side, the Government has already moved quite strongly in the area of controlling hospital and medical care costs and this trend is expected to accelerate over the next 10 years.

D. Comprehensive Health Planning

One of the major new directions that the Federal Government is taking will be directed toward implementation of the recently enacted National Health Planning and Resources Act of 1974. The Act replaces the ongoing programs of the Comprehensive Health Planning, regional medical programs and the Hill-Burton facilities construction program. It establishes a new system of state and local planning agencies in a combination formula and a project program for medical facilities construction.

E. Medical Malpractice Insurance

The availability of medical malpractice insurance for medical practitioners and hospitals is becoming more difficult to get as consumers

**NUMBER OF PERSONS WITH HOSPITAL EXPENSE PROTECTION  
BY TYPE OF INSURER**

In the United States

(000 omitted)

End of year	All insurers	Insurance companies			Blue Cross, Blue Shield and medical society plans	Other plans
		All insurance companies	Group policies	Individual and family policies		
1940	12,312	3,700	2,500	1,200	6,012	2,600
1945	32,068	10,504	7,804	2,700	18,899	2,665
1950	76,639	36,955	22,305	17,296	38,822	3,619
1955	105,452	57,286	39,029	24,131	50,726	4,530
1960	130,007	76,659	55,218	30,187	58,050	5,542
1961	133,876	78,063	56,920	30,817	58,664	7,155
1962	138,045	80,264	58,949	32,440	60,118	6,993
1963	142,775	83,121	62,424	33,710	61,016	7,221
1964	146,071	84,778	64,026	34,859	62,054	7,350
1965	148,826	87,014	66,490	36,107	63,347	7,376
1966	153,130	90,431	68,933	37,333	65,310	7,033
1967	157,831	93,118	72,679	36,624	67,214	7,450
1968	164,276	96,934	75,363	38,364	70,019	7,660
1969	167,858	100,740	79,360	40,065	72,692	8,030
1970	172,306	101,835	81,955	42,008	75,055	8,531
1971	175,800	104,103	82,094	44,952	76,539	8,545
1972:						
Under 65	167,019	101,821	81,657	44,086	71,537	8,440
65 and over	11,398	4,927	1,344	4,133	6,669	550
Total	178,417	106,748	83,001	48,219	78,206	8,990
1973:						
Under 65	170,256	103,918	82,272	46,837	72,715	8,876
65 and over	11,823	4,697	1,187	4,042	7,254	582
Total	182,079	108,615	83,459	50,879	79,969	9,458

Note: Data for 1961-1972 have been revised due to a change in methodology of data collection. Persons covered under Insurance Company Administered Programs and Minimum Premium Plans are excluded from the categories "All insurance companies" and "Group policies." The data refer to the net total of people protected, i.e. duplication among persons protected by more than one kind of insuring organization or more than one insurance company policy providing the same type of coverage has been eliminated.

Source: Health Insurance Association of America.

are becoming more aware of their rights to quality medical care. Physicians in many areas of the country are unable to obtain medical malpractice insurance; and where they are able to obtain this insurance, the cost of the premium is extremely high and is causing corresponding rate increases for the services that they provide.

Some feel that the PSRO program will help to reduce the cost of medical malpractice insurance by providing medically recognized norms of care for various diagnoses. This information could be used in litigation for determining whether the services rendered by a physician were appropriate at a particular point in time.

F. Trend Toward Group Practices and Physician Combines

There is a definite trend in the United States for physicians to combine into group practices which can provide comprehensive care to their patients. These combines and group practices vary in format and organization--all the way from two or three solo practitioners sharing a common facility to reduce operating costs, to organizations that are incorporated and consist of as many as 150 physicians, representing all specialties and having families assigned to a general family practitioner who refers problem cases to the specialty practitioners.

This type of practice is promoted by the Federal Government, since the Federal Government feels that care can be rendered on a higher quality basis at less cost than that of practitioners practicing on a solo basis.

G. Health Data Systems

Health data systems are becoming very essential for tracking and monitoring the various Federal programs that are being established. The

## NUMBER OF PERSONS WITH HEALTH INSURANCE PROTECTION BY TYPE OF COVERAGE

In the United States

(000 omitted)

End of year	Hospital expense	Surgical expense	Regular medical expense	Major medical expense	Disability income		Dental Expense
					Short-term	Long-term	
1940	12,312	5,350	3,000	—	N.A.	N.A.	—
1945	32,068	12,890	4,713	—	N.A.	N.A.	—
1950	76,639	54,156	21,589	—	37,793	*	—
1955	105,452	88,856	54,935	5,241	39,513	*	—
1960	130,007	117,304	86,889	24,375	42,436	*	N.A.
1961	133,876	122,644	94,546	30,993	43,055	*	N.A.
1962	138,045	126,376	99,131	35,552	44,902	*	N.A.
1963	142,775	131,152	104,834	40,184	43,946	3,029	N.A.
1964	146,071	134,440	111,103	45,255	44,728	3,420	N.A.
1965	148,826	138,224	114,871	50,656	46,403	4,457	N.A.
1966	153,130	142,038	119,564	55,276	49,409	5,002	N.A.
1967	157,831	147,435	125,849	60,548	51,304	6,682	2,399
1968	164,276	152,638	132,551	65,056	55,013	7,718	3,074
1969	167,858	157,205	138,446	70,361	56,958	9,076	4,735
1970	172,306	161,240	145,727	73,506	57,168	10,740	6,581
1971	175,800	163,060	146,513	76,539	58,178	12,011	7,790
1972:							
Under 65	167,019	155,173	139,704	78,154	60,396	14,130	N.A.
65 and over	11,398	9,642	8,372	1,632	—	—	N.A.
Total	178,417	164,815	148,076	79,786	60,396	14,130	8,909
1973:							
Under 65	170,256	159,462	143,155	81,170	61,894	15,332	N.A.
65 and over	11,823	9,954	9,012	1,315	—	—	N.A.
Total	182,079	169,416	152,167	82,485	61,894	15,332	11,150

\*Included in "Short-term," with the possibility of some duplication of disability income coverage for these years.

Note: Data have been revised due to a change in methodology of data collection. The data refer to the net total of people protected, *i.e.*, duplication among persons protected by more than one kind of insuring organization or more than one insurance company policy providing the same type of coverage has been eliminated. The "Hospital expense," "Surgical expense," and "Regular medical expense" categories represent coverage provided by insurance companies, Blue Cross, Blue Shield and medical society-approved plans, and other plans. The "Major medical expense" and "Dental expense" categories represent insurance companies only. The "Disability income" category represents insurance companies, formal paid sick leave plans, and coverage through employee organizations. N.A. — Not available.

Source: Health Insurance Association of America.

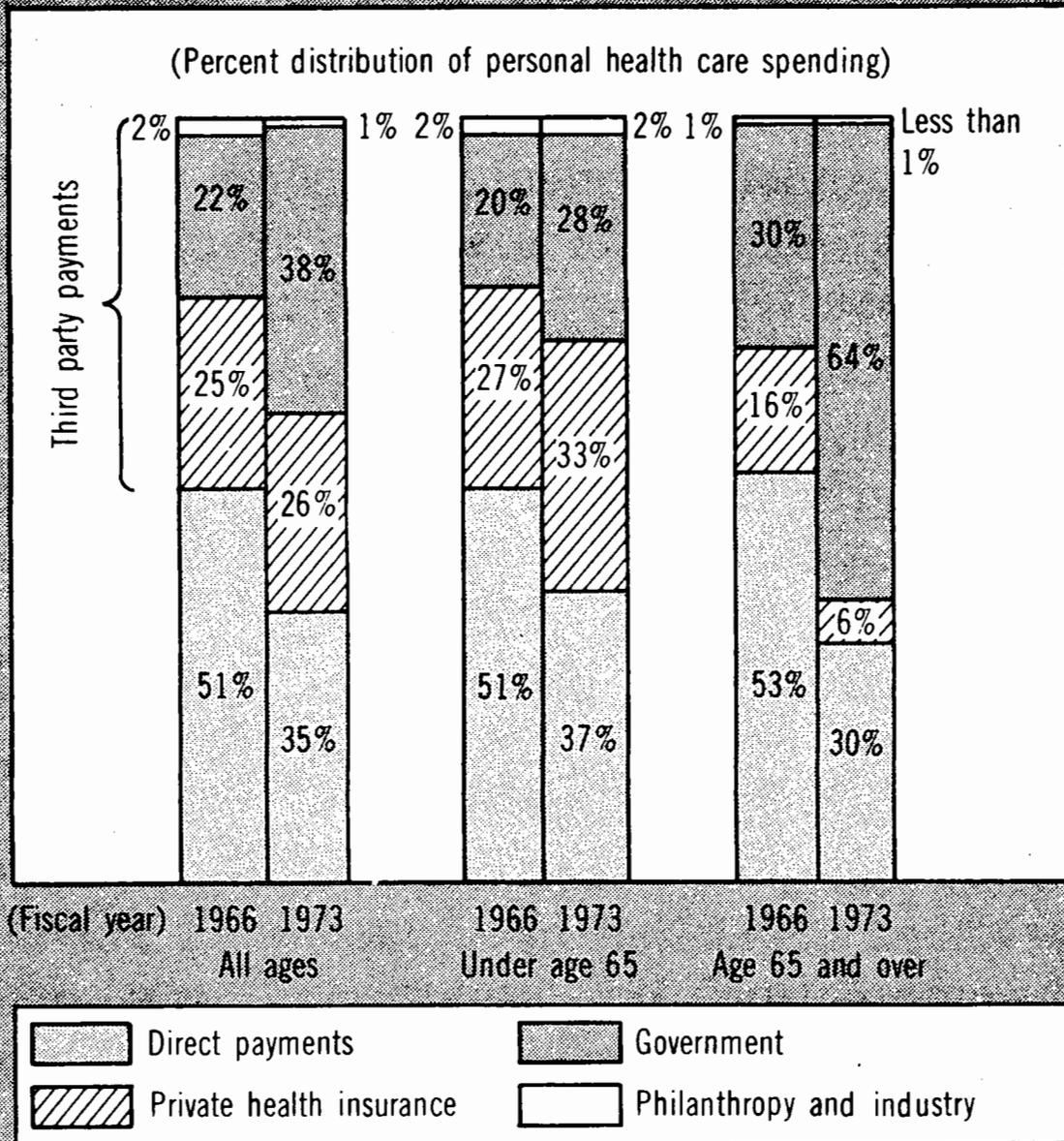
Department of Health, Education and Welfare indicates that the need to provide program evaluation emerges from the growing recognition of the need for a systematic data base to support policy making in the health field--both in the private sector and at all levels of government--to permit adequate evaluation of health trends and to measure the impact of Federal intervention on the health industry.

The Federal Government wants to know what the Federal health dollar is purchasing; who is being served; what the outcome is; and how the Federal programs compare with other approaches to health care delivery. The answers to these evaluative questions will depend not only on general purpose (baseline) statistics, but also on specific management statistics.

There are a number of commercial data systems that are being developed to help meet this need. In addition, there is a fragmented health statistics system throughout the Federal Governmental hierarchy. A partial listing of Department of Health, Education and Welfare data systems include the following:

- The Health Interview Survey, conducted annually since 1967, which obtains data on illness, injuries, disability, and cost and utilization of health services in the civilian, non-institutionalized population.
- The Health and Nutrition Examination Survey.
- The Vital Statistics Program.
- The National Survey of Family Growth.
- The National Ambulatory Medical Care Survey.

### Medical insurance benefits vary among age groups



Source: Social Security Administration

- The Cooperative Health Statistics Program of the National Center for Health Statistics.
- The Bureau of Health Manpower conducts a number of inventories to provide current information on the numbers, distribution, and characteristics of manpower in the various health professions.
- The National Drug Monitoring System.
- The Medically-oriented data system.
- The National Evaluation of X-Ray Trends.
- The National Institute of Mental Health conducts surveys on mental health facilities through the Division of Biometry.
- The alcoholism program monitoring system developed by the National Institute on Alcohol Abuse and Alcoholism.
- The National Institute on Drug Abuse, which is involved in the design, development and operation of an integrated drug abuse management information system.
- The Public Health Service, through a contract with the Association of State and Territorial Health Officers, supports the development and operation of the Health Program Reporting System.
- The National Cancer Institute, which collects, analyzes and publishes data on cancer incidence and patient survival through its Surveillance, Epidemiology and End Results Program.
- The Social Security Administration, which collects and publishes comprehensive health statistics.

As can be seen, the health data systems certainly have a great deal of impact on PSRO, since PSRO is really a monitoring system for the delivery of health care.

#### H. Manpower Shortages and Maldistribution

The manpower shortages and maldistribution were described in Section III, Subsection D, Health Manpower, above.

#### I. Pharmaceutical Promotional Practices

Pharmaceutical promotion activities are only one of several Federal influences currently being placed upon the pharmaceutical industry.

The Food and Drug Administration, which was established in 1906, regulates the multi-billion dollar food, drug and medical device industries. Its mandate primarily involves regulation of the safety and efficacy of products.

For example, there is strong pressure for regulation on claims of product superiority. Data to substantiate a claim must be part of the new drug application submitted to the FDA. A move toward class labeling is developing within FDA. The oral hypoglycemic controversy is a recent example.

Advisory committees and outside consultant groups will be called upon more frequently to guide the FDA in its decision-making role regarding the marketing of drugs. More and more clinical data generated outside of the U.S. will be accepted by the FDA as a part of the new drug application. However, new drugs will have to offer a significant and therapeutic advantage over existing products in the marketplace.

The pharmaceutical industry will also be pressured to become more "professional" in its promotional activities to physicians. In addition, there will be more of a trend towards continuing education for physicians. Companies will need to focus more and more attention on presenting educational materials to the doctor via professionally trained company representatives.

#### J. Criticism of Clinical Research

There has been considerable criticism of the results of clinical biomedical research in the last ten years. Some major issues include:

1. Definition of the national needs for biomedical research in the context of national health policy;
2. Reexamination and definition of appropriate Federal and non-Federal roles for biomedical research; and
3. Analysis of the organization, management, and financing needs of biomedical research.

In light of this development, the President's Panel on Biomedical Research was established by Congress to "review and assess" and "identify and make recommendations with respect to the policy issues" concerning the "subject, content, organization and operation" of biomedical and behavioral research conducted and supported under programs of the National Institutes of Health and ADAMHA. The Panel also is concerned with the processes by which the Executive branch and the Congress receive advice on biomedical and behavioral research. In carrying out its mission, the Panel will hold hearings, commission staff papers, and award contracts for special studies.

Table 11a

**FEDERAL OUTLAYS FOR HEALTH RESEARCH (in millions of dollars)**

	Outlays		
	1974 actual	1975 estimate	1976 estimate
Cancer.....	397	517	547
Cardiovascular.....	232	263	250
Mental health.....	123	133	124
Neurological and visual.....	140	158	151
Population and family planning.....	47	55	56
Environmental health.....	245	311	386
Aging.....	46	52	53
Metabolic diseases.....	143	161	149
Child health.....	72	82	77
Infectious diseases.....	132	132	136
Pulmonary.....	42	47	45
Dental.....	41	46	39
Other research and development.....	425	469	500
<b>Total.....</b>	<b>2,085</b>	<b>2,424</b>	<b>2,512</b>

The Panel will assess the "impact" research programs on health care and on higher education. It is now in the process of reviewing draft scopes for studies to be undertaken, which must be completed by the end of 1975. The report to Congress is to be prepared and submitted by April of 1976. The study areas proposed for the Panel include:

1. research priority studied in the Executive branch;
2. coordination of research growth;
3. potential of various reserach areas in relation to health needs;
4. dissemination of research results into medical practice;
5. the role of intramural research;
6. contract research; and
7. the cost benefits of science.

K. Politics of Health - Medical Care (A Congressional Line-up)

This section of the report will detail some of the political aspects of health-medical care issues in the United States Congress. The analysis is not meant to be comprehensive. However, the observer of PSRO should have a general idea of the political make-up on health care of the Congress.

On January 13, 1975, President Ford called for a one-year moratorium on new health spending programs. The moratorium includes national health insurance. The move reflects the Administration's desire to avoid increasing the inflationary trend by providing an increased liability for employers to provide these additional benefits to their employees.

House Speaker Carl Albert (D-Oklahoma) stated that Ford's moratorium would be ignored and that Congress would pass a health insurance bill over the President's veto. However, the House Ways and Means Committee and the

Senate Finance Committee, both of which have jurisdiction over national health insurance legislation, will certainly be preoccupied in the remaining months of the 94th Congress with the Administration's economic policies and programs.

Democrats want a national health insurance program in 1975, but the economy has given the Republican Administration a very easy excuse for not passing such a piece of legislation in 1975. In addition, organized labor would like to have national health insurance legislation; but it will be very difficult for them to keep the leaders focused on health insurance when many of their members are not employed. Representative Dan Rostenkowski (D-Illinois), Chairman of the House Ways and Means Subcommittee on Health, recognizes that the economic issues that face the nation are of primary importance at this time. However, he also would like to see a change in the health system.

The House Interstate and Foreign Commerce Committee, reconstituted as the Commerce and Health Committee, has been vested with new powers over health legislation. How they will actually share the powers with the Ways and Means Committee is yet to be seen. Representative Harley O. Staggers (D-West Virginia), plans to force the jurisdictional question since he has been named Chairman of this reconstituted Commerce and Health Committee.

Representative Paul G. Rogers (D-Florida), Chairman of the Commerce and Health Subcommittee on Public Health and Environment, has not devoted much time to the health program yet. However, there are signs that he is becoming increasingly interested in health issues. He will most likely

challenge the Ways and Means Committee.

Rostenkowski, in the meantime, has tried to obtain command over the national health insurance issue through his new Ways and Means Subcommittee on Health. Many of the health interest groups which are headquartered in Chicago supported his appointment as Subcommittee Chairman even though he has ties to organized labor. His views on health insurance legislation are not clear. He has a very close relationship with Chicago Mayor, Richard J. Daley. Rostenkowski also has a close relationship with Chicago's business community. He developed certain aspects of the pension legislation considered in 1974 by the Ways and Means Committee, in cooperation with Sears, Roebuck and Company.

Since August, 1974, when the House Ways and Means Committee unsuccessfully tried to issue a national health insurance bill, many various interest groups have been reassessing their legislative positions in light of the November election. The American Medical Association, one of the primary organizations that has met with HEW regarding the national health insurance program, is ready to liberalize its initial health insurance proposal. Former Representative Joel T. Broyhill (R-Virginia), who lost his bid for an 11th term, was one of the AMA's primary supporters.

The American Hospital Association supports a bill which is sponsored by Representative Al Ullman (D-Oregon), the new Chairman of the Ways and Means Committee. The AHA's proposal would create "health care corporations" to cover every geographic area of the country. The corporations would be community-based, non-profit groups capable of providing comprehensive health services to all residents in a given area.

The Insurance Association of America (IAA), which represents health insurance carriers of all sizes, has not made a firm commitment on the desired direction of national health insurance. Since December 1970, the Association has backed a proposal sponsored by Representative Omar Burelson, a member of the Ways and Means Committee, and by Senator Thomas J. McIntyre (D-New Hampshire). These measures propose three voluntary health insurance plans:

- (a) an employer-employee plan;
- (b) a plan for individuals; and
- (c) a plan for poor, uninsurable segments of the population.

Private insurance carriers would administer all the plans, with the State and Federal governments monitoring their operations. The proposals include provisions designed to increase the supply of health manpower, as well as to stimulate the development of ambulatory care centers.

Senator Edward Kennedy (D-Massachusetts), introduced his original health insurance bill (S-3) on January 15. In a letter to all the other Senators, dated January 8th, Kennedy said he believed that the 94th Congress "can do much more" than enact the former Kennedy-Mills Bill.

The above description of the various influences and forces dealing with the national health insurance program illustrates the diverse forces at work at the national level.

#### L. Medical Peer Review and PSRO

Medical peer review and the PSRO program are becoming implemented in the United States. These are discussed in greater detail below.

However, it should be said at this point in the report that the PSRO program is extremely experimental. It is a prototype quality assurance program which will become the keystone of a national health insurance program. It should also serve to provide immediate controls over the quantity and quality of the types of health services that are delivered.

M. Maximum Allowable Costs for Pharmaceuticals

MAC legislation grew out of the Kennedy Subcommittee hearings. The hearings had the objectives of reforming and restructuring the pharmaceutical industry via corrective legislation. These hearings were continued in 1975 and will perhaps extend into 1976.

The hearings also resulted in the Drug Bioequivalence Study Panel Report which recommends an official list of interchangeable drugs to be developed and divided into two categories: (1) those for which evidence of bioequivalence is critical, such as where the toxic and therapeutic ranges are narrow; and (2) those drugs where bioequivalence is not considered essential. The Panel's report forms the basis on which the Government will proceed to attempt to assure therapeutic equivalence for several products no longer under patent, in order to initiate the Maximum Allowable Cost Program for Federally-funded prescriptions.

The Kennedy hearings also resulted in the submission of the Drug Utilization Improvement Act, which includes proposals to restrict certain marketing activities. These marketing practices include samples, reminder advertising, and gifts to physicians. The Act also contains a recommendation that company representatives complete a training course which would

have government approval.

At the time of this writing, the MAC regulations have been approved by the Secretary of HEW and are in the process of being implemented.



SECTION V. DETAILED HISTORY OF MEDICAL PEER  
REVIEW IN THE UNITED STATES

This Section of the report will detail the precursor events to establishment of the PSRO program to include pre-Medicare peer review history; emergency medical care organization description; utilization review under Medicare; the forces behind the Bennett Amendment which resulted in the PSRO law; and finally, a summary of Public Law 92-603: The Bennett Amendment for the Social Security Act authorizing the PSRO program.

