Feds hear medicine's plea, drop one Medicare form

WASHINGTON — Come September, the long-protested "physician attestation" form will become Medicare history, a casualty of a White House "reinventing government" proposal.

The form, in which the physician attests to the accuracy of diagnosis and procedures listed on hospital discharge summaries, was born in 1984 with Medicare's prospective payment system for hospitals. Its purpose was to prevent hospitals from boosting payment by bumping diagnosis codes into higher-paying categories.

Physicians and hospitals have long argued that the form was a demeaning and unnecessary duplication of the discharge summaries, and at a July 11 White House briefing, Vice President Al Gore and first lady Hillary Rodham Clinton said the administration had reached the same conclusion.

Other initiatives to simplify federal health program paperwork include planned reductions in clinical laboratory surveys as well as a requirement that federal employee health benefits plans use the Medicare claim form.

In eliminating the attestation form, Medicare officials said they thought hospitals, rather than doctors, should be the focus of fighting hospital code creep and similar fraud and abuse. They estimated that 11 million forms would be eliminated and almost 200,000 hours of physician time saved. Steve Gleason, DO, who headed a panel that advised the White House on health reform and who worked on the new initiatives, projected nationwide savings of $136.8 million a year.

In a similar vein, the government also hopes to reduce the forms that physicians have to deal with when filing claims. Today, some federal employee plans use the Medicare 1500 form, but at least 12 do not. By September 1996, however, all fee-for-service plans in the government program will be required to use the Medicare form.

he hope is that some private carriers then will use the Medicare form for other private business, expanding the impact of this proposal and further streamlining physician claims-filing.

Several other plans outlined at the briefing would reduce and refocus government inspections aimed at assuring quality of care. The intent is to reward good performers, look at outcomes rather than process, and eliminate duplication between federal programs and with states.

Among the initiatives in this area are proposals to identify "good performers" in the clinical lab and kidney dialysis field. Inspections in these facilities would be less frequent than in others, although surveys would be resumed if quality complaints arose.

For dialysis facilities, officials in the Health Care Financing Administration intend to begin a "good performer" pilot sometime after November.

In the project, current certification standards and surveys would be waived and the dialysis units would be evaluated instead on whether they provide the patient with "adequate dialysis, anemia control and adequate water supply."

Those who did so consistently over six months will be awarded a HCFA "certificate of excellence."

In addition, current personnel standards in the pilot facilities would be waived so that HCFA could evaluate the feasibility of eliminating them for all facilities.

Other proposals would:

- Replace conditions of participation for home health agencies with an outcome-based approach employing a Standard Core Assessment Instrument.
- Revise hospital conditions of participation to center on patient care.
- Eliminate the requirement that mentally ill and mentally retarded nursing home residents be assessed annually; instead, they would be covered by other general requirements.
- Permit states to approve nurses aide training and competency evaluation programs offered in nursing homes.

PROJECT USA

Project USA, the AMA program that recruits physicians for short-term service in rural areas, is seeking doctors to practice family medicine at National Health Service Corps and Indian Health Service locations.

IHS vacancies are: Eagle Butte, S.D., Aug. 14-25; Fort Yates, N.D., Aug. 14-25; Red Lake, Minn., Aug. 14 to Sept. 1; Parker, Ariz., Aug. 14-25; Owyhee, Nev., Aug. 14-25; and Mescarlero, N.M., Aug. 14 to Sept. 1. An obstetrician is needed at Rosebud, S.D., Aug. 14-25. NHSC vacancy is: Baltimore, Md., Aug. 14-25.

For more information contact John Naughton at (312) 464-4702.

[illegible] hospital will pay for all that."

So instead of forming a physician-controlled network, they ended up with a physician-hospital organization. But Dr. Marcus says PHOs are usually weak managed care contractors and don't represent physician interests well.

"Why tie yourself to a hospital, a dying breed?" he asked. "Physicians would do better to retain control of health care themselves."

