The twentieth anniversary of Medicare and Medicaid

Memories of Great Ideas And Missed Opportunities

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The twentieth anniversary of Medicare-Medicaid prompts memories of improvements, changes, and disappointments brought about by the legislation.

The impact on racial discrimination by hospitals. Racial segregation in hospitals in the United States (North as well as South) was about as terrible, pre-Medicare, as apartheid in South Africa today—maybe worse. I remember working with Les Falk to get a staff appointment for a black surgeon, with the Urban League to break down segregation practices in semiprivate rooms, and with schools of nursing to get them to admit blacks, all in Pittsburgh in the early 1960s. The Commission on Hospital Care had made strong recommendations (*Hospital Care in the United States*, The Commonwealth Fund, New York City, 1947) against segregation, but no voluntary national or local leadership on the issue emerged. I was amazed at how fast Medicare money and rules turned this situation completely around. Within a year, I was a part of teams traveling the South, trying to advise communities on what to do about the "separate-but-equal" hospitals for blacks, which were all going bankrupt, as the other hospitals were opened up to black physicians and patients. I was never more impressed with the power government can wield when voluntary leadership is too timid and out of touch with the mood of the people.

Utilization review. I remember taking practicing physicians from Pittsburgh down to Washington while the legislation was being developed to show legislators and government officials real, live physicians who voluntarily and enthusiastically served on hospital medical staff utilization review (UR) committees. They had been told that physicians would not cooperate in UR, even if it were required by law. Our Pittsburgh physicians convinced them that the medical profession was ready to be responsible. The only places with hospital UR programs at that time were in the Pittsburgh and Detroit areas. Later the Joint Commission on Accreditation of Hospitals incorporated UR into the standards.

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Subversion of the intermediary relationship. I thought the intermediary relationship was one of the most innovative mechanisms ever devised for bringing out the best in the strange partnership among federal and state governments and the voluntary sectors that made Medicare work so well at the beginning. I learned a lot about how the side that pays the costs of the intermediary relationship inevitably will change it to an agency relationship if those who care do not work hard to protect what was created. Maybe nothing could have been done, but I thought that neither Blue Cross nor the American Hospital Association worked hard enough to protect the intermediary relationship from destruction by those who did not know the harm they were doing. In the process, I think the useful working relationship between hospitals and Blue Cross as "other side of the coin" community partners was severely damaged, almost beyond repair.

Prospective payment. My failure to sell the idea of making interim payments to hospitals on the basis of negotiated budget expenditures, after the law was passed, was my biggest disappointment. Medicare officials considered that suggestion but did not buy it. If they had, we could have developed prospective payment much earlier. I knew that, with solid budget negotiations and delayed final audited cost adjustments, almost all hospital management decisions and income and expense statements would have been based on interim payments. The final delayed adjustments could have been eliminated relatively quickly by legislation when everyone saw how unimportant they were. A good idea whose time has passed!

Federal rigidity on the risk factor in reimbursement experiments. As indicated in an article in *Hospital Progress* ("The Notion of Hospital Incentives," January 1969, pp. 63-68, 97), I thought I had convinced government officials that experiments could teach them a lot, but that they would not learn much if they required the experimenters to put their institutions at risk to get funding for a reimbursement experiment. They did not understand that scientists carry out experiments first in artificially controlled environments. What they learn can then be tried out in demonstrations and eventually in new programs. As a result, little was learned from largely meaningless experiments in which a lot of money was invested—a real missed opportunity.

Diagnosis-related groups (DRGs) as a basis for payment. I still cannot believe that the federal government actually is setting unit prices in Washington for hundreds of hospital service packages in this nation. But then I still do not believe that it decided to pay physicians on the basis of usual, customary, and reasonable fees (UCR) and still is doing it. Both of these decisions are sheer madness. UCR was a great idea when it was controlled by the marketplace, before Medicare; so was retrospective cost reimbursement. But neither works well as the dominant method. DRGs are no better. When will we get to community capitation payment rates?

These are my predominant impressions of the developments of the past two decades, although I have failed to mention how much I underestimated the extent to which Medicare and Medicaid would drive up costs; how much good and how little bad these programs would do for the aged and the poor; the extent to which the Medicare/Medicaid windfalls of hospital income would be identified as "cost shifting," of all things; how quickly the medical profession would absorb and take for granted the new payments for what had previously been largely contributed service; how much investor-owned national chains would develop and grow rich from ill-advised Medicare regulations and give all the credit to the free marketplace; how slowly but surely the health maintenance organization concept is evolving, etc. An amazing 20 years! ★

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