A. Pre-Medicare Review History

Pre-Medicare review of patient care was performed primarily on a local initiative basis. The private practice physician and the hospital administrator were responsible for reviewing the length of stay; types and quantity of ancillary services received; and review of the quality of medical care rendered within the institution. The administration and medical staff reported jointly to a duly-established board of trustees who carried the ultimate legal responsibility for the type and quantity of medical care delivered within the organization.

The restraints placed upon this activity were limited primarily to those imposed by the Joint Commission on Accreditation of Hospitals. The Commission is a non-profit, non-governmental organization formed by a consortium of other non-profit, health care trade associations, some of which include the American Medical Association, the American Hospital Association, the American College of Surgeons and the American College of Physicians.

The only other controlling factor affecting the quantity of care rendered within the institution prior to Medicare was the need for the institution to keep a minimum bed occupancy level at approximately 60%. Economically, this was felt to be the break-even point for financial operations.

In addition, if the hospital could maintain a utilization level at approximately 60%, the ancillary services of X-ray lab and pharmacy would also be utilized to the extent that any losses incurred in the bed/room charges would be picked up by profits made in these three areas. Historically, it is a well-known and documented fact that X-ray, lab, and pharmacy are the profit-makers on an inpatient basis and that the more these are utilized, the more profit will ensue to the hospital. Of course, this is a fact that is not well-publicized to the general public; but it is a well-known fact among the hospital administration profession. For obvious reasons, it would be politically inappropriate to publicize this fact.

On the quality side, the pre-Medicare review mechanisms were conducted primarily through the activities of the Tissue Committee and other professional medical staff activities operating within the institution. The Medical Audit Committee as well as the Tissue Committee usually meet monthly to review surgical specimens, both microscopic and macroscopic, removed during a surgical procedure. The specimens are routinely analyzed by pathological expertise and the findings post-operatively are compared with the pre-operative findings to determine whether diagnosis before the fact equals the diagnosis after the fact. If there are continued discrepancies between these two diagnoses for an

individual physician over a period of time, the physician would stand a chance of review by his peers and possibly also a rescinding of hospital admitting privileges.

However, the point to be realized in this analysis is that these types of reviews are self-imposed by the institution. The controls have little or nothing to do with regulation and imposition on the part of a governmental agency.

Another form of non-governmental peer review prior to the Medicare law was performed by the organized foundations for medical care. Foundations for medical care were developed in 1962 in response to the physician's need to gather together to perform certain medical care tasks and to gain benefit from an association of a number of physicians for specific financial purposes. As part of the foundation activity, peer review was firmly implanted. The medical care foundations that are most active in 1975 are also those that are far advanced in a peer review and professional quality review and quality assessment mode. These would include such foundations as the San Joaquin Foundation, New Mexico Foundation, the Salt Lake City Medical Care Foundation serving Utah, and Portland, Oregon Medical Care Foundation.

The American Medical Association has also been involved in medical peer review for some time. The Association sought implementation of a utilization review system that would enable an analysis of hospital medical care in 1959. Regional conferences were sponsored to focus attention on health insurance problems. As a result of the stimulus provided by these regional conferences, review functions in varying forms were established in many areas of the country. In 1962, the AMA

co-sponsored the first National Conference on Utilization with the American Hospital Association, Blue Cross Association and the National Association of Blue Shield plans.

In the course of these activities, the function of the Utilization Review Committee became more defined. As described in the AMA publication, Utilization Review--A Handbook for the Medical Staff, "...the Utilization Committee analyzes and identifies factors that may contribute to unnecessary or ineffective use of inpatient services and facilities, and makes recommendations designed to minimize ineffective utilization".

In 1964, the AMA sponsored the Clinical Convention of 1964. The House of Delegates adopted the conclusions and recommendations of the Association's Commission on the Cost of Medical Care. The major statement of the Commission can be summarized as follows:

Inasmuch as the judicious use of hospital facilities by the public is essential to the efficient and economic functioning of the pre-payment and voluntary health insurance system, the state and local medical societies should urge and assist the medical staffs of the hospitals to form hospital utilization committees.

In 1964, the AMA Commission on the Cost of Medical Care completed a study of the peer review that was being performed by local medical societies. After examining the techniques for medical care employed by some societies, the Commission made recommendations for the application of similar efforts by all units of medicine. These recommendations, approved by the AMA Board of Trustees, provided a major impetus for peer review development at the state and local levels. Programs would vary according to local custom and need to provide mutual understanding

by the medical profession, by voluntary pre-payment groups, and health insurance parties of each other's viewpoints.

B. Emergency Medical Care Review Organizations (EMCROs)

The Department of Health, Education and Welfare recognized the need to develop new organizations and methods to evaluate the quality of medical care effectively. Therefore, in 1970, the National Center for Health Services Research and Development began an experimental program called EMCRO--Emergency Medical Care Review Organization program. Its purpose was to develop working models with which to test the ability of conducting systematic and ongoing review of medical care under auspices acceptable to the several professional communities, to the public, to the government, and to third parties. The methods of review were to meet scientific and technical standards of objectivity and reliability.

From its inception, the National Center had given priority primarily to research aimed at improving methods of evaluating physician performance. Included in this were projects for developing better criteria, data collection methods and techniques of analysis. Although a few medical care foundations were conducting peer review to control utilization and cost, there were no existing organizations whose primary function was to review the quality of medical care in all settings. Apparently, anticipating the problems that would arise in an attempt to implement PSRO legislation, the National Center for Health Services Research and Development conceived of a research and development program for EMCROs through support of several well-qualified medical or other health professional organizations or institutions.

Therefore, in early 1970, guidelines were developed for potential applicants for EMCROs. The stated purpose of an EMCRO was the systematic analysis of the content of medical care being given to patients in hospitals, offices, clinics, extended care facilities, and skilled nursing homes. To be eligible, any proposed EMCRO has to have a potential total of at least 250 participating physicians. Applicants were requested to describe the proposed organization and staffing of the EMCRO, development of review methods, implementation of findings, and a plan of evaluation.

By "organization" was meant the relation of EMCRO to the applicant organization, local physicians, hospitals, health agencies, third parties, and other medical review organizations in their area. Priorities were to be set among the diseases, procedures or conditions to be reviewed in ambulatory, hospital or other care settings. The types and sources of data and methods of collection and analysis were to be specified. Each EMCRO was to base its review on explicit criteria for diagnosis, statement of treatment and overall management. The findings of the review bodies were to be incorporated into local, continuing education programs so that these would then be directed to specific and explicitly identified shortcomings in professional performance.

The EMCRO guidelines were mailed to approximately 400 county and state medical societies and other interested professional organizations. Thirty-two applications were reviewed. These were formally reviewed for scientific and technical merit by panels composed of non-federal health professionals and experts in medical care assessment. In June, 1971,

eight awards were made for periods ranging from 1 to 3 years. Two additional medical care review projects were funded in 1971.

Methods Used for Peer Review by EMCROs

EMCROs concentrated primarily on the process of care--i.e., the medical services provided--rather than on the end results of such services. In this "process" approach, information from claim forms or chart abstracts or diagnostic and therapeutic procedures is compared with the criteria to provide the data base for later judgment regarding the adequacy of the quality of care. Most EMCROs, having adopted diagnostic-specific criteria, intended to review care provided for entire episodes of illness. This would often encompass both hospitalization and office care, since this care would be required for the overall management of the specified illness.

A major educational opportunity came when review data indicated that physicians, either individually or in groups, had an area of practiced deficiency. In cooperation with medical schools, regional medical programs and expert practicing, these physicians were expected to tailor continuing education courses to correct these deficiencies.

EMCROs use two primary sources for data for evaluation: (1) insurance claim forms and (2) chart abstracts. Claim forms are usually filled out by billing in the physician's office, hospital, extended care unit, or nursing home, and then mailed to EMCRO or private or third party public parties for processing. The forms usually specify date, provider, patient, diagnosis, procedures, and drug prescribed. These data elements can be linked in the data processing systems to provide utilization

patterns. However, the adequacy of the diagnosis and the appropriateness of the procedures cannot be examined.

Chart abstracts are used in Hawaii, Mississippi, Georgia and Multnomah County (Portland, Oregon). Personnel especially trained to complete the forms may be employed by the hospital, nursing home or EMCRO. In accord with the EMCRO criteria, the abstracts contain corresponding items of history, physician examination, laboratory or other diagnostic procedures, treatment and outcome. This more complete detail permits review of the accuracy and adequacy of the diagnosis, pertinence of all procedures, and effectiveness of treatment.

#### C. Utilization Review Under Medicare

When the Medicare Law was passed in 1965, there was provision for inpatient review of medical care for patients receiving benefits under the Medicare Program, the Medical Assistance Program, and Title V--the Maternal and Infant Care Program. This gave the government a certain amount of experience in peer review on an institutional basis. However, according to the Department of Health, Education and Welfare estimates in 1967, the cost of the Medicare Hospital Insurance Program would overrun the original cost estimates by almost \$240 billion over a 25-year period. The monthly premium costs for Part B of Medicare, which finances the doctors' bills, rose from a total of \$6/month/person in July, 1966, to \$11.60/person in July of 1972. Medicaid costs were also indicative of this precipitous rate rise which occurred during the period. The Medicaid program is the state-sponsored, but federally-

Table 11b.

PRE-PSRO REVIEW REQUIREMENTS

AMENDMENT TO SOCIAL SECURITY ACT UNDER MEDICARE  
AND MEDICAL ASSISTANCE PROGRAM, 1965

TITLE I ACCESS TO RECORDS AND OTHER DATA

TITLE II GENERAL REVIEW REQUIREMENTS

TITLE III STATEWIDE PROGRAM REVIEW TEAMS

TITLE IV AUTHORITY TO SUSPEND PRACTITIONERS AND  
PROVIDERS

funded medical care program for indigent persons.

The rapidly increasing costs were attributable primarily to two factors. One of these was an increase in the unit cost of services, such as fees for physician's visits, surgical procedures, and hospital days.

The second factor which was responsible for the increase in the cost of these Medicare and Medicaid programs was an increase in the number of services provided to beneficiaries. The Committee on Finance of the U.S. Senate had, for several years, focused its attention on assuring proper utilization of services. That utilization controls were particularly important was extensively revealed in hearings conducted by the Subcommittee on Medicare and Medicaid. Witnesses testified that a significant portion of the health services provided under Medicare and Medicaid were probably not medically necessary. The economic impact of this over-utilization became extremely significant in view of the per diem costs of hospital and nursing facility care. In addition, it is not difficult to visualize the fact that unnecessary hospitalization and unnecessary surgery are not particularly consistent with proper health care.

The Senate Finance Committee report concerning PSROs made it very obvious that the Committee felt that the utilization review requirements and activities under Medicare were not adequate. To quote the Committee, "Under present law, utilization review by physician staff committees in hospitals and extended care facilities and claims review by Medicare carriers and intermediaries are required. These processes have a number of inherent defects. Review activities are not coordinated between Medicare and Medicaid. Present processes do not provide for an integrated

review of all covered institutional and non-institutional services which a beneficiary may receive. The reviews are not based upon adequately and professionally developed norms of care. Additionally, there is insufficient professional participation in and support of claims review by carriers and intermediaries; and consequently, there is only limited acceptance of their review activities. With respect to the quality of care provided, only institutional services are subject to quality control under Medicare, and then only indirectly through the application of conditions of participation..."

The detailed information which the Committee had collected and developed, as well as internal reports of the Social Security Administration, indicated clearly that utilization review activities had, generally speaking, been of a token nature and ineffective as a curb to unnecessary use of institutional care and services. Utilization review and Medicare could be characterized as more form than substance. The situation was appropriately described by a state medical society executive in these words: "Where hospital beds are in short supply, utilization review is fully effective. Where there is no pressure on the hospital beds, utilization review is less intense and often token."

The Medicare statute placed upon the intermediary as well as the state health agency, the responsibility for assuring that participating hospitals and extended care facilities effectively perform utilization review. However, it became apparent to the Committee that in many cases intermediaries had not been performing these functions satisfactorily, despite the fact that the Secretary of DHEW could not make agreements with an intermediary who was unwilling or unable to assist providers of services with utilization review functions.

Table 12.

**MEDICARE COVERAGE, BENEFITS, AND ADMINISTRATION**  
(In million of dollars)

	1974 actual	1975 estimate	1976 estimate
<b>Hospital insurance (HI):</b>			
Persons with protection (millions)	23.0	23.5	24.0
Beneficiaries receiving services (millions)	5.3	5.5	5.6
Benefit payments	\$7,806	\$9,646	\$10,020
Inpatient hospital services	\$7,537	\$9,320	\$9,683
Skilled nursing facility services	\$206	\$232	\$239
Home health services	\$64	\$94	\$98
Administrative expenses	\$259	\$287	\$330
Claims received (millions)	10.2	11.2	11.8
<b>Supplementary medical insurance (SMI):</b>			
Persons with protection (millions)	22.7	23.2	23.8
Beneficiaries receiving services (millions)	11.6	12.7	13.3
Benefit payments	\$2,874	\$3,551	\$4,126
Physicians' services	\$2,417	\$2,886	\$3,293
Outpatient services	\$347	\$529	\$677
Home health services	\$36	\$43	\$50
Other medical and health services	\$74	\$93	\$106
Administrative expenses	\$409	\$420	\$515
Claims received (millions)	80.6	94.6	102.5
<b>Total Ben. Payments &amp;</b>			
Adm. Expenses	\$11,089	\$13,617	\$14,661
% Charge in Total Ben. Payments	-	+ 18.6%	+ 7.7%
& Adm. Expenses			

Another issue was in connection with the performance of the carriers who were responsible for determining the reasonable uses of charges made by physicians. There was a wide degree of variation in terms of evaluating the medical necessity and appropriateness of such services. In addition, the physicians expressed great resentment when their medical determinations were being challenged by insurance company personnel.

In summary, the system of assuring proper utilization of institutional and physician services was basically inadequate. It was felt that the blame must be placed with the professionals, the intermediaries, and the institutions who are responsible for implementing the requirements of the Medicare Law.

The above situations are part of the reason why the amendment related to the PSRO program was passed.

D. The Bennett Amendment - Emphasis on Control of Medical Care Costs

Role of the A.M.A. in Initially Proposing a Peer Review Mechanism -

In mid-May of 1970, Senator Bennett was contacted by staff members of the A.M.A. who asked him to consider introducing a proposal they were developing that would establish "peer review organizations" in each state to review doctor services and charges under Part B of Medicare. Their proposals were forwarded to the Finance Committee staff for comment and analysis in terms of their experience with the Medicare/Medicaid programs. The Committee staff advised the Senator that the A.M.A. draft was definitely a step in the right direction and that the staff would also welcome this opportunity to investigate the entire question of peer review. However, the staff did render an opinion that they felt

Table 13.

**ESTIMATED MEDICAID BENEFITS, 1976**

	Outlays (millions)	Percent
Hospitals.....	\$1,767	26
Mental hospitals.....	\$281	4
Long-term care facilities.....	\$2,403	35
Physicians services.....	\$701	10
Outpatient drugs.....	\$453	7
Dental care.....	\$190	3
Outpatient hospital and clinic service.....	\$441	6
Other.....	\$593	9
<b>Total.....</b>	<b>\$6,829</b>	<b>100</b>

the A.M.A. plan was quite limited. A number of suggestions, modifications, and extensions were recommended to Senator Bennett. The staff believed the modifications would reflect the A.M.A.'s guiding principle that the key to making the present system workable and acceptable is the physician and his medical society. The A.M.A. proposal would limit review activity to services directly rendered by physicians. It was Bennett's opinion that this review should go considerably further. He felt that utilization of health care services--both inpatient and outpatient--is actually determined by the physician, even though the physician's direct services account for a relatively small portion of the Federal health care dollar costs. The bulk of these costs go for institutional care which is ordered by physicians. Since the physician determines the usage of institutional care, it seems appropriate to charge him with the responsibility for its review, as well as for the review of those services directly provided by his peers--namely, other physicians.

The second major difference between the A.M.A. proposal and the Senate amendment was that the Bennett amendment would place basic responsibility for the necessary review work at the local community level. Local emphasis was necessary according to Bennett because the practice of medicine may vary, within reasonable limits, from area to area. Local review would assure greater familiarity with the physicians involved in ready access to necessary data. Bennett felt that priorities should be given to arrangements with local medical societies who are willing and capable of undertaking comprehensive professional standards review.

It is interesting to note that during floor consideration of the Social Security amendments in the Senate late in 1970, a motion was

offered to strike the PSRO provisions. That move was overwhelmingly defeated. It also became abundantly clear that those who had an opportunity to study Bennett's proposal, including many medical societies and other health care organizations, began to provide increased support to the amendment.

At the Finance Committee hearings in July of 1971 on HR1, Secretary of DHEW Richardson reiterated his support for the professional standards of review approach and requested authority to proceed with formal implementation of those mechanisms.

While the concept was gaining official support, the PSRO concept had become a working reality in states such as New Mexico, Colorado and Georgia.

In the Congressional hearings, Senator Bennett stressed that Congress and the Department of Health, Education and Welfare were thoroughly familiar with the problems of the rapidly rising cost of health care. These rising costs affect all citizens through increased taxes, insurance premiums, and medical bills. In addition, Bennett noted that the rising health care costs fall disproportionately on those who have the greatest need for health services--the chronically ill, the aged, and the poor. Bennett pointed out the fact that increasing health care costs had resulted in a projected deficit totaling at least \$242 billion in the Medicare program over the next 25 years. He also indicated that the increase in health care costs has resulted in the aged paying about as much now for medical care per year as they were paying prior to the enactment of Medicare.

In addition to the rapidly rising costs of health care, he noted a problem exists with respect to the quality of that care. The Committee on Finance held two extensive series of hearings on health care in 1970. In the spring of 1970, the Committee held oversight hearings on Medicare and Medicaid; and, in the fall of 1970, the Committee held hearings on the Social Security amendments which contain many Medicare changes. During the course of these hearings, disturbing testimony was heard bearing on the quality of health care. Many physicians testified that in certain areas of the country, a good deal of unnecessary and avoidable surgery was being performed and excessive and inappropriate health care services provided. The most disturbing fact according to Bennett was that in most areas of the country no effective review mechanism exists whereby practicing physicians can, in an organized and publicly accountable fashion, determine on a comprehensive and ongoing basis if services are medically necessary and if they meet quality standards.

When Senator Bennett introduced his amendment, he made it very clear that the government has a responsibility to establish mechanisms capable of assuring effective utilization review and control of costs. The primary responsibility is to the millions of persons depending upon Medicare and Medicaid, to the taxpayers who bear the burden of billions of dollars in annual program costs, and to the health care system.

Senator Bennett believed that the critically important utilization review process must be restructured and made more effective through substantially increased professional participation. The Committee

believed that the review process should be based upon the premise that only physicians are in general qualified to judge whether services ordered by other physicians are necessary. The Committee was very much aware of the increasing instances of criticism directed at the use of insurance company personnel and government employees in reviewing the medical necessity of services. Generally, the Committee agreed with the principles of "peer review" which were enunciated in the report of the President's Health Manpower Commission issued in November of 1967. The report carried the following principles:

- "1. Peer review should be performed at the local level with professional societies acting as sponsors and supervisors.
2. Assurance must be provided that the evaluations groups perform their tasks in an impartial and effective manner.
3. Emphasis should be placed on assuring high quality of performance and on discovering and preventing unsatisfactory performance.
4. The more objective the quality of evaluation procedures, the more effective the review body can be. To enable greater objectivity, there should be substantial program research to develop improved criteria for evaluation, data collection methods, and techniques of analysis."

The philosophic base of the PSRO Amendment is best expressed in the Senator's own words:

"I believe that physicians, properly organized and with a proper mandate, are capable of conducting an ongoing effective review program which would eliminate much of the present criticism of the profession and help enhance their stature as honorable men in an honorable vocation willing to undertake necessary and broad

responsibility for overseeing professional functions. If medicine accepts this role and fulfills its responsibility, then the Government would not need to devote its energies and resources to this area of concern. Make no mistake: the direction of the House-passed social security bill is towards more- not less- review of the need for and quality of health care. I believe my amendment would provide the necessary means by which organized medicine could assume responsibility for that review.

In my opinion, if ultimately enacted, the Professional Standards Review proposal now being drafted would provide physicians with an imaginative and exciting opportunity to assume basic responsibility for reviewing health care as a whole. It would scrap the piecemeal review activities of varying effectiveness which have prevailed since 1966."

#### Politics of the Bennett Amendment

It became very evident that there would be a great deal of political battling related to the Bennett amendment. Organized medicine on the one hand was less enthused by the effects of the PSRO program, while the government was generally very enthused about being able to control costs under Medicare and Medicaid.

In connection with the objections made by organized medicine, it is interesting to note that the review activities which a PSRO is expected to undertake were generally authorized under the Social Security Act prior to the PSRO legislation. The motive of Bennett and others in enacting PSRO was to give practicing physicians priority in undertaking this activity, rather than utilizing bureaucrats and insurance company personnel to review care provided under the \$25 billion Medicare/Medicaid programs.

The American Medical Association was the primary critic of the PSRO amendment. The first objection was that the law should have been

written with a considerable amount of additional forethought. The AMA felt that the law itself was a creature of impulse. Senator Bennett indicated that, in fact, the professional standards review legislation was a product of years of effort, representing the input and testimony of many individuals and organizations. He noted that the beginnings of the law were the American Medical Association's own PSRO proposal which they asked Senator Bennett to consider introducing in early 1970. This amendment was before the public from July, 1970, when Bennett first announced his intention to introduce the legislation, to October, 1972, when it became law. Before this, the subject of extensive public testimony and hearings before the Finance Committee in 1970 and 1971--including testimony from the American Medical Association, the Council of Medical Staffs, and the American Association of Physicians and Surgeons. It was also testified to during the course of overall insurance hearings before the House Ways and Means Committee in 1971. The bill was formally before the Committee on Ways and Means in the form of HR-7182, and in many respects, that bill was similar to and in many respects also identical to the one that was sponsored by other Congressmen. It was passed twice by the Finance Committee as an amendment to the appropriate Social Security-Medicare bills, twice by the full Senate--including Senate rejection by a vote of 18-48 of a specific amendment by Senator Curtis of Nebraska to delete the PSRO provision--and it was considered and approved by a Conference Committee of both houses and finally signed by the Presidential Law as PL 92-603 on October 30, 1972.