Ala. judge says Medicaid must offer transportation

MONTGOMERY, Ala. (AP) — A federal judge ruled that Alabama's Medicaid agency must make free transportation available for its 550,000 benefit recipients to get to clinics for nonemergency medical services.

U.S. District Judge Harold Albritton gave the agency 30 days to show him a plan in which the state either pays the cost or otherwise can ensure that it has a transportation system using unpaid volunteers for Medicaid patients.

State Medicaid programs are required by the federal government to provide such transportation.

The suit by Legal Services Corp. of Alabama and the Southern Property Law Center on behalf of Medicaid recipients was aimed at forcing a start-up of transportation services.

Medicaid attorneys had said the state tried to arrange nonemergency transportation using volunteers, county welfare office staff and relatives.

The judge, in his ruling, said there was no objection to using volunteers. "The point is that transportation, whether free or paid for, must be ensured."

FIRST LADY HILLARY RODHAM CLINTON
REINVENTING HEALTH CARE REGULATION EVENT
THE WHITE HOUSE
JULY 11, 1995

[Acknowledgments: Vice President Gore, Secretary Shalala, HCFA Administrator Bruce Vladeck, Dr. Steve Gleason.]

Thank you all for joining us today. And thank you again for all of the work you did last year on health care reform and for all that you continue to do.

Last year, you taught all Americans that while we have the highest quality health care system in the world, that system is too complicated. And that while we boast some of the most talented and dedicated health professionals and advanced research institutions, those professionals and institutions are overburdened by paperwork, red tape and needless regulation.

As part of our work on health care reform last year, we looked for ways to simplify the health care system. We are here today in large part because of your ongoing commitment to that effort. At the same time, Vice President Gore's Reinventing Government Initiative began eliminating unnecessary regulatory burdens in all areas of government. The announcement today represents the perfect marriage of those two efforts. One step in an ongoing effort to free doctors, hospitals and other health care providers to do what they were trained to do. One step to maintain and enhance quality in our health care system -- not by micromanaging but by measuring results.

Hospitals today hire more administrative staff than medical staff -- simply to handle the avalanche of insurance forms and paperwork. Doctors and nurses spend hundreds of hours each month on administration. That's time not spent with a child who needs a check-up; time not spent diagnosing or treating a patient with pneumonia, or breast cancer. I will never forget talking to a nurse last year who summed it up for me. She said she had gone into nursing to care for people. If she had wanted to be an accountant she would have studied accounting and worked for an accounting firm. Instead, after training to be a nurse, she spent nearly 50 percent of her time filling out forms.

Even worse, many of you have made, or watched the institutions where you work make, difficult choices to hire more bookkeepers and clerical people while laying off nurses and medical technicians. That is an unacceptable choice that no physician, hospital or nursing home should have to face.

We can make a significant start on simplifying the health care system by improving how the Federal health programs do business. In recent months the health care debate has centered around the need to reform Medicare and Medicaid and to get spending under control. Everyone agrees that Medicare and Medicaid can be improved. And everyone agrees that Federal health spending is growing too fast. Over the next five years alone, almost 40 percent of the growth in Federal spending will come from the rise in Federal health care costs. They are growing faster than GDP. Faster than overall inflation. Faster than almost all other items of government spending.

But, as the President has been saying, there is a right way and a wrong to slow the growth in Medicare and Medicaid spending and to address the problems in these programs. The Republican proposal to take deep Medicare cuts to pay for tax breaks for the wealthiest Americans is the wrong way. Their Medicaid block grant proposal is the wrong way. Under the current block grant scenario, seven million children and nearly one million elderly and disabled Americans would lose coverage, and millions more would risk losing vital services, like nursing home care.

Instead, we need to remember that Medicare and Medicaid have lifted millions of Americans out of poverty and have helped millions more manage to pay for desperately needed health care services. The right way is to improve and strengthen these programs and make them more efficient.

- That's why the President proposed a budget that reaches balance in ten years but that has half of the Medicare and one-third of the Medicaid savings in the Republican plan.

- That's why the President's budget takes only the Part A cuts needed to strengthen the Medicare Trust Fund -- rather than playing on fears about the insolvency of the Fund to slash Medicare spending to pay for other priorities.