It is interesting to note that the AMA had many public comments in their own journal related to the PSRO amendment as introduced by Bennett, and their own "Medical Backgrounder" on PSRO legislative history indicated that Senator Wallace Bennett of Utah used the AMA concept as a base and developed the PSRO program. They indicated that a basic difference between the AMA and Bennett approaches was that under PSRO, a state medical society could not be the review agency. Rather, a new organization must be created.

The AMA objected also to the advance approval of admissions to hospitals for elective surgery, "national norms" of health care, monetary fines for violation of certain provisions, and government ownership of records of physicians and patients. It is interesting to note that the Senate Finance Committee modified PSRO in each of these areas to at least some degree.

The second major allegation by AMA was that the law requires development and application of "norms of care".

Senator Bennett responded to this allegation by stating that private health insurers and the Medicare and Medicaid administrators had been applying their own criteria of care and almost always retrospectively determining whether to approve or disapprove a claim for payment. In contrast, the amendment that Bennett visualized sought to substitute professionally developed norms and parameters of care which are the product of the work of practicing physicians in the local area. Bennett felt that it would far more acceptable to have the community of physicians in an area determine these factors than for

them to be the province of an anonymous insurance company or bureaucracy. All of the parameters would be well-known to the community of doctors who have developed and approved them.

In addition, the bill did not speak to a single norm or way of treatment as the definitive and only type for which payment will be made; rather, it refers to the "range of norms" acceptable to the PSRO for a given diagnosis. This acceptable range may well include patterns of care which serve to decrease the concern with and incidence of "defensive medicine". Further, and of great importance to Bennett, was the fact that these norms and parameters were only checkpoints--developed by the practitioners themselves--related to age and diagnosis which simply serve to establish reasonable points at which the attending doctor should indicate the need for continued care or service or why certain services were not provided. Assuming that PSRO approves care beyond these checkpoints, it would be paid by Medicare and Medicaid without each case being second-guessed by carriers, intermediaries, or state agencies.

Bennett felt that the alternative to appropriate professionally developed checkpoints in determining reasonableness for payment with public funds was to have no reference points, which obviously would be an untenable position. In addition, Bennett pointed out that a resolution approving the development of PSRO norms was adopted by the American Medical Association at its clinical convention in 1972 and that the AMA's resolution was completely in agreement with the language and tone of the PSRO statute and report.

Thirdly, the AMA charged that the PSRO program would violate confidentiality of patient records.

Senator Bennett replied to this allegation by stating that the health insurers, such as Blue Cross-Blue Shield, had been reviewing medical records for years--long before PSRO and long before Medicare. Although this review has not always been done discreetly or confidentially, the PSRO legislation would have specific statutory safeguards designed to safeguard patient identity and confidentiality. First, Section 1155 (a) (4) of the bill emphasizes that each PSRO shall utilize "to the greatest extent practicable in such patient profiles, methods of coding which will provide maximum confidentiality as to patient identity and assure objective evaluation".

Secondly, Section 1166 of the bill, entitled "Prohibition Against Disclosure of Information", read as follows:

"a. Any data or information acquired by any professional standards review organization, in the exercise of its studies and functions, shall be held in confidence and shall not disclose to any person except (1) to the extent that may be necessary to carry out the purposes of this part; or (2) in such cases and under such circumstances as the Secretary shall by regulation provide to assure adequate protection of the rights and interests of patients, health care practitioners or providers of health care.

b. It shall be unlawful for any person to disclose any such information other than such purposes and for such purposes, and any person violating the provisions of this section shall, under conviction, be fined not more than \$1,000, and imprisoned for not more than six months, or both, together with the costs of prosecution."

The next allegation made by the AMA was that the cost of PSRO review would outweigh any savings.

Senator Bennett answered this by stating that appropriate professional review mechanisms do not cost substantially. However, he did indicate that experience with operating PSRO prototypes--such as those in Colorado, New Mexico, Utah, and Sacramento and San Joaquin Counties in California--evidenced substantial cost savings above the costs of the review process itself.

The next criticism that the AMA targeted on the law was that fines may be imposed upon a physician, and these fines would have a stultifying effect on medical practice.

Senator Bennett answered this by stating that in actuality, the law does not contain any provision calling for fines. The original Bennett amendment did include a provision authorizing fines, but that was dropped subsequently. The PSRO statute does contain a provision allowing the local doctors to recommend a series of sanctions on the physician who flagrantly or consistently orders or renders services which are either unnecessary, improper, or of improper quality. Under Sections 1862 and 1903 of the Social Security Act (non-PSRO sections), the Secretary has the authority to suspend the physician from the programs. Under the PSRO provision, the local physicians themselves, rather than the Secretary, would have the authority to recommend appropriate sanctions. These sanctions can either be suspension or, if they decided a less severe sanction was called for, they can recommend a repayment by the practitioner of the actual costs paid by the government--not to exceed \$5,000--if excessive services have been rendered. It would

be difficult to construct an effective peer review law which had no sanctions such as recovery position, since the local physicians would then have no way to deal with an improper situation.

The remaining legislative history leading to the passage of the law is as follows:

"The Senate Finance Committee approved a modified form of the Bennett Amendment (No. 851) to the pending social security bill during October, 1970. Final action on the bill, however, was not taken by the 91st Congress. The bill was reintroduced to the 92nd Congress as Amendment No. 823 to the Social Security Act (H.R.1) on January 25, 1972. It was referred to the Committee on Finance and ordered to be printed.

The bill was again modified before it was reported out by the Senate Finance Committee late in 1972. Section 1170 authorizing demonstration projects to test the feasibility and economies of depayment through PSROs was eliminated.

The Bennett Amendment, as modified by the Finance Committee, was passed by the Senate and referred to a House-Senate Conference Committee. As a result of that conference, the House receded (accepting the amendment) with the following modifications:

- (1) 'Until January 1, 1976, the Secretary would be able to make an agreement only with a qualified organization which represents a substantial proportion of the physicians in the geographic area designated by the Secretary.
- (2) A professional standards review organization would not be required to review other than institutional care and services unless such organization chooses to include the review of other services and the Secretary agrees.
- (3) Until January 1, 1976, at the request of 10 percent or more of the practicing physicians in a geographic area designated by the Secretary, the Secretary would be required to poll the practicing physicians in the area as to whether or not an organization of physicians which has requested to conclude an agreement with the Secretary to establish a professional standards review organization in this area substantially represents the practicing physicians in that area. If more than 50 percent of the practicing physicians in the area responding to the poll indicate that the organization does not substantially represent the practicing physicians in the area, the Secretary could not enter into an agreement with that organization.'"

The bill became Public Law 92-603 on October 30, 1972.

E. Summary of Public Law 92-603: Bennett Amendment to the Social Security Act Authorizing the PSRO Program

The Bennett Amendment to the Social Security Act was made law by Public Law 92-603 which officially became law on October 30, 1972.

The summary of this amendment is as follows:

The professional standards review mechanism would take effect along the following lines:

The Secretary of Health, Education and Welfare would, after consultation with national and local health professions and agencies, designate appropriate PSRO areas throughout the Nation. This would be done by January 1, 1973. Area may cover an entire State (particularly those with smaller populations) or parts of a State, but generally a minimum of three hundred practicing doctors would be included within one PSRO area. Tentative area designations could be modified if, as the system was placed into practice, changes seemed desirable. The Secretary would also, in consultation with professional and other concerned organizations and interests, develop prototype review plans and would aid in the development of such plans with the view to securing acceptable arrangements for PSROs in all areas and to gain experience with several patterns.

Organizations representing substantial numbers of physicians in an area, such as medical foundations and medical societies, would be invited and encouraged to submit plans meeting the requirements of the programs. Where the Secretary finds that such organizations are not willing or cannot reasonably be expected to develop capabilities to carry out PSRO functions in an effective, economical and timely manner, he may then enter into PSRO agreements with each other agencies or organizations with professional competence as he finds are willing and capable of carrying out PSRO functions. Formal plans would specify the extent and nature of cooperating arrangements with all agencies necessary to proper administration of the program.

It is expected that an acceptable plan will be one which encompasses in its proposed activities and responsibilities to the greatest extent possible physicians engaged in all types of practices in the PSRO area, i.e., solo, group, hospital and medical school-based practice, etc.

The Secretary would approve those plans which can reasonably be expected to improve and expand the professional review process. The initial approval is to be made on a conditional basis, not to exceed two years, with the review organizations operating concurrently with the present review system. During the transitional period, carriers and intermediaries (in the case of Medicare) are expected to abide by the decision of the PSRO where the PSRO has acted. This reliance will permit a more complete appraisal of the effectiveness of the conditionally-approved PSRO.

In areas where no adequate plan was initially submitted, the Secretary will seek to aid in the improvement and expansion of plans offered and to develop plans through his own efforts, based upon organizations with professional competence such as State or local health agencies or claims paying organizations such as carriers and intermediaries if necessary.

Once an organization is accepted, the Secretary with the assistance of the Statewide organization and the National Advisory Council would monitor the performance of the PSRO plans using statistical and other appropriate means of evaluation. Where performance of an organization was determined unsatisfactory, and his efforts to bring about prompt necessary improvement fail, he could terminate its participation, after appropriate notice and opportunity for administrative hearing by the Secretary, if requested.

Provider, physician and patient profiles and other relevant data would be collected and reviewed on an ongoing basis to the maximum extent feasible to identify persons and institutions that provide services requiring more extensive review. Regional norms of care would be used in the review process as routine checkpoints in determining when excessive services may have been provided. The norms would be used in determining the point at which physician certification of need for continued institutional care would be made and reviewed. The physician, provider and patient profiles and other data would be collected in ways determined by the Secretary to be most efficient. The initial priority in assembling and using data and profiles would be assigned to those areas most productive in pinpointing problems so as to conserve physician time and maximize the productivity of physician review. The PSRO would be permitted to employ the services of qualified personnel, such as registered nurses who could, under the direction and control of physicians, aid in assuring effective and timely review.

Where advance approval by the review organizations for institutional admission is required, such approval would provide the basis for a presumption of medical necessity for purposes of Medicare and Medicaid benefit payments. However, if the review organization finds that ancillary services provided subsequent to its approval are excessive, payment under Medicare and Medicaid would be denied with respect to such excessive services.

Failure of a physician, institution or other health care supplier to seek advance approval where required may be considered cause for disallowance of affected claims.

In addition to acting on its own initiative, the review organization would report on matters referred to it by the Secretary. It would also recommend appropriate action against persons responsible for gross or continued overuse of services, use of services in an unnecessarily costly manner, or for inadequate quality of services; and would act to the extent of its authority or influence to correct improper activities.

The Secretary would be authorized upon recommendation of the PSRO to recover cost of excessive services--up to \$5,000--from the practitioner, supplier or institution at fault.

A National Professional Standards Review Council--composed of physicians with a majority selected from nominees of national organizations representing practicing physicians, and in addition physicians recommended by consumers and other health care interests--would be established by the Secretary to review the operations of the local area review organizations, advise the Secretary on their effectiveness and make recommendations for their improvement.

Those persons engaged in review activities would be exempt from liability for actions taken in the proper performance of these duties. In addition, physicians, providers and others involved in the delivery of care would be exempted from liability arising from conformity to the recommendations of such review organizations.



## SECTION VI. DESCRIPTION OF KEY PROVISIONS OF THE PSRO LAW

This Section of the report will detail the description of the key provisions of the PSRO law.

Generally, the legislation requires the Secretary of HEW to designate specific PSRO geographic areas in the country no later than December 31, 1973. Following final designation of the areas, the Department would then begin to support appropriate physician-sponsored organizations interested in developing or establishing PSROs in each area. Qualified groups of physicians could seek designation as conditional PSROs or, alternatively, may request them from HEW for the purpose of conducting planning activities toward the establishment of conditional PSROs. The Department would also fund qualified statewide organizations of physicians desirous and capable of serving PSRO technical and administrative resource centers. In addition, the Department would contract with medical specialty societies for the purpose of developing suggested norms, criteria and standards for various diagnoses which might assist local PSROs in the development of review plans.

State PSRO Councils are authorized in any state with three or more PSROs and should include representation from each PSRO in the state, other physicians, and the public. A National Council would be appointed by the Secretary, which will include eleven physicians, with a majority nominated by national physicians' organizations.

Table 14.

BASIC PSRO OBJECTIVES

REVIEW FOR MEDICAL NECESSITY

REVIEW FOR MINIMUM QUALITY

REVIEW FOR APPROPRIATENESS OF SETTING

FOR

CLAIMS RELATING TO

MEDICARE PROGRAM (TITLE XVIII)

MEDICAL ASSISTANCE PROGRAM (TITLE XIX)

MATERNAL AND CHILD HEALTH PROGRAM (TITLE V)

The PSROs will monitor the appropriateness of utilization and the quality of institutional services provided to beneficiaries of the Social Security Act (i.e., Medicare and Medicaid). They will be concerned with the necessity for quality of care, and with the use of an appropriate level of service, but will not be required to determine the reasonableness of individual charges. With the concurrence of the Secretary, PSROs will have the option to monitor ambulatory services as well.

PSROs will utilize norms of care, based on typical patterns of practice in the region, to evaluate the appropriateness of utilization and the quality of institutional services. Regional norms must be approved by the National Council. Justification will be required for any regional norms which significantly deviate from national norms.

PSROs are encouraged to use the services of many practicing physicians in the conduct of their reviews and to delegate responsibility for review to hospitals, HMOs, and other group practices which have demonstrated capability to conduct adequate reviews. Within this framework, PSROs are charged with the responsibility for: (1) pre-certification of institutional services; (2) periodic sample reviews by diagnosis or condition; (3) regular review of patient and provider profiles; (4) monitoring the certification requirements of the Social Security Administration; (5) physician education concerning the program; and (6) appropriate reporting of violations.

The State Councils will coordinate the activities of the various PSROs, serve as an appeal agent, and assist the Secretary in the conduct of the program.

Table 15.

CATEGORIES OF PEER REVIEW

1. POLICE TYPE OF FRAUD DETECTION TO PREVENT OVERPAYMENT AND OVERUTILIZATION TO (a) SAVE MONEY AND (b) IDENTIFY ABUSES.
  
2. THE IMPROVEMENT OF THE QUALITY OF CARE THROUGH EDUCATION AND ESTABLISHMENT OF CRITERIA FOR GOOD MEDICAL CARE MANAGEMENT.
  
3. BROAD EVALUATION TO IDENTIFY SYSTEMS AND PROCEDURES CAPABLE OF PROVIDING BETTER CARE, MORE EFFICIENT DELIVERY OF SERVICES OR LOWER COSTS.

The National Council will prepare, revise, and distribute regional norms; provide technical assistance in the use of these norms; review the performance of the State Councils and PSROs; and advise both the Secretary and the Congress on the progress of the program.

PSROs themselves are authorized to undertake professional inquiry before and/or after the provision of any service covered by the legislation; to examine pertinent records; and to inspect physical facilities where such care is rendered. After proper notification, no Medicare or Medicaid claim will be paid if the service is subject to the review of the PSRO and has been disapproved.

Each health care provider and practitioner is obligated to provide services consistent with the intent of the amendment. Recurrent or flagrant violations may lead to an exclusion from the program or a fine. An appeals route is defined for dissatisfied patients, practitioners, or other providers. The legislation provides for the transitional assumption of PSRO duties over a two-year conditional period and for the continuation of presently authorized reviews during the transition. Appropriate funding through the Hospital Insurance Trust Fund and the Supplementary Medical Trust Fund is provided for technical assistance in the reasonable and necessary expenses of PSROs, State Councils and the National Council.

The legislation is designed to utilize professional expertise through peer review, subject to public accountability, to assure the appropriateness and quality of institutional services purchased under provisions of the Social Security Act.

The explicit objectives of the legislation include review of the services provided all federal beneficiaries to evaluate the:

- (1) necessity for institutional admission;
- (2) duration of institutional service;
- (3) appropriateness of the level of institutional care; and
- (4) adequacy and relevance of the services provided.

The implied objectives of the legislation are to: (1) contain the utilization and thereby the cost of federal health services at a minimum level, and (2) assure that the services purchased are medically necessary and appropriate.

The remainder of this section of our report will provide a detailed description of the key provisions of the PSRO law.

A. Declaration of Purpose

The purpose of the PSRO is to promote efficient, effective, and economical health services of proper quality. The amendment applies to services partially or wholly under the Social Security Act (Medicare, Medicaid, Maternal and Child Health). Payments for services are to be made only if the services are medically necessary and provided in an appropriate facility or setting.

B. Structure and Membership of PSROs

Section 1152(B) defines the structure and membership of the PSROs. It indicates that the PSRO organization can only be comprised of non-profit professional associations. Only MDs and DOs are allowed

to join; however, membership shall be voluntary on the part of the professional. A substantial proportion of the MDs and DOs licensed and practicing in the area must join. There is no requirement for the professional who joins the PSRO that he be a member of the medical society.

C. Alternate Structure and Membership

If by January 1, 1976, there is no PSRO established in an area, Section 1152(B) authorizes the Secretary to appoint an alternate structure in membership. However, the initial membership structure of the PSRO will be accepted by the Secretary if--on the basis of his examination and evaluation of a formal plan submitted to him by the association, agency or organization--he finds it willing and capable of performing in an effective, timely and objective manner, the duties, functions and activities of the PSRO requirement. Under Section 1152 (E), the Secretary may eliminate other reviews now required under the Social Security Act if he finds that PSRO review activities are effective within the PSRO organization. In other words, there would not need to be duplication of review activities.

D. Avoiding Duplication of Peer Review

As described above, Section 1152(E) seeks to avoid duplication of peer review activities.

E. Status of Present Review

Section 1153 states that reviews now authorized (which are primarily utilization reviews under the Medicare and Medicaid aspects of the Social Security Act) will continue until the PSRO is approved for full review responsibility.

F. Trial Period for a PSRO

Section 1154 of the Act states that the trial period for any PSRO may not exceed twenty-four months. The number and type of such duties during the trial period will be progressively increased as the organization becomes capable of added responsibility, so that by the end of twenty-four months, the organization will be considered a qualified organization only if the Secretary finds that it has substantially carried out in a satisfactory manner the activities and functions required of PSROs under the law with respect to the review of health care services.

G. Duties and Functions of a PSRO

Section 1155(A)(1) requires that the following types of review shall be insured under a PSRO program: (a) medical necessity of services; (b) quality of services; and (c) appropriate facility or setting.

Section 1155(A)(2) gives the PSRO responsibility for preadmission certification. There must be certification for elective admissions or extended or costly services.

Section 1155(A) (3) states that each PSRO will publish lists for preadmission certification requirements if there are any.

Section 1155(A) (4) relates to patient profiles as well as to profiles for facilities, physicians, and other providers. It states that there must be maintenance and regular review of profiles of care and services received and provided. These profiles will be reviewed on an ongoing basis with respect to each health care practitioner and provider to determine whether the care and services ordered or rendered are consistent with the criteria specified in other parts of the law.

Sections 1155(A) (5) and (6) relate to reviewing physicians and says that only physicians with active staff privileges in an area PSRO hospital can do reviews. Physicians who have a financial interest in any particular facility are not allowed to review cases within that facility nor are they allowed to review their own cases.

Section 1155(C) relates specifically to peer review and essentially says that only MDs or DOs can make final determinations about the work of other MDs or DOs.

Section 1155(E) deals specifically with the hospital's own review mechanisms. This section gives sanction to the facility's own review mechanisms if it is determined by the PSRO that the review mechanism is timely and effective.

Section 1155(F) simply states that the PSRO will collect data relevant to its functions.

#### H. Establishing Norms

Section 1156(A) requires the PSRO to apply norms (statistical representations of actual practice in its region) of care, diagnosis, and treatment as principal points of evaluation and review. The National Review Council and the Secretary of HEW are supposed to provide technical assistance to the PSRO in utilizing and applying such norms where the actual norms differ from professionally developed regional norms of care and diagnosis. The PSRO can apply for special deviation.

#### I. Attending Physician Certification

Section 1156(D) requires the attending physician to certify the medical necessity for the care delivered to inpatients. The provision further requires the attending physician to periodically recertify that continued inpatient care of the patient is medically necessary to effectively meet the minimum health care needs. Recertification is required to take place not later than the 50th percentile of lengths of stay for patients of similar age groups and with similar diagnoses. The length of stay criteria must be consistent with professionally developed norms of care and treatment. In order to develop the norms, data must be developed which will enable a retrospective analysis of length-of-stay trends for patients in that particular institution. The analysis will most likely be based upon a grouping technique, i.e., all patients of a similar age, similar diagnosis, similar injuries, similar complications.

#### J. Non-Payment and Hearings on Claims

Section 1158 relates to non-payment and hearings on claims and

merely states that the PSRO decision is final on disapproval of services. In other words, if--after review--the PSRO disapproves the services, payment from Federal funds may not be made.

Section 1159 deals with hearings on denying claims and provides an appeal mechanism for denied claims, based on the size of the claims.

K. Provider's Obligations

Section 1160(A) states the requirements placed on provider obligations. In essence, all practitioners and other providers must assure that the services for which payment is requested are medically necessary and of professionally recognized quality. There must be assurance that the care was provided in the most economical setting.

L. Sanctions Against and Notices to Providers

Section 1160(B) provides sanctions against the provider. The Secretary of HEW may apply the sanction against providers failing to comply with the obligations. These sanctions are: (1) deny eligibility to provide services on a reimbursable basis, and (2) require repayment for medically improper or unnecessary services up to \$5000.

Section 1161 requires that the PSRO give immediate notice to the practitioner or other provider of all adverse decisions and provide opportunity for discussion.

M. Statewide PSRO Review Councils

Section 1162 relates to Statewide PSRO Review Councils. A State Council (including members other than physicians) is required in any state with three or more PSROs. Membership of the Council shall

include one representative from the PSRO, four physicians, and four persons knowledgeable in health care from the state at large.

The duties of the statewide professional standards review council consist of:

- (1) coordination; this will include disseminating information and data among the PSROs within the state, including uniform data-gathering procedures and operating procedures;
- (2) assisting the Secretary of HEW in evaluating the performance of each PSRO; and
- (3) where the Secretary determines it appropriate, the Council will assist the Secretary in replacing a PSRO and arranging for a qualified replacement organization.

N. National PSRO Council

The National PSRO Council is supposed to consist of eleven physicians who are appointed by the Secretary of HEW for three-year terms. This is authorized by Section 1163(A) of the law. It is significant to note that the legislation requires that membership of the Council shall include physicians who have been recommended for membership on the Council by consumer groups or other health care interests.

Section 1163(E) defines the duties of the National Council.

These include:

- (1) advising the Secretary of HEW in the administration of the program;
- (2) providing for the development and distribution among the statewide PSRO councils and the PSRO organizations of information and data which will assist them in carrying out their functions;
- (3) reviewing the operations of the statewide organizations and the individual organizations with a view to determining the effectiveness and comparative performance of the separate organizations in carrying out the program; and

Table 16.

NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL (NPSRC): GENERAL INFORMATION

- . P.L. 92-603 OF THE SOCIAL SECURITY AMMENDMENTS OF 1972 MANDATED ESTABLISHMENT OF THE COUNCIL
  
- . COUNCIL IS IN ITS THIRD YEAR; IT WAS CHARTERED IN MAY, 1973 AND RECHARTERED ON MAY 1, 1975
  
- . COMPOSED OF ELEVEN "PHYSICIANS OF RECOGNIZED STANDING AND DISTINCTION IN THE APPRAISAL OF MEDICAL PRACTICE"

- (4) arranging for the performance of studies and investigations with the objective of developing and recommending to the Secretary of HEW and to the Congress measures designed to more effectively carry out the program.

O. Disclosure of PSRO Information

Section 1166 deals with disclosure of information. It says essentially that the PSRO shall hold in confidence information except as needed to carry out its duties.

Section 1167 provides a limitation on liability for the PSRO. It states that no person providing information to any PSRO shall be liable for civil or criminal liability unless the information is unrelated to the performance of the duties and functions of that person with regard to the PSRO, and unless that information is false and the person providing such information knew or had reason to believe that such information was false.

P. Technical Assistance to PSROs

PSROs may contract for technical assistance in performing their functions. These services may include consulting services, data processing services, physician services and others.

Q. Continuing Medical Education

Continuing medical education will be an essential component of the PSRO program. The major thrust of the PSRO should be the improvement of the quality of health care. The review processes, admission certification, continued stay review, medical care evaluation studies and profile analyses will uncover problems affecting the quality and utilization of medical services.

## Table 17.

NPSRCFUNCTIONS

(SPECIFIED BY SECTION 1163 (e), P.L. 92-603)

1. ADVISE THE SECRETARY IN THE ADMINISTRATION OF TITLE XI, PART B OF THE SOCIAL SECURITY ACT RELATING TO PROFESSIONAL STANDARDS REVIEW
2. PROVIDE FOR THE DEVELOPMENT AND DISTRIBUTION OF DATA AND INFORMATION TO STATE AND LOCAL PSROs
3. REVIEW AND EVALUATE THE EFFECTIVENESS AND COMPARATIVE PERFORMANCE OF STATE AND LOCAL PSROs
4. MAKE OR ARRANGE FOR MAKING SPECIAL STUDIES WITH GOAL OF RECOMMENDING TO THE SECRETARY AND CONGRESS MORE EFFECTIVE PERFORMANCE OF PSROs
5. PROVIDE TECHNICAL ASSISTANCE TO PSROs IN "UTILIZING AND APPLYING NORMS OF CARE, DIAGNOSIS AND TREATMENT. "INFORMATION ABOUT REGIONAL NORMS WILL BE DISTRIBUTED BY THE COUNCIL TO PSROs. LOCAL VARIATIONS MUST BE APPROVED BY THE COUNCIL

Table 18.  
MEMBERS, NATIONAL PROFESSIONAL  
STANDARDS REVIEW COUNCIL

Clement R. Brown, M.D.  
Director, Medical Education  
Mercy Hospital & Medical Center  
Stevenson Expressway at King Drive  
Chicago, Illinois 60616

Ruth M. Covell, M.D.  
Health Science Planning Officer  
University of California  
at San Diego  
School of Medicine  
La Jolla, California 92037

Merlin K. DuVal, M.D.  
Vice President for Health Sciences  
University of Arizona  
Tucson, Arizona 85724

Robert J. Haggerty, M.D.  
Professor of Pediatrics  
University of Rochester  
School of Medicine & Dentistry  
260 Crittenden Boulevard  
Rochester, New York 14642

Donald C. Harrington, M.D.  
445 West Acacia Street  
P. O. Box 230  
Stockton, California 95201

Robert B. Hunter, M.D.  
P. O. Box 429  
Sedro Woolley, Washington 98284

Alan R. Nelson, M.D.  
2000 South 9th East  
Salt Lake City, Utah 94105

Raymond J. Saloom, D.O.  
301 Prairie Street  
Harrisville, Pennsylvania 16038

Ernest W. Saward, M.D.  
Professor of Social Medicine  
University of Rochester  
School of Medicine & Dentistry  
260 Crittenden Boulevard  
Rochester, New York 14642

Willard C. Scrivner, M.D.  
6600 West Main Street  
Belleville, Illinois 62223

Cornelius L. Hopper, M.D.  
Vice President for Health Affairs  
and Director, John A. Andrew Clinics  
Tuskegee Institute  
Tuskegee Institute, Alabama 36088

Many problems detected through PSRO review may be problems of organization and administration of the health delivery systems. A few may be problems of the physical construction of facilities. Some, however, may be problems of inadequate knowledge or skills and will require an educational solution. The PSRO can serve as the mechanism for identifying problems and developing solutions.

#### CME Process

Once a problem area is identified through the review process, it will be essential to identify its underlying cause in order to develop appropriate corrective solutions. Objectives stated in measurable terms should be set for each problem identified so that evaluation of the CME process is possible.

The Education Committee within the PSRO is the appropriate body to carry out the CME functions of problem identification, determination of cause, objective setting, identifying solutions and evaluation of results.

Example: A higher incidence of post-operative wound infections may be detected through a CME study. The possible causes of such a problem are many:

- a. Poor physician technique;
- b. Poor nursing technique;
- c. Improper sterilization procedures;
- d. Physical conditions in one or more operating rooms; or
- e. A combination of the above.

Additional study to determine which of these items is involved will be required before an appropriate corrective program can be developed.

If problem analysis reveals contamination of sterile operating room supplies by a malfunctioning sterilizer, the program objective would be simply to repair the sterilizer so that all supplies meet prescribed bacteriologic standards of sterility. If problem analysis indicates that improper sterile technique is being followed by the operating room nursing staff, the objective might be to improve nursing techniques such that reaudit in six months demonstrates a reduction of X% in post-operative wound infections.

In the development of solutions to identified deficiencies, educational programs which bring about long-term behavioral changes should be given serious consideration. These might include programs such as programmed texts or preceptorships in which the active participation of the learner is required.

Evaluation of the CME program is accomplished by reviewing the problem area at a later date and comparing the data with the objectives previously set.

#### Continuing Medical Education Responsibilities

##### 1. PSRO Responsibilities:

- a. Serve as a clearinghouse to assure the development of appropriate educational programs on topics identified by institutional review committees.
- b. Work closely with hospitals, medical schools, other health professional schools, specialty societies, medical societies, appropriate voluntary health associations and regional medical programs within the PSRO area.
- c. Work with local institutional review committees to assure that appropriate individual programs of education are developed for individual PSRO members.
- d. Evaluate the effectiveness of continuing health education programs through follow-up review.

- e. Stimulate the teaching of medical care evaluation and peer review in medical and other health professional schools in the PSRO area.
- f. Work with professional organizations to secure continuing education credit for participation in PSRO review.
- g. Work with educational institutions to assure the development of appropriate programs of consumer health education where review indicates a need for such education.

2. State PSR Council Responsibilities:

- a. Work with the statewide support center and local PSROs to assist in and disseminate information on the education of physicians in methodologies for conducting review.
- b. Work with the statewide support center and local PSROs to assist in and disseminate information on the continuing health education activities of PSROs.
- c. Identify statewide needs in health education and work with health professional institutions and organizations to fill those needs.



SECTION VII. STATUS OF PEER REVIEW AND PSRO PROGRAM IMPLEMENTATION AS OF SEPTEMBER, 1975

This Section will review the status of the PSRO program and peer review as of September, 1975. The PSRO program itself is in a state due to turnover in Federal employees, the need for more adequate funding, and other various aspects which will be described below. However, peer review as a concept in medical care delivery appears to be fairly entrenched in the future of the country's health care delivery system. Therefore, consideration of problems relating to the viability and future of the PSRO program itself, should be considered in relation to the far more important thought that medical peer review will, in some form, become an integral part of our national health care delivery system.

A. PSRO Federal Organization

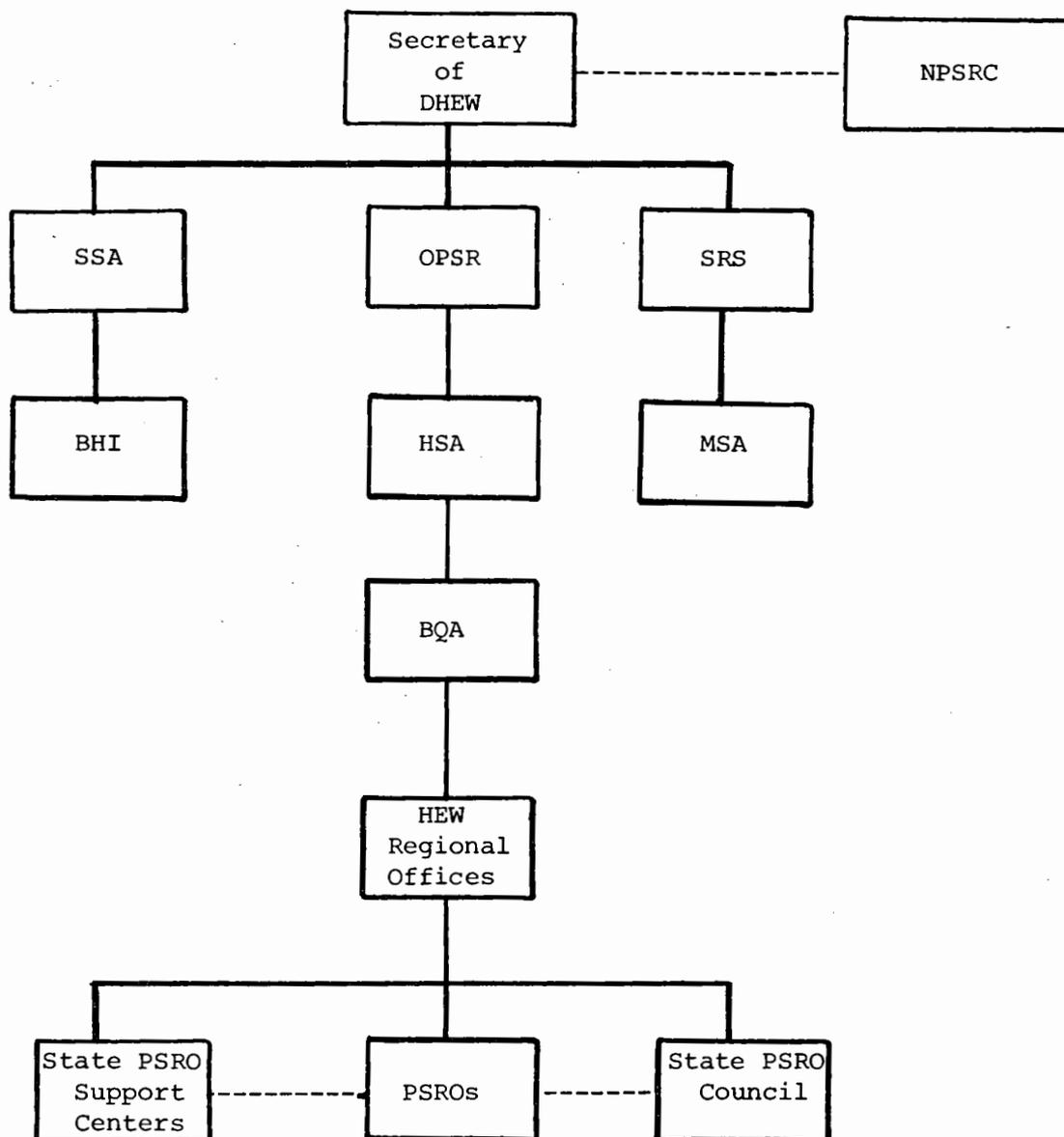
The Secretary of the Department of Health, Education and Welfare has overall responsibility for the PSRO program, and is given advice on policy matters by the National Professional Standards Review Council (NPSRC). The Council is discussed in more detail below.

The program is organizationally undergoing quite a mutation. However, originally the Office of Professional Standards Review (OPSR) was the agency within DHEW with policy responsibility for the PSRO program. OPSR was established as a unit administratively on a par with the Social Security Administration and the Social and Rehabilitative Services, to assure that both quality and cost would be considered as an integral part of these agencies' programs. While the OPSR establishes and monitors PSRO policy, the Bureau of Quality Assurance (BOA), as part of the Health

Figure 22.

ORIGINAL PSRO FEDERAL ORGANIZATION

(See Figure 22 for Revised PSRO Federal Organization)

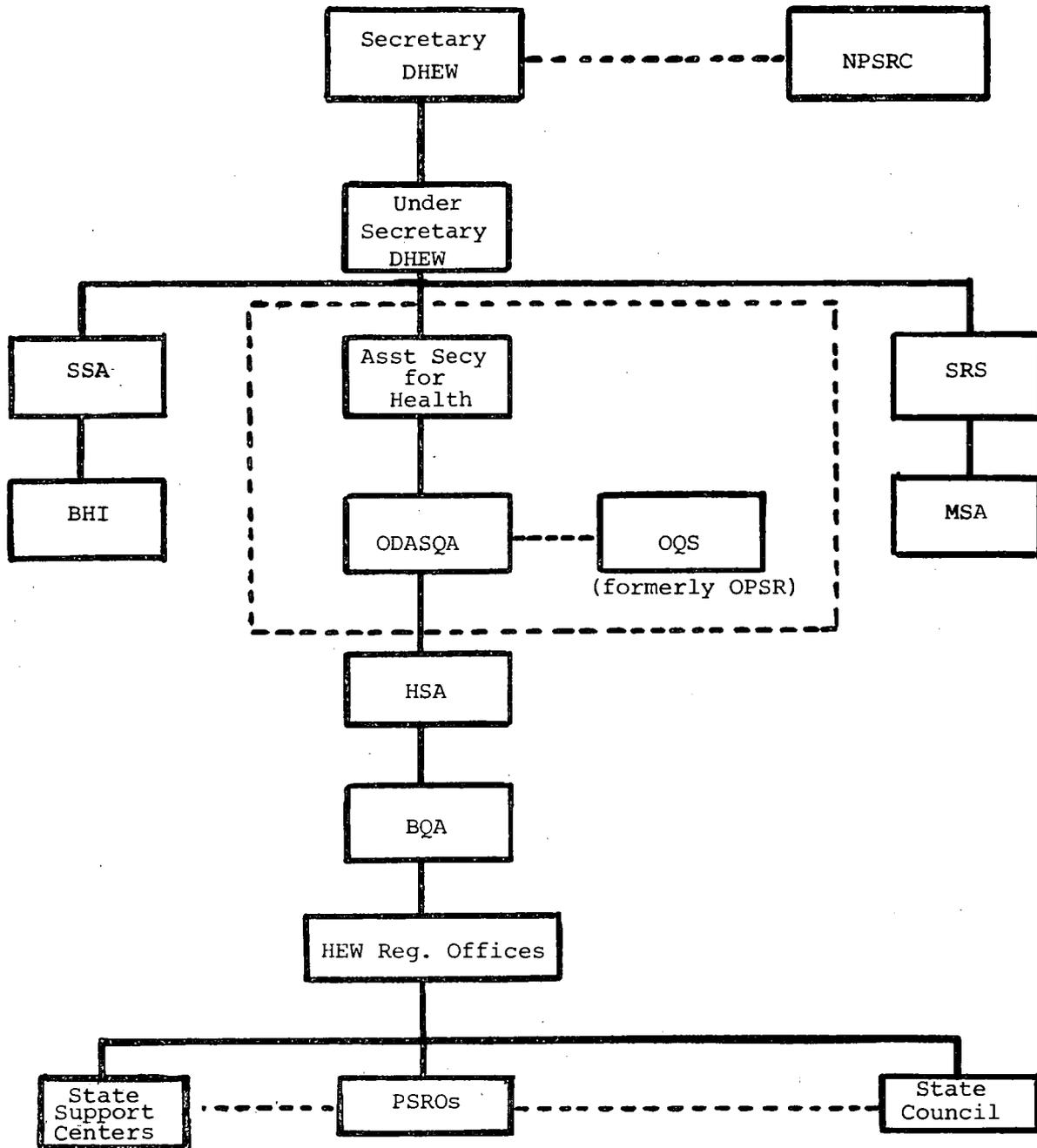


DHEW - Department of Health, Education & Welfare  
 SRS - Social and Rehabilitation Service (Medicaid)  
 SSA - Social Security Administration (Medicare)  
 OPSR - Office of Professional Standards Review  
 HSA - Health Services Administration  
 BQA - Bureau of Quality Assurance  
 NPSRC- National Professional Standards Review Council

OPSR has the responsibility for quality of medical care within DHEW.

REVISED PSRO FEDERAL ORGANIZATION

(Announced in the "Federal Register" on October 20, 1975)



- Indicates area of major organizational change, effective Oct. 20, 1975

- DHEW - Department of Health, Education & Welfare
- SRS - Social and Rehabilitation Service (Medicaid)
- SSA - Social Security Administration (Medicare)
- OPSR - Office of Professional Standards Review
- HSA - Health Services Administration
- BQA - Bureau of Quality Assurance
- NPSRC - National Professional Standards Review Council
- OPSR - Office of Professional Standards Review  
(Name changed to Office of Quality Standards)
- ODASQA - Office of Deputy Assistant Secretary for Quality Assurance
- OQS - Office of Quality Standards
- MSA - Medical Services Administration

Services Administration (HSA), is the operational arm. Within this general framework, local PSROs are required to report to OPSR through the Bureau of Quality Assurance representative. This representative is located in the DHEW Regional Office in the PSRO's service area. Figure 25 provides an organizational table which illustrates the relationship of these various units within the Federal government.

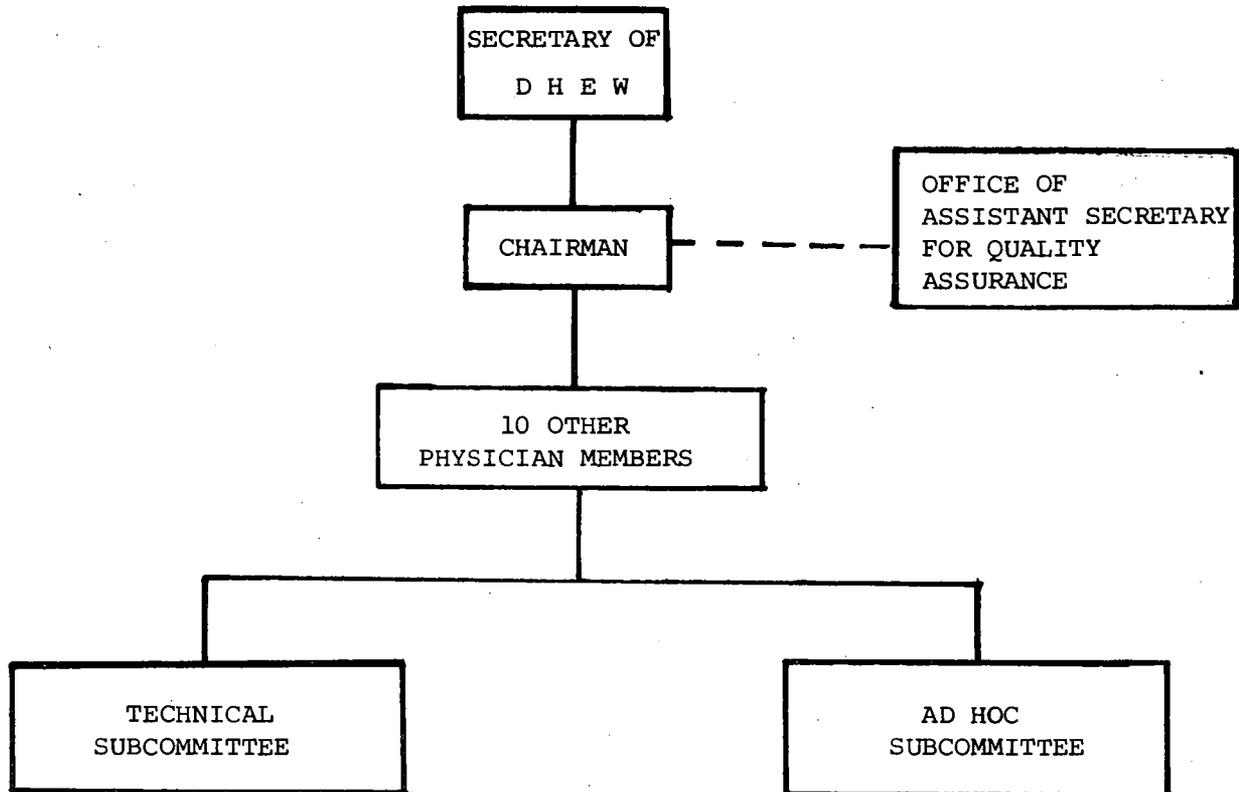
The Department has been working vigorously to carry out the requirements of the legislation. These requirements may be categorized generally as follows:

1. guideline preparations;
2. districting;
3. selection and funding of PSROs;
4. technical assistance to PSROs;
5. central data collection;
6. PSRO evaluation; and
7. support of the National PSRO Council.