- And as the President has consistently said, he will take these Medicare and Medicaid savings only in the context of health care reform. That's why his budget proposal takes the first steps toward reform.

    - By making the insurance market more fair.

    - By helping workers who lose their jobs pay for health insurance and making insurance more affordable for small businesses and the self-employed.

    - By giving states more flexibility under Medicaid while protecting coverage.

- And by giving Medicare beneficiaries more choices, and investing in new Medicare benefits and long-term care.

As an important part of our reform efforts, there are also changes that we can make in Federal health care programs right now. Changes that will improve these programs -- and improve your ability to work with these programs -- bit by bit, piece by piece. We can simplify the system and regulate the right way, without compromising quality.

In the past two and a half years we've made progress. HCFA has simplified the forms and statements that Medicare beneficiaries get each month. They have improved the system for processing claims. They have taken real first steps toward making quality standards more sensible and the enforcement of these standards more flexible -- to take just a few examples.

The reforms that the Vice President will outline today are part of this ongoing process. I hope that we can build off of the work we've done so far and leave here with the promise and the challenge of continuing a working relationship that involves the White House, HHS in Washington, its regional offices, those of you working in communities across the country, and those of you who represent health care professionals nationwide. With your help, we can continue to identify unnecessary and burdensome regulations and work together to simplify and improve our health care system.

[Introduce Steve Gleason.]

###

FIRST LADY HILLARY RODHAM CLINTON
REINVENTING HEALTH CARE REGULATION EVENT
THE WHITE HOUSE
JULY 11, 1995

[Acknowledgments: Vice President Gore, Secretary Shalala, HCFA Administrator Bruce Vladeck, Dr. Steve Gleason.]

Thank you all for joining us today. And thank you again for all of the work you did last year on health care reform and for all that you continue to do.

Last year, you taught all Americans that while we have the highest quality health care system in the world, that system is too complicated. And that while we boast some of the most talented and dedicated health professionals and advanced research institutions, those professionals and institutions are overburdened by paperwork, red tape and needless regulation.

As part of our work on health care reform last year, we looked for ways to simplify the health care system. We are here today in large part because of your ongoing commitment to that effort. At the same time, Vice President Gore's Reinventing Government Initiative began eliminating unnecessary regulatory burdens in all areas of government. The announcement today represents the perfect marriage of those two efforts. One step in an ongoing effort to free doctors, hospitals and other health care providers to do what they were trained to do. One step to maintain and enhance quality in our health care system -- not by micromanaging but by measuring results.

Hospitals today hire more administrative staff than medical staff -- simply to handle the avalanche of insurance forms and paperwork. Doctors and nurses spend hundreds of hours each month on administration. That's time not spent with a child who needs a check-up; time not spent diagnosing or treating a patient with pneumonia, or breast cancer. I will never forget talking to a nurse last year who summed it up for me.

She said she had gone into nursing to care for people. If she had wanted to be an accountant she would have studied accounting and worked for an accounting firm. Instead, after training to be a nurse, she spent nearly 50 percent of her time filling out forms.

Even worse, many of you have made, or watched the institutions where you work make, difficult choices to hire more bookkeepers and clerical people while laying off nurses and medical technicians. That is an unacceptable choice that no physician, hospital or nursing home should have to face.

We can make a significant start on simplifying the health care system by improving how the Federal health programs do business. In recent months the health care debate has centered around the need to reform Medicare and Medicaid and to get spending under control. Everyone agrees that Medicare and Medicaid can be improved. And everyone agrees that Federal health spending is growing too fast. Over the next five years alone, almost 40 percent of the growth in Federal

spending will come from the rise in Federal health care costs. They are growing faster than GDP. Faster than overall inflation. Faster than almost all other items of government spending.