#### B. National PSRO Council

The National Professional Standards Review Council (NPSRC), as specified by the legislation, is to consist of eleven members (including the Chairman). All members are appointed by the Secretary of Health, Education and Welfare. The majority of the members are to be recommended by national organizations representing physicians, but the Council does include physicians recommended by consumer groups and other health care interests as well.

Figure 24.

NPSRCORGANIZATION

FUNCTION IS TO MAKE RECOMMENDATIONS  
TO THE COUNCIL AND DHEW STAFF IN THE AREAS OF:

1. DATA AND INFORMATION SYSTEMS
2. EVALUATION OF PSROs
3. MEDICAL CARE NORMS, STANDARDS AND CRITERIA

The duties of NPSRC are specified in Section 1163E of Public Law 92-603, and include:

1. Advising the Secretary in the Administration of Title XI, Part B of the Social Security Act relating to Professional Standards Review;
2. Providing for the development and distribution among statewide professional standards review councils and professional standards review organizations, of information and data which will assist such review councils and organizations in carrying out their duties and functions;
3. Reviewing the operations of Statewide Professional Standards Review Councils and professional standards review organizations with a view to determining the effectiveness and comparative performance of such review councils and organizations in carrying out the purposes of Part B;
4. Arranging for the conducting of studies and investigations, with a view to developing and recommending to the Secretary and to the Congress, measures designed to accomplish more effectively the purposes and objectives of Part B.

Additionally, Section 1156 requires NPSRC to provide technical assistance to PSROs in "utilizing and applying norms of care, diagnosis and treatment." Information about regional norms is to be distributed by the Council to PSROs. Local variations must be approved by the Council. Figure 26 lists the current members of NPSRC.

During fiscal 1974, the Council met eight times. In fiscal year 1975, it met ten times. The meetings of the Council are open to the public. Items discussed are of general interest to the PSRO program. During 1974, the Council placed major emphasis on advising the Secretary on policy issues related basically to PSRO. In the view of the Council, this acti-

Figure 25.

MEMBERS, NATIONAL PROFESSIONAL  
STANDARDS REVIEW COUNCIL

Clement R. Brown, M.D.  
Director, Medical Education  
Mercy Hospital & Medical Center  
Stevenson Expressway at King Drive  
Chicago, Illinois 60616

Ruth M. Covell, M.D.  
Health Science Planning Officer  
University of California  
at San Diego  
School of Medicine  
La Jolla, California 92037

Merlin K. DuVal, M.D.  
Vice President for Health Sciences  
University of Arizona  
Tucson, Arizona 85724

Robert J. Haggerty, M.D.  
Professor of Pediatrics  
University of Rochester  
School of Medicine & Dentistry  
260 Crittenden Boulevard  
Rochester, New York 14642

Donald C. Harrington, M.D.  
445 West Acacia Street  
P. O. Box 230  
Stockton, California 95201

Robert B. Hunter, M.D.  
P. O. Box 429  
Sedro Woolley, Washington 98284

Alan R. Nelson, M.D.  
2000 South 9th East  
Salt Lake City, Utah 94105

Raymond J. Saloom, D.O.  
301 Prairie Street  
Harrisville, Pennsylvania 16038

Ernest W. Saward, M.D.  
Professor of Social Medicine  
University of Rochester  
School of Medicine & Dentistry  
260 Crittenden Boulevard  
Rochester, New York 14642

Willard C. Scrivner, M.D.  
6600 West Main Street  
Belleville, Illinois 62223

Cornelius L. Hopper, M.D.  
Vice President for Health Affairs  
and Director, John A. Andrew Clinics  
Tuskegee Institute  
Tuskegee Institute, Alabama 36088

vity has carried a two-fold responsibility: first, advising on program policies within the requirements and intent of the legislation; and secondly, interpreting the needs and views of both the public and health professions and communicating these to the Federal administration. In addition, Council members were individually very active in discussing the program with interested groups of persons around the country.

During the early phases, the Council developed three temporary committees: one relating to policy development; one devoted to the issues of data and norms; one devoted to PSRO evaluation. Through a subcommittee structure, the Council members discussed issues with the staff and with the consultants and then brought their recommendations back to the full Council.

The major Council activity has been in the following areas:

1. Communication about PSROs with interested groups by way of meetings with these groups. Included among them was the American Medical Association, the American Nurses Association, the American Podiatry Association, and the American Hospital Association;
2. Designation of PSRO areas;
3. Development of statewide PSRO-support centers;
4. Notification and polling regulations; and
5. Policy guideline development.

C. Status and Examples of Statewide Support Centers

Related to statewide support centers PSRO amendments require the following:

1. any state with three or more PSROs will

Table 19.  
NPSRC  
ACTIVITIES IN 1974 - 1975

1. DEVELOPMENT OF NORMS, STANDARDS AND CRITERIA
2. DELEGATION OF REVIEW TO HOSPITALS
3. PSRO ROLE IN CONTINUING MEDICAL EDUCATION
4. DEVELOPMENT OF PROGRAM MANUAL
5. REVIEW OF ANCILLARY SERVICES
6. LONG TERM CARE REVIEW
7. PRESENTATION BY CONDITIONAL PSROs TO NPSRC
8. MEMORANDA OF UNDERSTANDING (MOU)
9. COMPOSITION OF GOVERNING BODIES OF PSROs
10. PHYSICIAN REIMBURSEMENT FOR REVIEW ACTIVITIES
11. PSRO STATEWIDE SUPPORT CENTER PRESENTATION
12. PSRO INFORMATION AND DATA SYSTEMS
13. CONFIDENTIALITY OF DATA AND INFORMATION
14. PSRO EVALUATION TECHNIQUES
15. UTILIZATION REVIEW REGULATIONS
16. PROGRAM REVIEW TEAM DEVELOPMENT
17. STATEWIDE PROFESSIONAL STANDARDS REVIEW COUNCILS  
(SPSRCs ARE REQUIRED IN ALL STATES WHICH HAVE THREE OR  
MORE CONDITIONAL OR OPERATIONAL PSROs)
18. ADVISORY GROUPS TO STATEWIDE PSRCs AND PSROs
19. POLICY RECONSIDERATIONS, HEARINGS AND APPEALS
20. JOINT MEETING WITH HEALTH INSURANCE BENEFITS ADVISORY COUNCIL
21. PRIVATE INITIATIVE IN PSRO
22. CONSUMER PRESENTATIONS TO NPSRC
23. NATIONAL HIGH BLOOD PRESSURE EDUCATION PROGRAM
24. INSTITUTE FOR PROFESSIONAL STANDARDS TRAINING CONTRACT
25. BUDGETARY RESTRICTIONS

require the Secretary to establish and appoint the membership of a State Council;

2. one representative must be designated by each PSRO and there must be four physicians (two designated by the state medical society and two designated by the state hospital association);
3. four of the appointees must be knowledgeable public representatives (two of which may be recommended by the Governor).

The law states that each State Council, and the PSROs in states without a Council, will have an advisory group of seven to eleven members, including representatives of health care practitioners other than physicians in hospitals and other facilities which provide Medicare and Medicaid services in the state.

The functions of the State councils are to:

1. review, comment upon, and to transmit to the Secretary any reports received from the PSROs concerning violations of the program;
2. review any appeals to a PSRO decision involving more than \$100;
3. coordinate the activities of, and disseminate information and data among the various PSROs in the state;
4. assist the Secretary in developing uniform data-gathering procedures to insure efficient and objective comparison;
5. assist the Secretary in evaluation of each PSRO;
6. assist the Secretary in developing and arranging for a qualified PSRO replacement when necessary.

Table 20.

NUMBER OF PSRO AREAS DESIGNATED BY STATE

	<u>Final Areas</u>		<u>Final Areas</u>
ALABAMA	1	MAINE	1
ALASKA	1	MARYLAND	7
ARIZONA	2	MASSACHUSETTS	5
ARKANSAS	1	MICHIGAN	10
CALIFORNIA	28	MINNESOTA	3
COLORADO	1	MISSISSIPPI	1
CONNECTICUT	4	MISSOURI	5
DELAWARE	1	MONTANA	1
DISTRICT OF COLUMBIA	1	NEBRASKA	1
FLORIDA	12	NEVADA	1
GEORGIA	1	NEW HAMPSHIRE	1
HAWAII, AMERICAN SAMOA, GUAM TRUST TERRITORIES OF THE PACIFIC ISLANDS	1	NEW JERSEY	8
IDAHO	1	NEW MEXICO	1
ILLINOIS	8	NEW YORK	17
INDIANA	7	NORTH CAROLINA	8
IOWA	1	NORTH DAKOTA	1
KANSAS	1	OHIO	12
KENTUCKY	1	OKLAHOMA	1
LOUISIANA	4	OREGON	2
		PENNSYLVANIA	12
		PUERTO RICO	1

Table 20. (continued)

NUMBER OF PSRO AREAS DESIGNATED BY STATE

(Continued)

	<u>Final Areas</u>		<u>Final Areas</u>
RHODE ISLAND	1	VIRGIN ISLANDS	1
SOUTH CAROLINA	1	VIRGINIA	5
SOUTH DAKOTA	1	WASHINGTON	1
TENNESSEE	2	WEST VIRGINIA	1
TEXAS	9	WISCONSIN	2
UTAH	1	WYOMING	1
VERMONT	1		
		TOTAL . . . . .	203

The Appendices include a list of the area designations and the list of state support centers that have been funded.

D. Status and Examples of Specific PSROs

Local PSROs must go through three major growth phases before they are recognized as being fully active PSROs:

1. planning phase;
2. conditional phase; and
3. operational phase.

In the first phase (planning), the PSRO is merely in the process of organizing the physicians and gathering support from the local area to operate as a PSRO. In the second or conditional phase, the PSRO has gained the recognition from the Bureau of Quality Assurance that it is, in fact, conducting peer review on a routine basis for certain services. Thirdly, the PSRO becomes fully operational after it has demonstrated to the Bureau of Quality Assurance that it indeed has the capability to competently perform the review requirements as specified by the legislation.

This section will describe the Utah PSRO as an example of a PSRO that is in the conditional stage. It most likely will be recognized as an operational PSRO in the near future.

The Appendices provide a list of the 203 geographically designated areas and an analysis of those areas where:

1. there is no PSRO organization established;
2. where the PSRO is in the planning phase;
3. where the PSRO is in the conditional phase;

Table 21:

CURRENT STATUS OF LOCAL PSRO DEVELOPMENT

. 203 DESIGNATED PSRO AREAS

. 121 PHYSICIAN ORGANIZATIONS HAVE QUALIFIED AS  
PSROs IN THE 203 PSRO AREAS

"Table 21 (continued)"

CURRENT STATUS OF LOCAL PSRO DEVELOPMENT (continued)

OF THE 121 ORGANIZATIONS,

58 ARE IN THE PLANNING PHASE

63 ARE IN THE CONDITIONAL PHASE

ABOUT HALF OF THE 121 ORGANIZATIONS ARE PERFORMING ACTUAL REVIEW OF THE QUALITY AND NECESSITY OF MEDICAL CARE DELIVERED IN INSTITUTIONS UNDER THE MEDICARE, MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS

40 - 50 ADDITIONAL GROUPS ARE EXPECTED TO QUALIFY BY JULY 1, 1976

PSRO ACTIVITY EXISTS IN ALL BUT FOUR (4) STATES

THERE ARE 13 SUPPORT CENTERS ESTABLISHED TO ASSIST PSROs IN THEIR STATES

OF THE ORIGINAL 91 PLANNING PSROs DEVELOPED IN FISCAL 1974-75, 49 ADVANCED TO CONDITIONAL STATUS (14 CARRYOVERS FROM PREVIOUS YEAR PLUS THESE 49 NEW CONDITIONALS EQUALS 63)

"Table 21 (continued)"

CURRENT STATUS OF LOCAL PSRO DEVELOPMENT (continued)

. 3 PSROs WERE IN THE POLLING PROCESS AT THE END OF JUNE 30, 1975

. 39 PLANNING PSRO's CONTINUED IN THE PLANNING PHASE DURING  
1974 - 75

. 16 NEW PLANNING ORGANIZATIONS WERE ADDED IN 1974 - 75 TO  
COMPRISE A TOTAL OF 58 PLANNING PSROs

. ABOUT 90,000 PHYSICIANS WERE MEMBERS OF PSRO's AT JUNE 30, 1975  
(ABOUT 30% OF ALL HOSPITAL BASED AND OFFICE BASED "PATIENT CARE"  
PHYSICIANS; ABOUT 22.5% OF ALL FEDERAL AND NON-FEDERAL PHYSICIANS  
IN THE U.S. AND POSSESSIONS)

4. where the PSRO is in the operational phase.

The following material was provided by the Utah Professional Review Organization:

#### History

The Utah Professional Review Organization (UPRO), a non-profit corporation, was established July 14, 1971 under the sponsorship of the Utah State Medical Association (USMA). The objectives of UPRO are the promotion of quality medical care and the effective and efficient delivery of health care services. This is effected through:

1. Quality evaluation of physician services according to guidelines established by peer committees.
2. Physician education to correct quality deficiencies identified by the review process.
3. On-site concurrent review of hospital care, attentive to both quality audit and appropriate utilization.
4. On-going review of the effectiveness of physician education techniques.

The scope of activity began in the population-dense area of the State and is being extended peripherally as education and development make it practicable to do so, aiming ultimately to involve all physicians within the State of Utah.

UPRO was formed following affirmative action of the Utah State Medical Association House of Delegates which endorsed the proposed concepts and objectives of the organization. The USMA Board of Trustees voted to advance funds for the initial operation of UPRO and this seed money was used to prepare an application for grant funds which was submitted to the National Center for Health Services Research and Development (NCHSRD).

The initial grant application was approved by the National Center, thus enabling UPRO to begin a planning and development activity in early August, 1971. During its one-year planning phase, UPRO brought one project to an operational, and essentially self-supporting, stage while two other projects, primarily of a research nature, were drafted. Additional funding from NCHSRD was then sought. That grant was approved July 1, 1972, providing the necessary resources to implement the two research projects and to expand existing activities over a two-year period. These activities and the grant itself

were a part of NCHSRD's Experimental Medical Care Review Organization (EMCRO) program.

On October 11, 1973, the physician leadership of UPRO formed a new non-profit corporation known as the Utah Professional Standards Review Organization (Utah PSRO). This membership corporation, open to allopathic and osteopathic physicians licensed in the State of Utah, was organized to preserve and improve the quality and efficiency of health care services and treatment rendered to patients within the State of Utah by creating and maintaining a system or systems of professional review of such services, care and treatment, utilizing the services of competent professional personnel.

On June 18, 1974, a contract was signed between the Utah PSRO and the Department of Health, Education and Welfare, Bureau of Quality Assurance to conduct review programs as mandated by Public Law 92-603. Utah PSRO and UPRO have integrated the review programs and staff so as to realize the benefits of the common professional review program for patients whose medical care is paid for by either private insurance or public funds. Support for these ongoing review and research activities, therefore, is derived from contracts and grant agreements with a variety of public and private agencies and organizations.

#### Organization

The work of UPRO is carried out primarily through the Board of Directors and its five standing committees. The Board and the Committees are supported and assisted by a staff consisting of an Executive Director, Executive Administrator and Project Director, Assistant Project Director, Senior Nurse Coordinator, Neighborhood Health Center Project Manager, Nurse Coordinators, and secretarial staff.

#### Board of Directors

The UPRO Board of Directors is composed of fifteen physicians and six non-physicians. The President, President Elect and immediate past President of USMA each serves as a member of the UPRO Board by virtue of the office he holds. The remaining twelve physicians are elected by the USMA House of Delegates for three-year terms.

One seat on the Board is reserved for a representative of UPRO's Advisory Council of Allied Health Professionals.

Of the remaining five lay members of the Board, one is recommended by the Governor and represents consumers. The other four, recom-

mended by their respective organizations, include representatives of the Health Insurance Council, Blue Cross-Blue Shield, Utah State Hospital Association, and the Utah State Division of Health.

The Board of Directors is directly responsible for the management of the organization, the appointment of Medical Advisors, establishment of length of stay norms and quality evaluation guidelines, development of training manuals, and employment of professional and clerical staff adequate to meet the needs of the program.

#### Executive Committee

An Executive Committee composed of the UPRO President, Vice President, Secretary and Treasurer, and the President-Elect of USMA, assists the Board of Directors.

#### Standing Committees

The five committees established by the Board of Directors of UPRO are:

- Committee on Quality Evaluation
- Committee on Medical Education
- Committee on Constitution and Bylaws
- Committee of Medical Advisors
- Committee on Protection of Human Subjects

The Quality Evaluation Committee is composed of representatives of seventeen medical specialties plus the chairman. Specialties represented are: Anesthesiology, Dermatology, Family Practice, General Surgery, Internal Medicine, Neurology, Neurosurgery, Obstetrics-Gynecology, Ophthalmology, Orthopedics, Otolaryngology, Pathology, Pediatrics, Psychiatry, Radiology, Thoracic Surgery and Urology. Each of the members of the Committee is responsible to chair a subcommittee representing his specialty.

Under the direction of the parent committee, the various subcommittees have developed quality care guidelines for their respective specialties. To date, guidelines of inpatient care have been prepared for over 130 diagnoses and problems. These inpatient guidelines have been published and are available to Utah physicians.

In addition, the subcommittees have been engaged in a process of refining and formalizing many of the guidelines used in the day-to-day operation of UPRO's On-Site Concurrent Hospital Utilization Review (OSCHUR) program. This activity includes such issues as general indications for hospital admission, level of care guide-

lines, and length of stay guidelines.

The subcommittees have also prepared a variety of criteria for UPRO's ambulatory care review program. This process will be ongoing, based on continuing review of the data being produced by the system.

The Committee on Medical Education is studying methods for directing educational efforts toward deficiencies discovered through the peer review process. This Committee established liaison with the Council on Scientific Education of the USMA and has found a number of areas of overlapping interests. In January, 1973, the USMA formed, as a subsidiary, the Academy for Continuing Medical Education. All efforts by this Committee are coordinated with the efforts of the Academy. Educational needs identified by UPRO programs are referred to the Academy for further action.

The Committee on the Constitution and Bylaws has formulated bylaws for the organization, had them adopted by UPRO's Board of Directors and approved by the USMA Board of Trustees.

The Committee of Medical Advisors consists of the UPRO designated Medical Advisor in each of the hospitals participating in the OSCHUR program. These include: Holy Cross, Latter-Day Saints, University of Utah, Primary Children's, St. Mark's and Cottonwood Hospitals in Salt Lake City; McKay-Dee and St. Benedict's Hospitals in Ogden; Utah Valley LDS Hospital in Provo; Valley View Medical Center in Cedar City; Latter-day Saints Hospital in Logan; and South Davis Community Hospital in Bountiful.

The Committee is responsible for reviewing the performance of the OSCHUR program and for developing recommendations designed to improve the operation of the program, to enhance physician understanding of the program objectives, and to resolve administrative problems which may be identified.

An Executive Committee of the Committee of Medical Advisors represents the Committee in hearing appeals of medical decisions requested by the patient, the attending physician or the hospital. It is also responsible for working with the medical staff leadership in the participating hospitals toward the objective of a coordinated approach to the process of medical review and its related educational requirements.

Each Medical Advisor is appointed by the UPRO Board of Directors in consultation with the Executive Committee of each participating hospital. He is responsible for selecting the Committee of Consultants representing each of the specialties within the

hospital and serves as chairman of that group. Medical Advisors and specialty consultants are paid appropriate fees for their review efforts.

On-Site Concurrent Hospital Utilization Review (OSCHUR)

UPRO's OSCHUR program has emerged from a desire to find a uniform, equitable, and objective method for evaluating the quality and utilization of hospital services in the State of Utah. The program has been developed in consultation with hospital administrators, health insurance carriers, and appropriate government agencies. It is intended that the program will be responsive to the administrative and financial concerns of these disciplines, and that it will establish a mechanism for evaluating and upgrading the quality of physician services in the hospital.

The program began in September, 1971 when a model project was established in a twenty-bed section of Holy Cross Hospital in Salt Lake City. The model functioned for five months during which operational theories were tested and administrative procedures, forms, etc., were developed.

On April 1, 1972, OSCHUR commenced full-scale operations, following the execution of a contract between UPRO and Blue Cross-Blue Shield of Utah, calling for application of OSCHUR to persons covered under the Blue Cross Federal Employee Program. This contract provided that UPRO review all FEP admissions in four of the major hospitals in Utah. In exchange, Blue Cross agreed to pay the hospitals for all care certified by UPRO and to reimburse UPRO for the direct costs of operating the program. In July, 1972, UPRO obtained similar contracts with Educators Mutual Insurance Association and with the Salt Lake Neighborhood Health Center (now the Utah Group Health Plan). On August 1, 1973, similar agreement was made with the State of Utah for Medicaid patients. Effective July 1, 1974, the OSCHUR program was utilized by Utah PSRO for Titles V, XVIII and XIX patient reviews. Additional marketing of the OSCHUR program is anticipated in the private insurance and Blue Cross sectors.

The OSCHUR program is operational in twelve hospitals located in Salt Lake City, Ogden, Provo, Logan, Bountiful and Cedar City. Patients currently being reviewed are those whose care is reimbursed under the Title V (maternal and child health), Title XVIII (Medicare), Title XIX (Medicaid) programs; Educators Mutual Insurance Association; Utah Group Health Plan; and the Salt Lake County Medical Eligibility Program.

UPRO and Utah PSRO have agreements with participating hospitals which outline responsibilities of the hospital, medical staff,

UPRO and Utah PSRO. Additional agreements of understanding exist with Medicare fiscal intermediary (Blue Cross-Blue Shield of Utah), the Bureau of Health Insurance (SSA), the State of Utah and other governmental agencies, outlining a variety of responsibilities relative to the review process.

The key element in the day-to-day operation of OSCHUR is the Nurse Coordinator. Each of UPRO's Nurse Coordinators was selected for her combination of nursing skills, human relations' talents, and motivation.

The OSCHUR review process is initiated by the Nurse Coordinator within twenty-four hours following the admission of a covered patient to the hospital. From that point to the day of discharge, she monitors the patient's chart and determines, according to UPRO guidelines, the:

1. Necessity for hospital admission.
2. Appropriateness of the level of care and transfer to other levels of care when indicated.
3. Quality of care according to criteria established by peer committees.
4. Utilization of allied health services.
5. Appropriateness of the length of stay.

After her initial review of the chart, and having established that the criteria for admission have been met, the Nurse Coordinator attaches an indicator of UPRO review to the patient's chart and calculates an expected range of stay according to the admitting diagnosis or problem. During the course of stay the Nurse Coordinator reviews the patient's hospitalization every two to five days depending on the condition and prepares a patient profile which may be studied by the Medical Advisor if there are questions of utilization or deviations from quality care. When she identifies a need for hospital stay beyond the duration initially certified, she places an extension sticker alongside the original length of stay. If she has questions regarding any of the hospital treatment, she refers the record to her Medical Advisor or the Specialty Consultant. She serves as a data collector for the Medical Advisor or Consultant, and it is he who judges quality or utilization deviation. If the Medical Advisor questions the care being given, he arranges for a conference with the patient's physician. Usually this contact with the attending physician resolves the question, either because the physician provides data not previously available or

because he concurs with the recommendation of the Medical Advisor.

UPRO has the authority to withdraw certification for some aspect of the patient care upon advance notice to the physician. The fact that this authority has rarely been exercised is testimony to the inherent education effect of the personal interaction between the Nurse Coordinator, the Medical Advisor and the attending physician.

(The details of the OSCHUR program are fully presented in the next section of this brochure).

The final aspect of the OSCHUR program involves the abstracting of selected data from the charts of reviewed patients. The data collected are those required to measure the extent to which the UPRO criteria for quality of care are being met. This function is performed by the Nurse Coordinator. A computerized data processing system has been developed to analyze the patterns of physician practice and to present the results in a form amenable to ready interpretation by physician peer committees.

#### Physician Ambulatory Care Evaluation (PACE)

On July 1, 1972, the Utah Professional Review Organization began development of an ambulatory review system as a part of its overall effort to review and improve the quality of care provided by physicians. The project was specifically designed to test the extent to which it is possible to judge quality of care under the relatively limited data generated from health insurance claim forms containing information on physician-generated services. It is anticipated that this information, arrayed in a variety of formats demonstrating patterns of care for the individual patient and for the particular provider, would make possible professional judgments which could then lead to educational programs designed to improve the quality of medical care.

As with all of UPRO's projects, the analysis of the quality of care is performed on the basis of objective criteria which have been developed by UPRO's Quality Evaluation Committee. These criteria are designed to be responsive to two questions:

1. Is the therapy or procedure critical to ideal care for that condition?
2. Is the therapy or procedure inconsistent with ideal care for that condition?

The criteria act as screens through which data on actual performance can be passed. Some criteria are keyed on single encounters, some analyze a patient's history of care, and still others apply to profiles of a physician's complete practice.

The PACE program utilizes claim forms being submitted by physicians and other appropriate providers under the State of Utah's Medicaid program. The claim forms are currently being submitted following the payment process. However, it is anticipated that in early 1975 a pre-payment review system will be undertaken. If this project proves successful, expansion of the program to include data from other carriers is anticipated.

UPRO and the State of Utah jointly developed and tested a revised claim form which will generate information in a format designed to permit a more accurate evaluation of the quality of care rendered. The structure of the new form enables the physician to relate each service provided to a specific diagnosis and requests an identification of medications either prescribed or injected. A test of a new claim form has been completed and the results were incorporated into the claim forms currently being implemented together with a Medicaid Management Information System (MMIS).

The PACE project data processing system was developed under a contract with Optimum Systems Incorporated (OSI), a consulting systems and data processing firm with headquarters in Santa Clara, California. The contract was for a facilities management organization for this project, including the development and operation of the system for comparing the data collected from the Medicaid claim forms with UPRO's quality of care criteria.

Systems development is now complete and over 225,000 claim forms are contained in the computer's history files. These files were organized in such a way as to provide linkages for both patient and provider profiles. All of the claims have been screened against the automated quality of care criteria and this data base may also be passed against subsequently developed criteria to determine the extent of application.

Reviewing physicians have immediate on-line access to the information relating to cases which have failed the screening criteria. Supportive information including the patient's history and a profile of physician performance is also available on-line to support the professional review.

It is important to note that UPRO's primary aim in this project is to review physician performance from the standpoint of

quality. As presently formulated, the project does not involve UPRO in any fee judgments or in any utilization/fiscal control. UPRO is primarily interested in identifying patterns of physician behavior which suggest the need for correction and in improving the quality of care through an educational process.

This project is being continued with federal and state support for an expanded objective, including the integration of a professional review component into the Medicaid Management Information System. Appropriate computer linkages between the state claims processing system and the professional review component have been developed. The quality assessment process will be enhanced by the expanded criteria, including utilization of physician services, as well as the medications provided.

#### Neighborhood Health Center (NHC)

UPRO, as part of its MECRO project, contracted with the Salt Lake Neighborhood Health Center to develop and implement a review project designed to evaluate the quality of care provided by NHC staff and by a control group of physician volunteers from the Salt Lake County community. The methodology chosen for this project involved the application of peer-generated criteria for selected diagnoses and procedures to data abstracted from the office records of participating physicians. Evaluation techniques included both independent and comparative analyses of the performances of the two physician groups.

A registered nurse project manager was employed in September, 1972, and she spent approximately two months in preparing data collection systems, assisting in criteria development, orienting participating physicians and other personnel, and generally planning for the conduct of this experimental project. Actual data collection began in November, 1972.

A solicitation was made for volunteer physicians from specialties of Pediatrics, Internal Medicine and Obstetrics-Gynecology. Of the sixty respondents, thirteen were selected to participate in the project. Responsibility for developing the criteria, following the concept of critical to ideal care, and having some degree of discriminatory value, was assigned to the appropriate specialty subcommittees of UPRO's Quality Evaluation Committee. The subcommittees included one physician member of the NHC staff for the creation of criteria used in this study.

The elements selected for review were designed to permit the early accumulation of a wide data base and at the same time, to be broadly representative of physician skills. These elements fall into three categories as follows:

1. Disease in which the process requires only limited documentation. The emphasis in this category is on therapy and outcome.
2. Activity in which the process and its recording receive primary attention. The primary emphasis here is on process of care and recording of a data base by the physician.
3. Conditions in which both the process of care and the pursuit of treatment and investigative modalities are monitored. The attempt here is to identify the physician's thoroughness in establishing the necessary data base or benchmarks required for continuing care and evaluation of the patient as well as his analytic skill and interpretation and his capacity to select proper treatment alternatives.

In the above three categories, criteria were developed for eighteen conditions and/or examination situations.

The UPRO project manager conducted the data collection by visiting the Neighborhood Health Center and physicians' offices. By agreement, charts were identified and flagged prior to the visit for the purpose of abstracting information against the criteria. Exceptional cooperation has been evident by the physicians, their office staffs and the Neighborhood Health Center staff.

Abstracting the quality care data consisted of a "yes-no" response for each element--a "yes" indicating that a particular item was mentioned in the record. For conditional criteria, provision was also made for a "not applicable" response. Other information was gathered, such as date of service, patient birth-date, sex, marital status, race, and source of payment. Brief free form comments were also allowed as part of the abstracting process.

The issue of confidentiality of both the patient and physician received high priority. The confidentiality was preserved by a professionally responsible person, aware of the sensitivity of medical information, abstracting data from the record. Logs and records were never removed from the medical record room or from physician offices. A coding system for patients and physicians

was maintained by the project manager and used on all data collection forms.

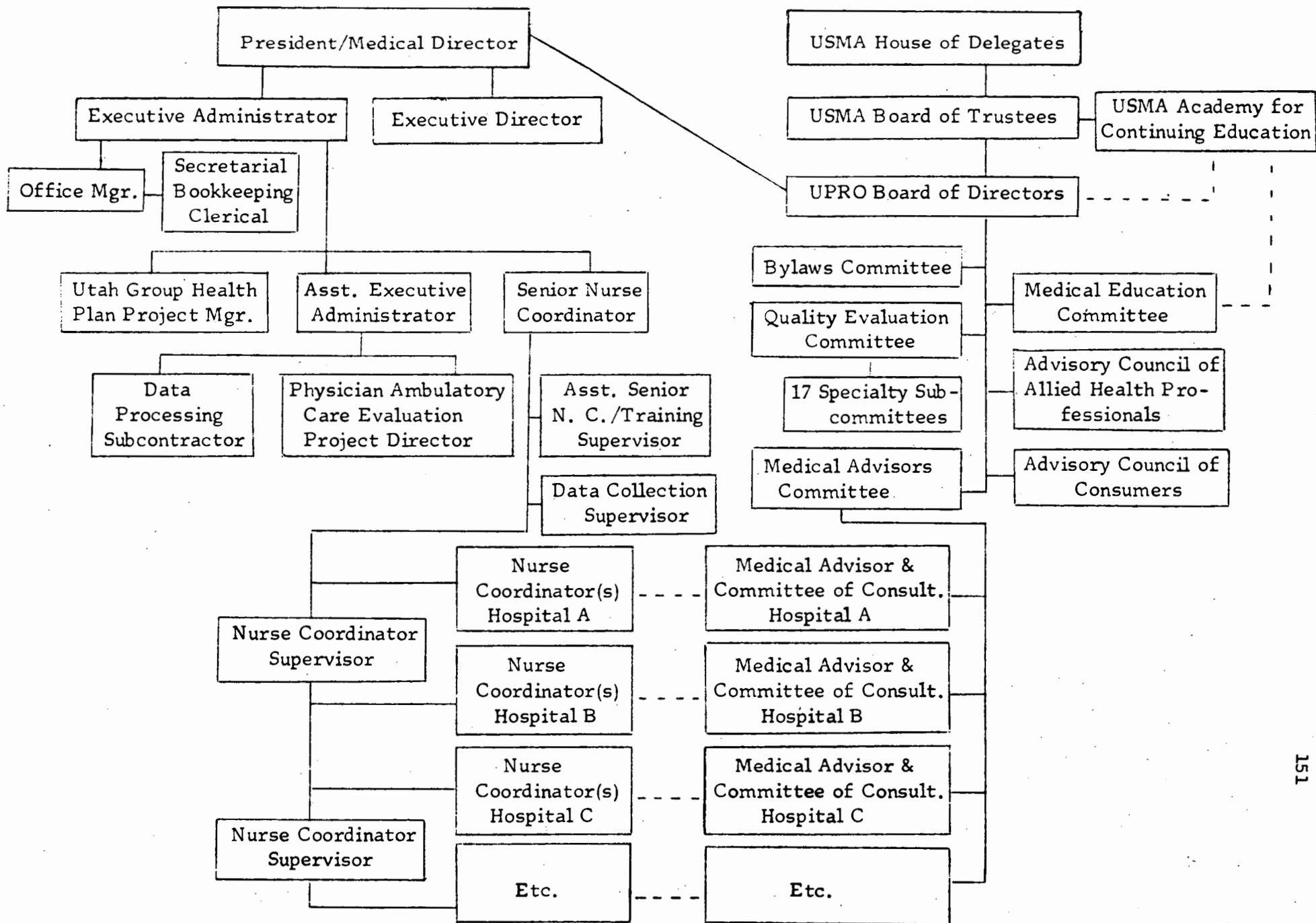
A data collection system was developed by Optimum Systems Incorporated (previously mentioned in connection with the PACE project). The data accumulation and reporting system allowed for a tallying of responses related to each of the criteria elements and aggregated by individual physicians, by NHC physicians as a group and by private physicians as a group. Over 6,500 charts were reviewed with periodic reports being provided to the NHC for inclusion in the ongoing educational process. Reports were also presented to specialty subcommittees which created the criteria.

An assessment is currently being made of the impact of the educational programs conducted periodically during the review process. The combination of audit and educational programs at the NHC will be the independent variable for this experiment. Physician performance and compliance with each criterion will be the dependent variable. Conclusions as to the results of this project have not yet been formulated.

#### Staffing and Responsibilities

The next page is a schematic representation of the organizational chart and functional responsibilities with regard to policy and advisory committees. Not indicated on the chart are the variety of interfaces with agencies and organizations such as those participating in the OSCHUR program, State and local planning agencies, the State Department of Social Services, professional organizations and societies, etc.

Figure 26.  
UPRO ORGANIZATION CHART



#### E. Norms and Screening Criteria Set Development

One of the major functions of the Bureau of Quality Assurance and NPSRC is to develop suggested norms of medical care and screening criteria sets for adaptation and consideration by local PSROs.

The American Medical Association delivered the final set of criteria standards and norms of the specialty societies to the National Council in the summer of 1975. These standards are to be utilized by the local PSROs in reviewing claims. The major diagnoses for each subspecialty are outlined, with recommended treatment patterns given for each of the diagnoses. Copies of this document are available from the Government Printing Office, Washington, D.C., or are available for discussion through IMS.

Norms are defined as "medical care appraisal; norms are numerical or statistical measures of usual observed performance." Standards are "Professionally developed expressions of the range of acceptable variation from a norm or criteria." Criteria are "a set of pre-determined elements against which aspects of the quality of a medical service may be compared." All three parameters are developed by professionals relying on professional expertise, experience, and review of the literature.

Screening is a process in which norms, criteria and standards are used to analyze large numbers of items, activities, and transactions in order to select a smaller sample for study in greater depth.

The obvious concern of the medical profession in this regard is that the norms and criteria would become so rigid that they would establish a system of "cook book medicine". Of course, this issue is still alive today.

Criteria explicitly identify the elements of medical care which

characterize quality of care for each diagnosis or condition studied. The quality of care rendered to an individual is measured by whether or not the criteria are met by consensus among local professional committees. Given the present state of the art, they relate predominantly to the processes rather than the results of medical care. Most current criteria are optimal, describing the best practical care obtainable. In some cases minimal criteria have been used to instruct nonprofessional reviewers in the selection of cases for which professional review is mandatory.

Norms generally specify quantitative levels of performance. They are usually developed empirically through the measurement of performance in a stated sample. However, they may be modified. Norms deal with length of stay, frequency of patient visits, charges, and mortality rates. Selected norms may be optimal, average, or minimal. They may also describe the frequency distribution of a given event in a defined sample. Norms have been developed for both the processes and the outcomes of medical care.

Standards specify the degree of desired conformity between actual practice and explicit criteria or norms. Standards may alternately be set by measured compliance in a stated sample or by deliberate and professional judgement concerning what should exist. The former method tends to emphasize average standards and the latter, optimal standards. In most cases, both standards are used--one for initial selection and the other for validation, yielding standards which fall between average and optimal.

#### F. Management Information Systems

In order to evaluate medical care, there must be data available for review. In order to collect data on a large scale, there must be adequate management information systems. The computer and MIS will be used for analysis of the PSRO program in the following ways:

1. As a tool for retrospective analysis and identification of situations which can be improved or corrected through an educational process.
2. To evaluate criteria previously developed. Where the data show consistent variance from established criteria, both the medical practices producing the data and the criteria itself will most likely be reviewed to determine which needs adjustment.
3. In certain limited situations, to advise carriers on the proper amount of reimbursement for reasonable and necessary services.

The Department of Health, Education and Welfare has been very active in developing an information system for the PSRO program. The PSRO Management Information System lays out the requirements for routine reporting from the PSROs to the Federal government. The reports specified by this system request the following types of data:

1. data on hospital review activities;
2. PSRO and delegated hospital costs; and
3. hospital utilization activities for Federally-funded patient care.

Basically, the types of reporting are:

1. concurrent review reporting;
2. medical care evaluation study reporting;
3. PSRO hospital discharge data sets; and
4. cost reporting.

Table 22.

"PSRO HOSPITAL DISCHARGE DATA SET (PHDDS) ELEMENTS"

DATE OF BIRTH	CERTIFICATION/EXTENSION STATUS
SEX	PRE-ADMISSION CERTIFICATION GRANTED
HOSPITAL IDENTIFICATION	CONCURRENT ADMISSION CERTIFICATION GRANTED
ADMISSION DATE	CONCURRENT ADMISSION CERTIFICATION GRANTED
ADMISSION HOUR	AFTER REFERRAL TO PHYSICIAN ADVISOR
DISCHARGE DATE	CONCURRENT ADMISSION CERTIFICATION DENIED
DIAGNOSES (PRINCIPAL AND OTHER)	TOTAL NUMBER OF EXTENSIONS GRANTED
PROCEDURES (PRINCIPAL AND OTHERS)	NUMBER OF EXTENSIONS GRANTED AFTER
DATE OF PRINCIPAL PROCEDURE	REFERRAL TO PHYSICIAN ADVISOR
DATE OF FIRST PROCEDURE	EXTENSION DENIED
DISPOSITION OF PATIENT	DAYS CERTIFIED AT ADMISSION CERTIFICATION
EXPECTED SOURCE OF PRINCIPAL PAYMENT	DAYS USED CERTIFIED AS MEDICALLY NECESSARY
	DAYS USED CERTIFIED AS NECESSARY FOR OTHER
	REASONS

SOURCE: Bureau of Quality Assurance

The development of the PSRO Federal reporting requirements began with an assessment of management information systems used in prototype PSROs, such as those designed by American Health Systems and the Dikewood Corporation for the EMCRO project. Secondly, there was a review of the data requirements for PSRO program evaluation. This study was prepared by Macro Systems, Inc., for the DHEW Office of Planning, Evaluation and Legislation. Subsequently, an inter-agency work group (which included representatives from the BQA, SSA, and SRS), scheduled a series of site visits with organizations engaged in health care review. These meetings focused on the systems currently in place, their use, and suggestions for changes required for PSRO purposes.

Based on the review of existing systems during selected site visits, the first draft of the PSRO Management Information System (PMIS) was prepared. This draft was presented to interested DHEW agencies and the National Professional Standards Review Council for review. A pilot program was tested in the Utah and Colorado PSROs during the fall of 1974. The intent of the original PMIS manual was to provide guidance to local PSROs for developing the management feedback necessary for sound operation, as well as to meet the routine information requirements of DHEW and the National Professional Standards Review Council.

The reporting requirements of the Federal Government in the PSRO are intended to accomplish the following:

1. To fulfill the intent of Section 1155 (F) (1) and (b) of Public Law 92-603, which authorizes the DHEW to establish Federal reporting requirements for PSROs.
2. To define that sort of information which will both assist each PSRO to monitor and assess its activities at the

local level and allow the Federal government to meet its monitoring responsibilities.

3. To build a data base for:
  - a. preparing reports allowing PSROs to compare the extent and type of their activities and expenditures with the data for similar PSROs; and
  - b. providing technical assistance to PSROs.
4. Allow the Federal government to obtain summary information on PSRO activities and costs to contribute to contract renewal decisions.

A more detailed analysis of the reporting requirements described above follows:

(1) Concurrent Review Reporting:

The Government has provided BOA Form No. 121, entitled "Concurrent Review Activity Summary", and instructions for its completion. This form is a quarterly report on the concurrent review activities of the PSRO in delegated hospitals. Its purpose is to allow an assessment of concurrent review workload within each PSRO area. Copies of this form and all other forms described below may be found in the Appendix.

(2) Medical Care Evaluation Study Reporting:

Three forms are provided, namely BQA 131, BQA 133 and BQA 135. BQA 131 is the "Medical Care Evaluation Study Abstract", used for describing the procedures involved in each medical care evaluation study. BQA 133, the "MCE Restudy Report," is used for reporting information on follow-ups to the initial steps of MCE Studies. The purpose of these two forms is to provide information for a central clearing house of successful MCE study methodologies and criteria to report PSRO monitoring of MCE Study activity. The third form, BQA 135, is "MCE Study Status Report", which is designed as a register of MCE studies in progress and is completed by the PSRO in delegated hospitals.

(3) PSRO Hospital Discharge Data Set (PHDDS):

The PSRO Hospital Discharge Data Set is a form which has data elements identifying individual patients. However, names and identities of the practitioners have been excluded from PHDDS reporting to conform with PSRO confidentiality policy. The PHDDS form is filled out for each patient discharged from the hospital. It is channeled through the various data processing systems and is used for monitoring trends in hospital utilization patterns and for developing national regional norms.