But, as the President has been saying, there is a right way and a wrong to slow the growth in Medicare and Medicaid spending and to address the problems in these programs. The Republican proposal to take deep Medicare cuts to pay for tax breaks for the wealthiest Americans is the wrong way. Their Medicaid block grant proposal is the wrong way. Under the current block grant scenario, seven million children and nearly one million elderly and disabled Americans would lose coverage, and millions more would risk losing vital services, like nursing home care.

Instead, we need to remember that Medicare and Medicaid have lifted millions of Americans out of poverty and have helped millions more manage to pay for desperately needed health care services. The right way is to improve and strengthen these programs and make

them more efficient.

- That's why the President proposed a budget that reaches balance in ten years but that has half of the Medicare and one-third of the Medicaid savings in the Republican plan.
- That's why the President's budget takes only the Part A cuts needed to strengthen the Medicare Trust Fund -- rather than playing on fears about the insolvency of the Fund to slash Medicare spending to pay for other priorities.
- And as the President has consistently said, he will take these Medicare and Medicaid savings only in the context of health care reform. That's why his budget proposal takes the first steps toward reform.
    - By making the insurance market more fair.
    - By helping workers who lose their jobs pay for health insurance and making insurance more affordable for small businesses and the self-employed.
    - By giving states more flexibility under Medicaid while protecting coverage.

- And by giving Medicare beneficiaries more choices, and investing in new Medicare benefits and long-term care.

As an important part of our reform efforts, there are also changes that we can make in Federal health care programs right now. Changes that will improve these programs -- and improve your ability to work with these programs -- bit by bit, piece by piece. We can simplify the system and regulate the right way, without compromising quality.

In the past two and a half years we've made progress. HCFA has simplified the forms and statements that Medicare beneficiaries get each month. They have improved the system for processing claims. They have taken real first steps toward making quality standards more sensible and the enforcement of these standards more flexible -- to take just a few examples.

The reforms that the Vice President will outline today are part of this ongoing process. I hope that we

can build off of the work we've done so far and leave here with the promise and the challenge of continuing a working relationship that involves the White House, HHS in Washington, its regional offices, those of you working in communities across the country, and those of you who represent health care professionals nationwide. With your help, we can continue to identify unnecessary and burdensome regulations and work together to simplify and improve our health care system.

[Introduce Steve Gleason.]

###

Reinventing Health Care Regulations

HCFA Regulatory Reform Initiatives

The following proposals are the next major HCFA initiatives to evolve from the regulatory reform process.

1. **Physician Attestation:** Eliminate the physician form required to certify the accuracy of all diagnosis and procedures before submission for payment by Medicare. Ending this requirement eliminates 11 million forms a year, saving almost 200,000 hours of physician time and decreasing hospital administrative costs by approximately $22,500 per hospital annually.

2. **Clinical Laboratory Improvement Amendments:** Reduce burden and improve the CLIA system by rewarding good performance by laboratories, creating incentives for manufacturers to develop more reliable testing equipment, allowing private organizations that meet certain standards to accredit laboratories, and using proficiency testing as an outcome measure to monitor laboratory performance.

3. **Outcome Performance Measures:** Change current regulations that focus solely on requirements for measuring processes, rather than outcomes of care. Changes affect:

- Home Health Agency Conditions of Participation
- Medicare Hospital Conditions of Participation
- ESRD Facility Conditions of Coverage
- Rules for ESRD Facilities - A Pilot for Good Performers
- Elimination of Personnel Requirements for Excellent ESRD Facilities

4. **The HCFA-1500 Form:** Require participating Federal Employee Health Benefit Plan (FEHBP) carriers to use the HCFA-1500 form for physicians' and other practitioners' claims. The HCFA-1500 is currently used by physicians and others to submit claims for reimbursement of health care services under Medicare. This change will mean that physicians and other practitioners will be able to use a single form to submit claims for many patients -- both Medicare beneficiaries and patients enrolled in the FEHBP.

5. **Annual Preadmission Screening and Annual Resident Review (PASARR):** Currently, there are two Federal requirements for assessing nursing home patients. This change eliminates the requirement under PASARR that mentally ill and mentally retarded nursing home residents are assessed. Resident assessments and reassessments conducted by States under the general nursing home requirements ensure that residents' continuing needs are properly evaluted and met. The preadmission screening for these residents under PASARR is retained.