(4) Cost Accounting

Two forms are involved here: BQA 151, which is the "Quarterly PSRO Function Cost Summary", and BQA 153, which is "Quarterly Delegated Hospitals Function Cost Summary". These cost reports, as well as the public vouchers submitted to the HSA contracts office, are used to monitor PSRO expenditures and program activities.

At the time of writing this report, the Federal government is in the process of implementing several management consulting contracts to set up the PMIS and to test-monitor it as the data is generated through the PSRO system. Each PSRO will be responsible for generating its own data, but the type of data, of course, is regulated by the reports as defined above. Most of the local PSROs are subcontracting the data collection activity to outside vendors. The PSRO then submits the summary data to a national data processing firm, a contractor to the Federal government, to report the summary data to the Federal government. The Federal government then provides summary and output reports to all of the PSROs, and to the Federal agencies concerned in implementation of PSRO and financing of medical care. The reports are also used for studies within the department, and by the Congress, as well, for policy making and additional legislative measures.

#### G. Physician Reimbursement

Physician reimbursement for review activity has been a very controversial issue ever since the PSRO program was established. Physicians want to be reimbursed for the review activity as they sit on the PSRO panels in their area. The Federal government at the time of this writing will allow a PSRO--both at the PSRO level and at the hospital-delegated review level--to reimburse the physician at the rate of \$35 per hour for review of charts, for review of medical care, and for making judgements upon the quality and appropriateness thereof. However, most physicians feel that they should be reimbursed more than this amount.

#### H. Implementation of Utilization Review Regulations

The utilization review regulations for hospital admission, continued stay, and discharge planning were scheduled to be implemented on February 1, 1975. However, the American Hospital Association provided such a tremendous lobby at the Washington level that implementation of the regulations was postponed until July 1, 1975. Given this concession, however, the American Medical Association and the American Hospital Association coalesced and filed suit in U.S. District Court in Chicago, Illinois, around mid-August, 1975, and successfully convinced District Court Judge Julius Hoffman that he should order an injunction prohibiting the Department of Health, Education and Welfare from implementing the utilization review regulations.

This is not to say that the peer review program and the PSRO program are being discontinued by the Federal government. This is merely an injunction against the utilization review regulations, which were actually

part of the Medicare program and which were in existence even prior to the passage of the PSRO law. The AMA subsequently withdrew the suit when DHEW and the AMA came to an agreement over major issues in the regulations. The primary change in the regulations was the extension of certification of the necessity for admission of the patient within seventy-two hours rather than forty-eight hours after admission.

Further discussion concerning legal problems and court cases appear in Subsection U of Section VII.

#### I. Relationship of PSRO to Planning Agencies

The National Planning and Resources Act of 1974 authorized the merger of three former planning organizations:

1. local comprehensive health planning agency;
2. the regional medical programs agency; and
3. the Hill-Burton program planning agency.

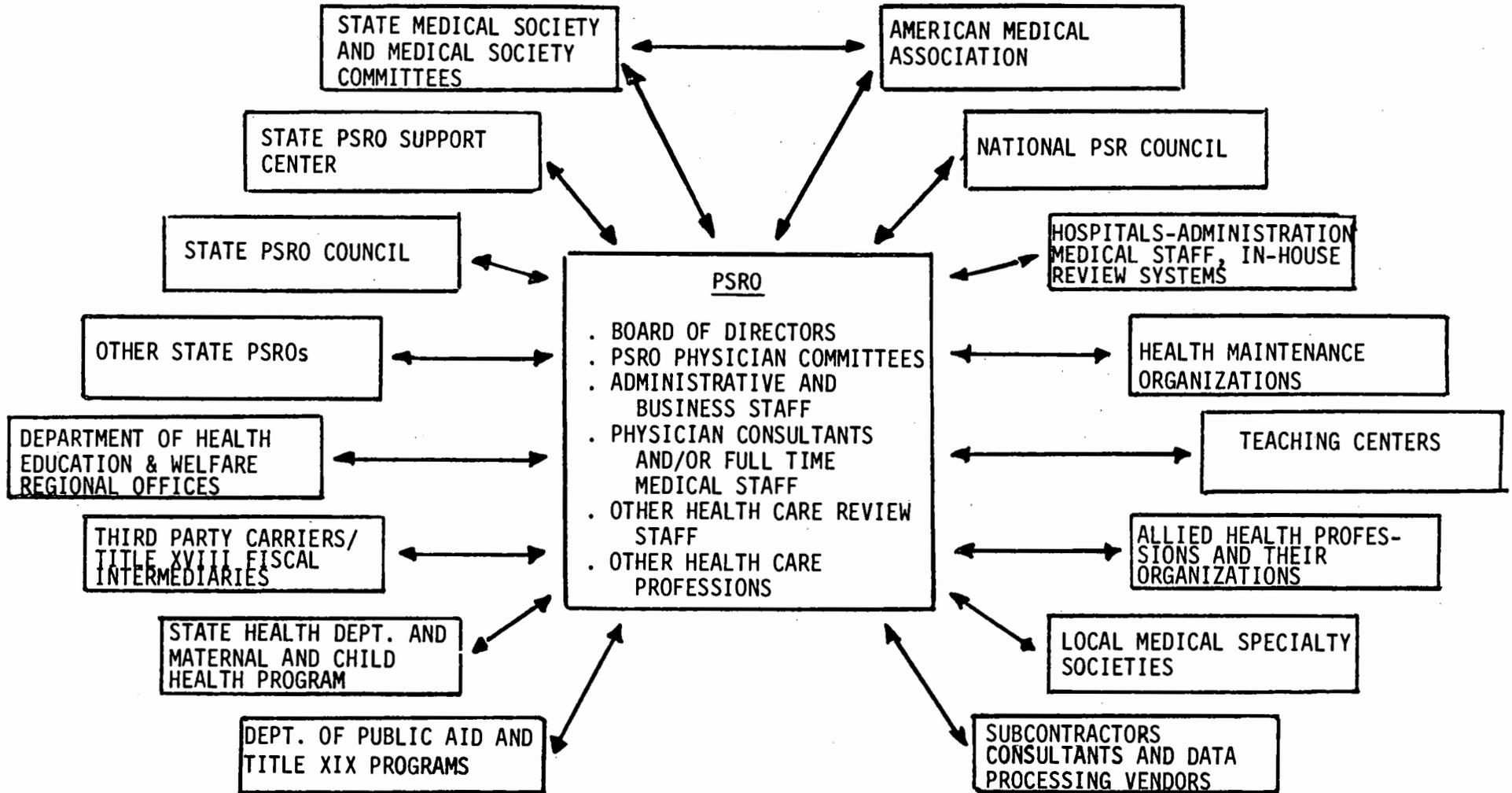
The new agency is called the Health Systems Agency.

The major function of the Health Systems Agency is to review all local requests for Federal funds and for review of requests for expansion of existing programs. Many felt that the PSRO program would provide a duplication of function here, but this is not really the case. PSROs will work very closely with the Health Systems Agencies. The PSRO will review the care rendered in the PSRO area for appropriateness and minimum quality standards. On the other hand, the Health Systems Agencies will provide a review of the appropriateness of establishing new programs of medical care, and will prepare and coordinate the development of an areawide plan for delivery of health care services, rather than monitor the quality of the

Figure 27.

PSRO

RELATIONSHIP TO OTHER HEALTH AGENCIES



care that is rendered.

J. Relation of PSRO to Social Security Administration Programs

The PSROs will be required to monitor all care that is funded through the Social Security Administration. This includes medical care funded through the Social and Rehabilitative Services, as well as the Bureau of Health Insurance. When national health insurance becomes a reality, the PSRO will also monitor the care funded under that program.

K. Medical Malpractice in PSROs

The PSRO program will have an impact on the whole concept of medical malpractice and medical malpractice insurance. Until Congress passed the PSRO legislation, many experts in the field felt that the medical profession had not begun to establish standards against which quality could be monitored. Therefore, some say it is very difficult in court to determine whether, in some cases, the medical care provider was actually providing adequate and appropriate care, or whether his practices could be construed as incompetency.

There is some thought that the PSRO program--through the establishment of norms, criteria and standards--will enable a court of law to evaluate whether the care rendered by a physician was proper and appropriate. Therefore, this could have an impact on medical malpractice premiums, and could discourage the filing of medical malpractice suits. In summary, there could be a reduction in malpractice insurance costs, as well as a reduction in the number of medical malpractice suits filed.

The American Medical Association took a strong stance against Senator Kennedy's feeling that PSROs should affect medical malpractice, and as

the AMA President, Dr. Malcolm C. Todd, stated: "The PSRO system necessitates the development and promulgation of criteria of care describing generally recognized patterns of care applicable to specific disease entities... We submit that it was never intended that these guidelines of care be established specific cases."

This would indicate that the AMA is opposed to the concept of PSRO quality standards being used to decide court cases and medical malpractice claims.

#### L. Methods of PSRO Program Evaluation

The issue of how to evaluate the Federal PSRO program and the review activity of local PSROs has been very controversial. Since PSROs will be implemented nationwide, assessment will take place on three levels. First, PSROs will be evaluated in respect to their long-term goals. On the second level, individual PSROs will be evaluated to determine whether they are operating in the most efficient manner. Thirdly, an analysis will need to be made to determine the direct and indirect effects of the existence of a national system on medical care review organizations and the health care system in general.

A more indepth analysis of these review processes seems appropriate. In evaluating PSROs in relation to their effectiveness in attaining their long-term goals as required by Public Law 92-603, there must be a consideration of methods for assuring that the quality of medical care is attained at a high level. There must also be evidence of changing patterns of utilization of health services on a national basis. There must be a method for containing the cost of medical care; and there must be acceptance of

the program by providers, third party intermediaries, and consumers.

In evaluating whether individual PSROs are operating efficiently, there must be some method of measuring their effectiveness, assuring that the actions of individual PSROs are accurate, that they are utilizing manpower properly, and that costs of operation are reasonable in connection with the benefits accrued thereof.

Thirdly, there must be a method for evaluating the direct and indirect effects of the existence of the national system. Is there a shift in care, for example, to less expensive facilities? Is there a shift from long and short-term general hospitals to outpatient and extended care facilities? Did this really result in lower overall occupancy rates and fewer concentrations of costly episodes? Has there been a shift in the supply and distribution of medical manpower as a result of the PSRO program? These types of questions will need to be answered under an evaluation scheme which has yet to be developed. The Management Information System described in Subsection F will be used to monitor the system and, it is to be hoped, answer some of these questions.

M. Training Grants

The Bureau of Quality Assurance is currently awarding training grants to develop paramedical individuals to assist in the review process on the local level. These grants are awarded directly to the PSROs and the PSRO statewide support centers.

N. Ancillary Medical Services Review

The question of whether a PSRO is responsible for the review of ancil-

Table 23.

PSRO

ELEMENTS OF A MODEL ANCILLARY SERVICES REVIEW SYSTEM

1. A SET OF EXPLICIT CRITERIA WHICH DESCRIBE ACCEPTABLE ANCILLARY SERVICE USE.
2. AN ASSESSMENT OF THE WAYS ANCILLARY SERVICES ARE ACTUALLY BEING USED, COMPARED TO THE WAY THEY SHOULD BE USED AS SET FORTH BY THE CRITERIA.
3. AN EDUCATIONAL PROGRAM FOR PRACTITIONERS BASED ON DEFICIENCIES FOUND IN THE ASSESSMENT PHASE.
4. A REASSESSMENT TO DETERMINE IF THE DEFICIENCIES HAVE BEEN CORRECTED.
5. SUBSEQUENT REPETITIONS OF THE CYCLE USING REVISED CRITERIA SET.

lary services is confirmed by certain passages from the report of the Senate Committee on Finance (No. 92-1230).

The rapidly increasing costs of these programs are attributable to two factors. One of these is the increase in the unit cost of services such as Physicians' visits, surgical procedures, and hospital days. The second factor is an increase in the number of services provided to the beneficiaries. The local PSRO would be primarily responsible for the review of all Medicaid and Medicare services rendered or ordered by the physicians in its area.

Where advance approval by the review organizations for institutional admission was required and provision of services was approved by the PSRO, ... advanced approval of the institutional admission would not preclude a retroactive finding that ancillary services (not specifically approved in advance) provided during the covered stay were excessive.

Generally, when a PSRO disapproves of the items or services furnished under Medicare and Medicaid, payment for such items and services will not be made for these disapproved ancillary services.

The methods of reviewing these ancillary services have not been determined as yet. However, if it is suspected that certain ancillary services are being improperly ordered, these services may be added to the list of critical screening criteria used for continued-stay review. However, many of these services are considered "routine", and would not be found on a list of critical screening criteria. The major problem is, that few services ordered or provided would even come under the scrutiny of review to determine medical necessity.

Secondly, there is the problem of the massive workload imposed upon a hospital review coordinator. In summary, ancillary services will all

be subject to review by the PSRO. There appears to be little question about that.

O. Drug Utilization Review

Drugs are simply one of the ancillary services that will be reviewed by PSRO. Drug utilization review, however, is getting more and more attention from the Federal Government since drug use represents a large dollar amount of medical care services delivered on an inpatient basis.

Five medical specialty groups--the American College of Physicians, the American College of Surgeons, the American Academy of Family Physicians, the Academy of Pediatricians, and the Infectious Disease Society of America--have proposed that the PSRO program provide them with funds to conduct an extensive investigation of inpatient antibiotic utilization and to then develop guidelines for appropriate patient intake. Such a grant was awarded to the American College of Physicians to study antibiotic usage in selected hospitals in the United States.

In addition, other grants and contracts have been awarded to document and evaluate existing drug utilization review systems in the country. (IMS America won such a contract which was started on June 27, 1975.) Secondly, these contracts will call for evaluating how closely the DUR systems meet the PSRO requirements for monitoring adequacy and appropriateness of care. Thirdly, the contracts will establish four models of drug utilization review to be analyzed in depth for approximately a twelve-month period. Finally, the contract will serve to draw up guidelines and procedure manuals for use by PSROs on a local level in establishing their own programs. IMS America has been very actively involved in performing

Table 24.

AMERICAN COLLEGE PHYSICIANS STUDY

- . PURPOSE: DEVELOP ANTIBIOTIC UTILIZATION MATERIALS FOR MEDICAL PEER REVIEW PROCESS
  
- . PREPARATION OF CRITICAL SCREENING CRITERIA AND STANDARDS THAT ARE BOTH DRUG AND DISEASE SPECIFIC
  
- . THREE MAJOR PRODUCTS FROM THE STUDY:
  1. GUIDELINES FOR USE OF ANTIBIOTICS
  2. UNIFORM FORMATS FOR SCREENING AND MEDICAL AUDIT CRITERIA AND STANDARDS
  3. DETAILED CRITERIA AND STANDARDS THEMSELVES.

some of these latter functions through special contracts to the Bureau of Quality Assurance.

P. Hospital Delegation Decisions - PSRO Relationships to Hospitals

PSROs are expected to utilize the services of and accept the findings of the review committees of the hospitals. However, the hospital committees must demonstrate to the PSRO that they have the capacity to conduct effective and timely review in such a way as to aid the PSRO in fulfilling its mandated responsibilities. The PSRO, however, retains the responsibility of assuring the effectiveness of the review system.

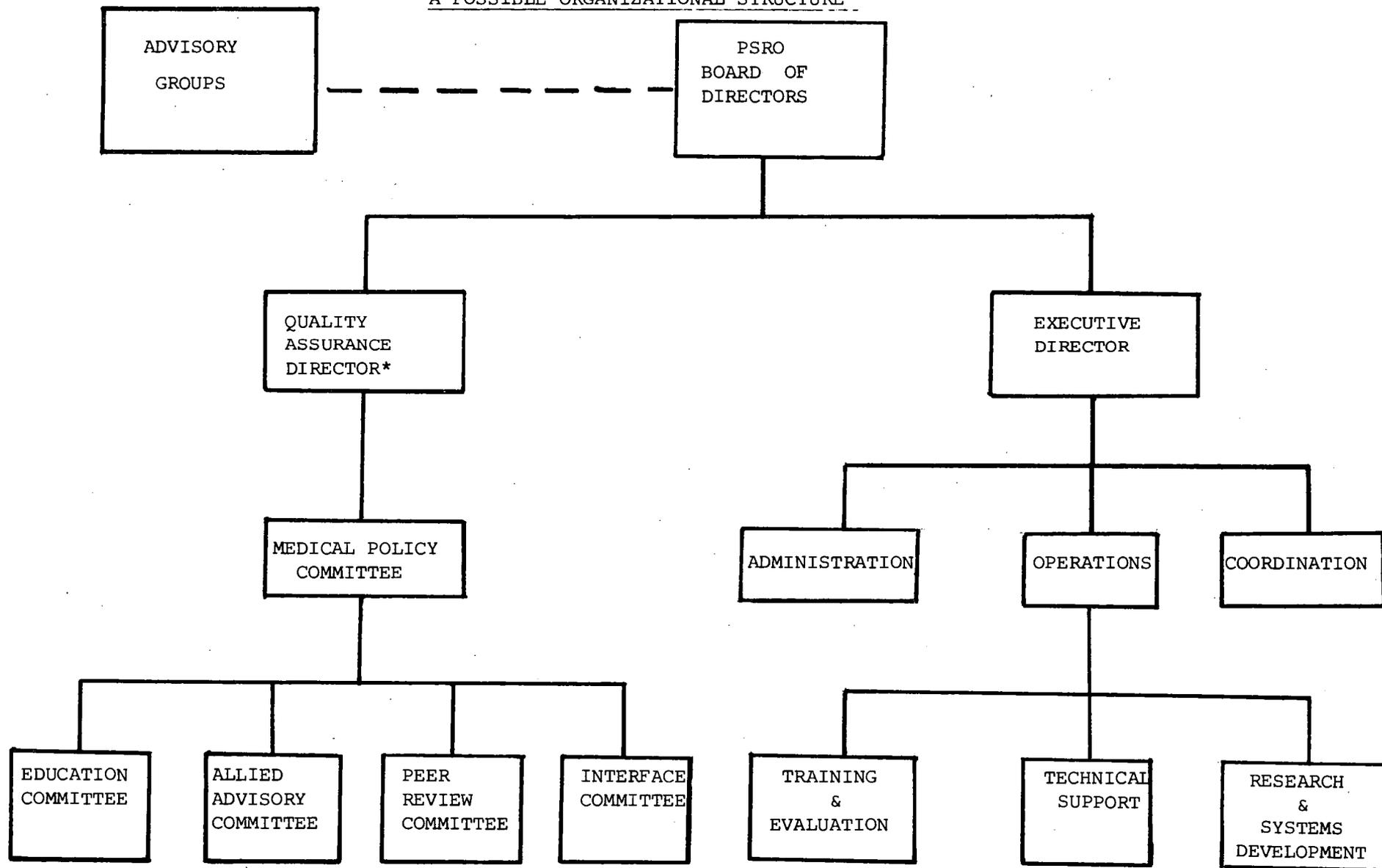
The major steps in the delegation process as suggested by the AMA, are as follows:

1. PSRO Notification - The PSRO must provide written notification of the steps in the delegation process and the criteria upon which delegation decisions will be based to each hospital in its area.
2. Initial expression of interest by the hospital medical staff, Board and administration, including an indication of the review functions for which delegation is sought.
3. PSRO assessment of the hospital's review capability, including review of information from Medicare intermediaries, the Medicaid State Agency, and other available sources.
4. Hospital development of a review plan to conform with PSRO requirements.
5. PSRO determination of hospital capabilities, and decision on review functions, if any, to be delegated.
6. Written agreement signed by the PSRO and the hospital staff, Board and administration detailing the nature of their relationship and the review functions, if any, to be conducted by the hospital.
7. Implementation of the hospital review plan.

Figure 28.

PSRO ORGANIZATION

A POSSIBLE ORGANIZATIONAL STRUCTURE



\* PROVIDES STAFF SUPPORT FOR COMMITTEES

8. PSRO periodic reassessment and on-site inspection of the operation of the hospital review plan, including monitoring through the PSRO Management Information System.

#### Other Considerations

Hospitals should utilize the norms, criteria and standards adopted or ratified by the PSRO for concurrent review. A hospital may substitute alternative norms, criteria and standards only with adequate justification and approval by the PSRO. At least 25 percent of those physicians with active hospital staff privileges shall be members of the PSRO and participate in PSRO activities, including review of patients in their own hospital.

(The 25% figure is contained in draft regulations issued by BQA in November, 1974. However, the PSRO Program Manual states that a majority of physicians with active staff privileges are required to be members of the PSRO. Chapter V, page 11, paragraph 2.) Physicians shall not participate in the review of their own cases. The hospital shall include in its review plan provisions for the inclusion of non-physician health care practitioners in peer review within their respective disciplines.

#### Letter of Intent

The PSRO shall attempt to elicit an expression of interest in delegation from the hospital's medical staff, Board of Trustees and administrators in the form of a letter of intent from the hospital to the PSRO. The letter should contain information concerning:

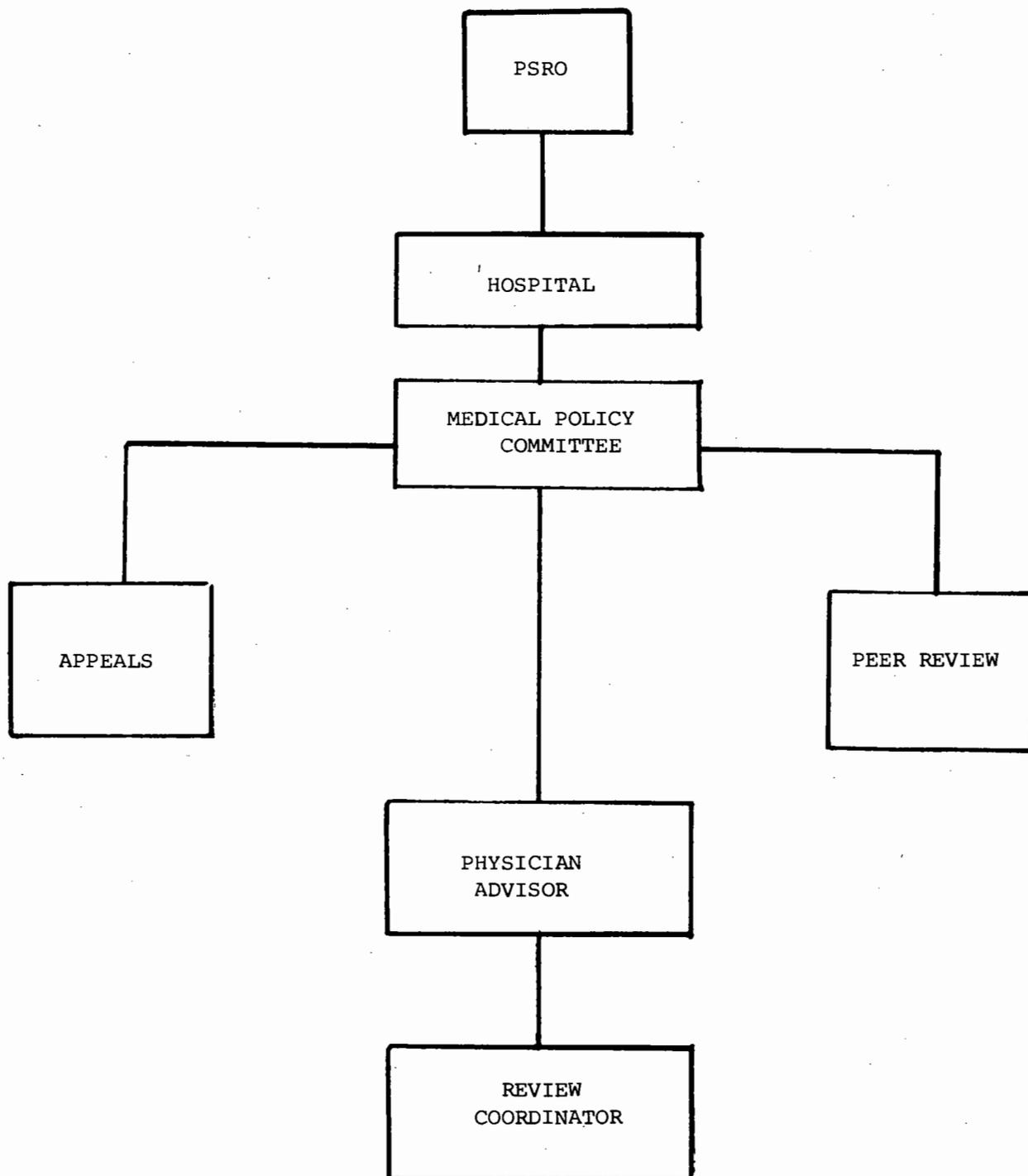
- a. What part(s) of the review system the hospital is interested in performing.
- b. What they are capable of performing based on the general requirements and PSRO's delegation criteria.
- c. An indication of the hospital's willingness to allow PSRO periodic evaluation and monitoring of its review system.

Figure 29.

PSRO ORGANIZATION

HOSPITAL DELEGATED REVIEW

A POSSIBLE ORGANIZATIONAL STRUCTURE



If a response is not obtained from the hospital within 30 days, the PSRO shall communicate with the hospital at least once more, allowing an additional thirty days for response, before assuming the hospital does not desire delegation.

#### Hospital Data

After the hospital's expression of interest, the PSRO shall assess the hospital's capability, utilizing the following criteria:

- a. Review of information from appropriate Medicare intermediaries concerning the hospital's past performance in Medicare utilization review.
- b. Review of information from the Medicaid State Agency concerning the hospital's past performance in Medicare utilization review.
- c. Review of information received from the hospital concerning other types of review taking place in the hospital.
- d. Assessment of information which characterizes the hospital (e.g., number of beds, total admission per year, Medicare, Medicaid, and Maternal and Child Health admissions per year, type of ownership, teaching affiliations, size and type of medical staff, etc.)
- e. Specific information about the hospital's existing review system, including all data concerning operating procedures, results and follow-up, and the changes needed to qualify for delegation.

#### Hospital Plan

The plan for PSRO approval shall be developed by the medical staff, including the chairman of utilization review, medical audit, and other appropriate committees, with participation by non-physician health care practitioners, medical records personnel, etc., and must be approved by the Board of Trustees.

The Plan should include:

Table 25.

STATUS OF CONDITIONAL PSRO REVIEW AUTHORITY

SECRETARY DHEW SIGNED POLICY DECISION ON FEBRUARY 24, 1975

## PROVISIONS:

1. CONDITIONALLY DESIGNATED PSRO (IF FOUND COMPETENT BY DHEW), WILL EXERCISE AUTHORITY ON QUALITY AND NECESSITY OF CARE FOR PURPOSES OF CLAIMS PAYMENT FOR BOTH MEDICARE AND MEDICAID
2. WHERE STATE MEDICAID AGENCIES OBJECT, THE DHEW WILL RECONSIDER THE COMPETENCY OF THE PSRO AFTER A DEFINITIVE PERIOD (NOT TO EXCEED 12 MONTHS)
3. REVIEW SYSTEMS IMPLEMENTED BY CONDITIONALLY DESIGNATED PSROs WILL REPLACE TITLE XVIII AND XIX REVIEW REQUIREMENTS

1. Description of the organization of the review effort including:
  - a. Number and types of hospital personnel to be used for each type of review
  - b. Functions to be performed by PSRO personnel for those review mechanisms not delegated.
  - c. Current relationships with Title 18 and 19 claims payment agencies
  - d. Current relationships with data collection agencies
2. Description of the types of review to be performed by the hospital including for each type:
  - a. Phasing-in schedule
  - b. Method of selection of cases for more detailed review.
  - c. Nature and source of data to be collected
3. Description of the use of PSRO norms, criteria and standards including:
  - a. Description of their use in admission certification and continued stay review, with justification for any proposed deviations from PSRO approved norms, criteria and standards
  - b. The method of development of criteria and standards for MCE studies
4. The content and frequency of reports to be generated for:
  - a. PSRO evaluation and monitoring
  - b. Hospital internal monitoring and management
  - c. PSRO use in modification of norms, criteria and standards
5. Methods by which review findings will be incorporated in in-house and/or areawide continuing education programs.
6. Types of technical assistance and education needed to implement the proposed review system and who will provide it.
7. The number of physicians on the hospital's medical staff who are eligible for PSRO membership, those who are

members of the PSRO, and the members who are participating in PSRO activities.

The PSRO shall initiate review in the hospital if the hospital has not submitted its review plan within 90 days of the date of its initial expression of interest in delegation.

Based on the findings of the PSRO hospital assessment and in evaluation of the hospital review plan, the PSRO shall determine what review functions, if any, are to be delegated to the hospital. Such determination shall be completed within 90 days after the PSRO has received the hospital review plan.

#### Memo of Understanding

After completion of the preceding steps, the PSRO and the hospital must prepare a written Memorandum of Understanding, signed by both parties, describing the nature of their relationship and specifying review functions to be considered by the hospital and by the PSRO. The Memo will also include a phasing-in schedule for review and it shall specify conditions or reasons that will lead to termination of the relationship, the nature of PSRO monitoring and data exchange, and those conditions that will lead to the hospital assuming increased review responsibilities.

#### Q. Problems of Publicity

Publicizing peer review on the local level is extremely important for the success of the entire PSRO program. In the initial stages, publicity is usually the concern of the medical society; the physicians of the community must be aware of the growing concept of peer review and the PSRO program. There is really a marketing function to be performed here in allaying the fears of the medical profession about peer review

and PSRO programs.

The National PSRO Council is visiting some of the local medical societies to explain the program; the Bureau of Quality Assurance staff and staff individuals from the Regional Offices of the Department of Health, Education and Welfare are also doing whatever they can to present information about the program and solicit cooperation from the local medical staff members.

In essence, the objective is to inform all the physicians in the community of peer review. Secondly, there must be specific contact with the hospital utilization review committee representatives to discuss potential means of cooperation and mutual assistance in review efforts. Finally, there is the need to provide good public relations with private financing organizations and government agency representatives to encourage their use of the peer review process.

#### R. Problems of BQA Funding

The PSRO program has had some difficulty in obtaining adequate funding to do its function on the scale envisioned by the legislation. This will always be a problem in a program that is as controversial as PSRO. Nor will the problems disappear for at least the next few fiscal years. The original budget allocation for fiscal year 1975-76 was \$57 million, but this was slashed to \$37 million. In light of what must be accomplished with this amount of money, the amount is very small.

The DHEW has requested and has been denied a fiscal 1976 supplemental appropriation of \$37 million for PSRO activities from the Office of Management and Budget. The OMB's decision reflects the Ford Administration's

general opposition to budgetary increases, rather than a negative view of the PSRO. DHEW Assistant Secretary for Health, Dr. Theodore Cooper, has indicated that adequate funding for PSRO is of "highest priority" as he encourages the OMB to reconsider its negative decision.

#### S. Data Systems

The data systems to collect the information as outlined in the section entitled Management Information Systems, are a very critical problem. Many PSROs in the planning and conditional stages are asking the Commission on Professional and Hospital Activities (a private non-profit medical data abstracting service) to provide base-line data on length of stay and patterns of care as a starting point for measurements in their own areas. It would seem that they should have pre-PSRO data primarily because the CPHA data can identify the problems in areas which need to be attacked immediately. Secondly, the base-line data will provide a basis upon which the PSRO can later check to assure that it is effective in light of legislative requirements.

The Professional Activity Study (PAS) data, one of the major products of the Commission on Professional Hospital Activities, covers more than fifty percent of all U.S. hospital discharges, and therefore provides a valid data base for measuring performance.

There appears to be general agreement on the use of a modified Uniform Hospital Discharge Data Set as a starting point for hospital responsibility to PSRO's. Known as PHDDS (PSRO Hospital Discharge Data Set), this data set includes:

1. personal patient identification,

2. date of birth
3. sex
4. race
5. residence of patient
6. hospital identification
7. admission date
8. discharge data
9. nature of admission
10. certification - extension status
11. attending physician
12. operating physician
13. diagnosis
14. procedures and dates
15. disposition of patient
16. expected principle source of payment

Another major data systems question is the issue of proper coding schemes for diagnoses and procedures. The NPSBC has recommended, through its Data and Norm Subcommittee, that this question be placed in abeyance for the time being. Several coding systems have been developed and are being used for different purposes. The potential uses of coded medical information seem to be many and the needs obviously vary. The adequacy of any coding system in meeting the needs of a multitude of different users apparently will be studied in more depth by the DHEW program staff and the Technical Subcommittee.

Another major systems issue is the confidentiality of PSRO data. A major factor is the point that some information is "privileged information",

with such information becoming non-disclosable outside the confines of the hospital - PSRO review process. Four solutions in defining "Privileged information" emerged from one of the NPSRC meetings:

1. Restrictive Approach: This approach would prohibit disclosure of medical data and information about individual patients. It would also prohibit disclosure of information about the practice patterns or practice profiles of individual health care practitioners.
2. Liberal Approach: This approach would require permission for release of data and information only in cases where the medical practitioner is identified.
3. Ralph Nader Health Research Group Approach: Endorsed by several of the consumer organizations, this approach would require permission for the release of information where information about both individual practitioner and provider is requested.
4. Nelson Approach: Suggested by Dr. Alan R. Nelson, an NPSRC member, this approach would allow a release of aggregate provider claims form data and information. However, information and data relating to an evaluation of the competency of an individual provider would not be released.

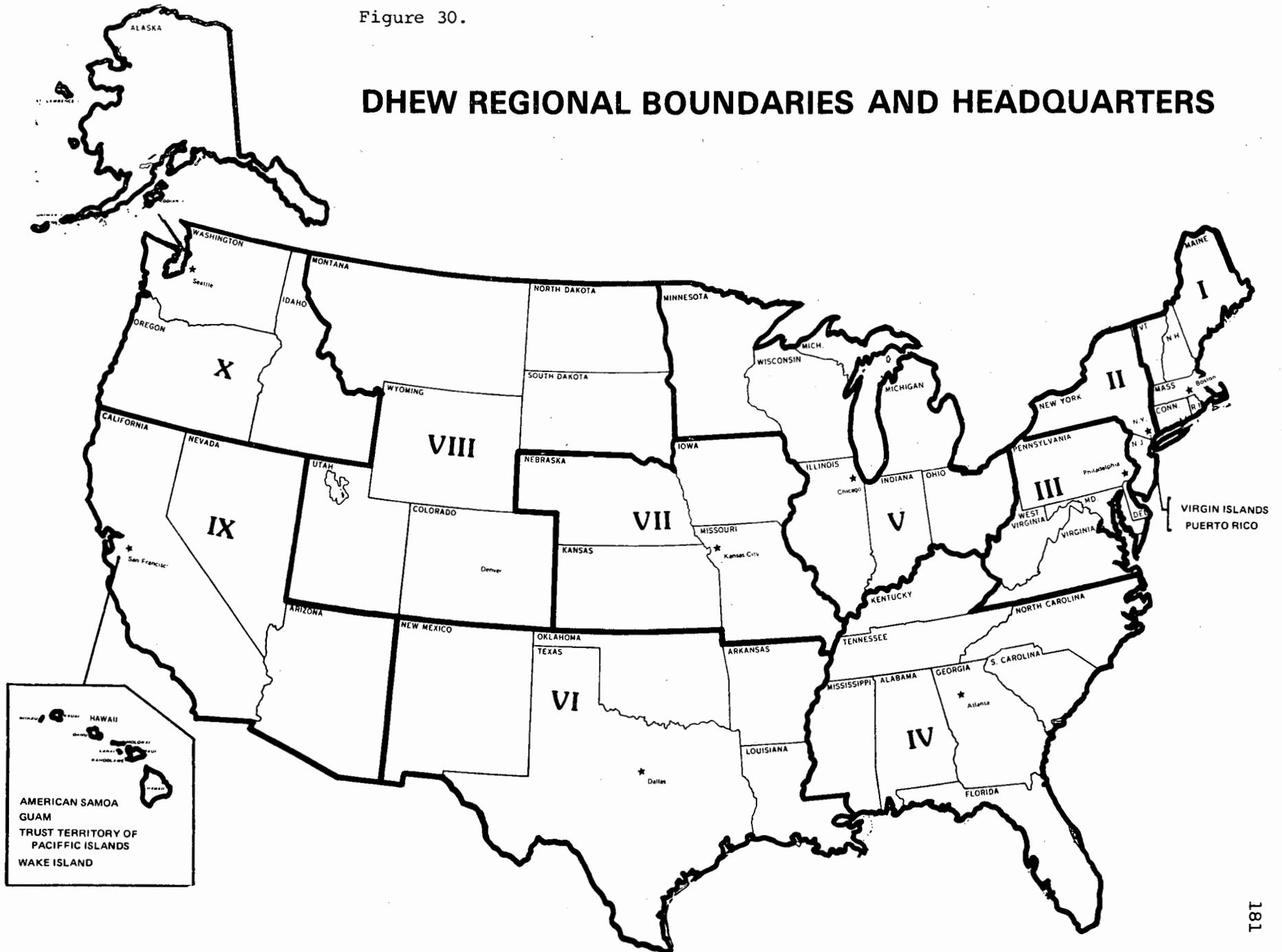
Discussion is taking place around several of the points described above.

#### T. Area Designation

The PSRO legislation required that the country be divided into designated PSRO review areas. The designations generally follow the six basic guidelines originally established by the Department of Health, Education and Welfare, with states having more than 2500 physicians broken into multiple PSRO areas. However, there are exceptions to this. Colorado, for example, has approximately 4000 physicians, and Kentucky has approximately 3400 physicians. These two states are each designated as

Figure 30.

## DHEW REGIONAL BOUNDARIES AND HEADQUARTERS



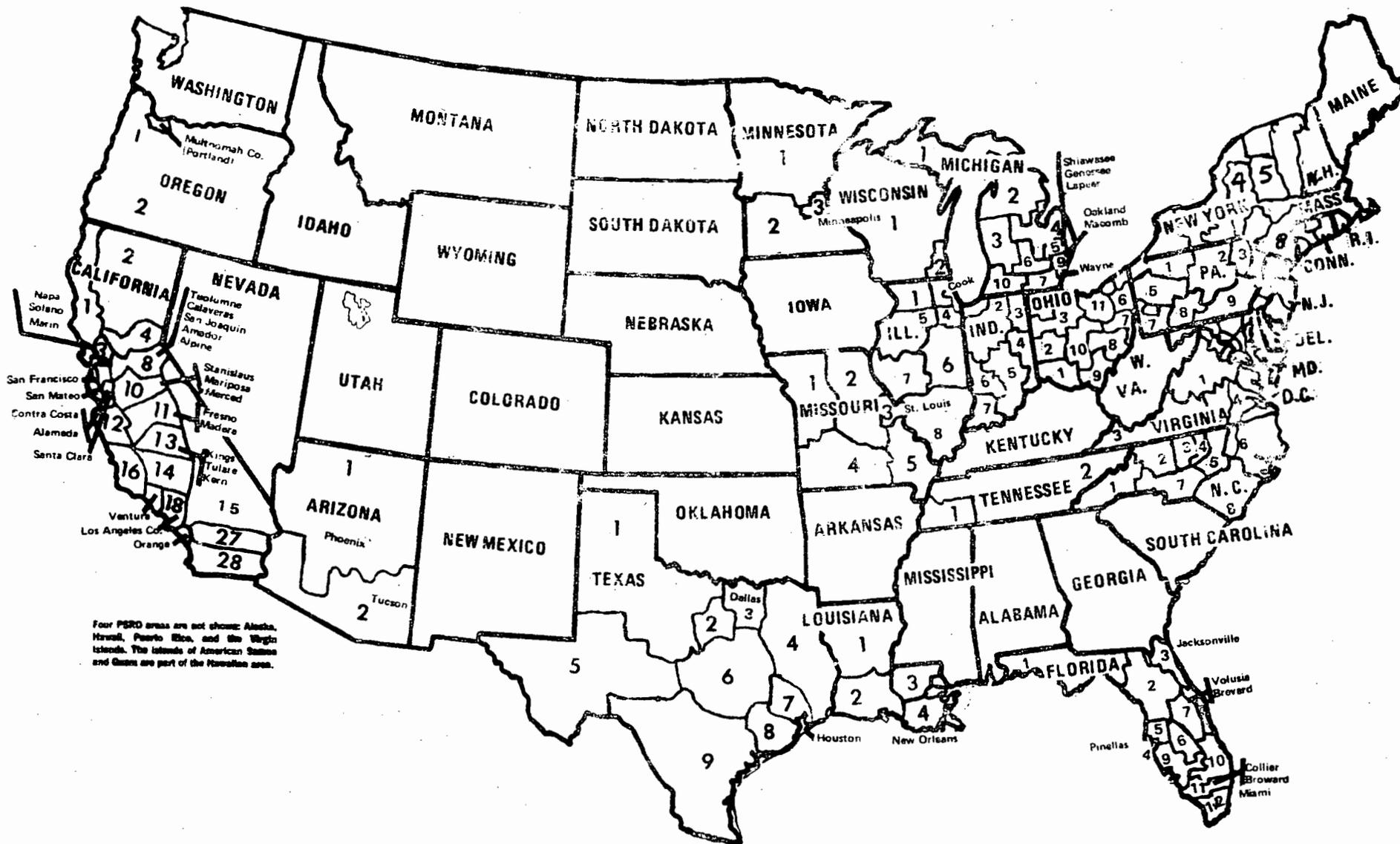
statewide PSRO areas in accordance with staff recommendations of the Department of Health, Education and Welfare. In Georgia, where more than 5000 physicians are practicing medicine, there was a strong pressure from pro-statewide forces which resulted in there not being a single PSRO designation even though PSRO staff strongly opposed this move. In the metropolitan areas, such as Chicago and Los Angeles, which are based on the county designations of Cook County and Los Angeles County respectively, there has been adherence to the guideline of not dividing counties. There also was agreement that there should be no state lines crossed in the first designation, but in places like Washington, D.C., St. Louis, and Kansas City, where medical service areas encompass more than one state, it was felt to be wise to arrange to develop and to facilitate the review process across state lines. Table 20 indicates the number of PSRO areas designated by state. Figure 31 is a map of the PSRO areas in the country, and Figure 32 indicates the PSRO areas in the northeast.

#### U. Court Cases and Legal Problems

The PSROs are having legal difficulty in being implemented in the United States, primarily because of the resistance by the American Medical Association to the utilization regulations. This was alluded to above. Although the U.S. Court of Appeals has upheld the preliminary injunction issued by U.S. District Court Judge Julius J. Hoffman, to block Federal utilization review regulations, it should be noted that the decision was only a judgment on the injunction. The constitutional questions raised in the May 24 AMA suit against HEW were not addressed. The Appeals Court agreed that the regulations "may have the effect of directly

Figure 31.

U. S. MAP OF DESIGNATED PSRO AREAS



Four PSRO areas are not shown: Alaska, Hawaii, Puerto Rico, and the Virgin Islands. The islands of American Samoa and Guam are part of the Hawaiian area.

influencing the doctor's decision on what type of medical treatment will be provided, thus directly interfering with the practice of medicine," and that such an interference "would be in violation of that... various statutes perhaps amount to unconstitutional conduct." The Appeals Court emphasized that the Trial Court would have to rule on this issue.

The AMA withdrew the suit before such questions could be addressed and answered. The UR regulations will be adopted based upon agreements reached between DHEW and the AMA.

Figure 32.

PSRO AREAS OF THE NORTHEAST UNITED STATES