6. **Nurse Aide Training and Competency Evaluations:** Permit States to approve nurse aide training and competency evaluation programs offered in nursing homes.

July 10, 1995

REINVENTING HEALTH CARE REGULATION EVENT

DATE: Tuesday, July 11
TIME: 1:00 pm
LOCATION: Room 450, OEOB
FROM: Brenda Costello

I. PURPOSE

To announce a package of health care regulatory reforms as part of the Clinton Administration's ongoing efforts to improve the health care system and as part of our Reinventing Government Initiative.

II. BACKGROUND

This event will highlight the work we have been doing on two fronts -- as part of our ongoing health reform efforts and as part of the Reinventing Government Initiative -- to reduce regulatory burdens in the health care system.

During the both the development of the Health Security Act (HSA) and the deliberations around the HSA, physicians and other providers often pressed for regulatory and administrative changes which we could implement without congressional action. This event seeks to illustrate that our Administration began these efforts to reduce health care regulatory burdens and to ease paperwork requirements early in 1993 (the document announcing our recommendations summarizes all Health Care Financing Administration (HCFA) regulatory reform changes since the beginning of our Administration) and Phase I concludes with today's announcement.

We see this process as a continuum in which no single announcement or change may appear particularly weighty, but taken as a whole our reform efforts show significant reduction in the requirements placed on providers. The conclusion of Phase I demonstrates our commitment to re-look at every health care paperwork form and every regulatory requirement with an eye to "does the benefit outweigh the cost (time and financial) to the provider (and ultimately the patient)."

A third of the audience are members of the National Health Policy Council (NHPC), a group founded with the belief that decisions about health care and health care financing should be patient oriented, and believes that all Americans should have access to quality health care at a reasonable cost. The activities of the NHPC are to: educate and empower a wide cross-section of provider and consumer groups; provide a platform for debate of health issues by presidential candidates.

The NHPC served as the provider surrogate speakers bureau through which we referred hundreds of HSA speaking requests. These physicians, nurses, and other health professionals spent many hours during the past two years traveling the nation as advocates of the HSA and always at their own expense.

[Reminder of health reform efforts?]

Attached please find a summary and longer description of the regulatory reforms being announced today.

The remarks have been divided into the following topics:

Sec. Shalala: Brief introduction of HRC

HRC: Outline of the problem and description of this regulatory reform effort as part of the Administration's ongoing commitment to improving the health care system

Dr. Gleason: Description of the current regulatory burden on health care providers and the impact of these changes

VP: Description of the health care regulatory reform package and of these efforts in the context of the Administration's Reinventing Government Initiative

III. PARTICIPANTS

The audience includes approximately 60 members of the National Health Policy Council (Steve Gleason's group), approximately 65 individuals representing physician, hospital, and nursing home national organizations, and approximately 30 staff from the Health Care Financing Administration (who have worked on developing these regulatory changes).

List attached.

IV. SEQUENCE OF EVENTS

- HRC arrives in Room 450
- HRC, Vice President Gore, Secretary Shalala and Dr. Gleason are seated on stage
- Secretary Shalala introduces HRC
- HRC gives remarks and introduces Dr. Gleason
- Dr. Gleason gives remarks
- HRC introduces the Vice President
- Vice President gives remarks

V. Press

Open press

VI. REMARKS

Prepared by Jennifer Klein

Vice President Gore Remarks
ReGo 2 — HCFA Regulatory Reform
July 11, 1995
(draft as of 07/07/95 10:44 AM— 1,500 words)

[The First Lady describes the problems with health care regulations that she discovered in her earlier work, and contrasts the right way with the wrong way to fix health care. She introduces Steve Gleason as a representative of the doctors who told her what was wrong and how to fix it. Gleason talks about the regulatory burden, highlighting the "physician attestation form," ~~then introduces Vice President Gore.~~]

→ Mrs. Clinton introduces VP.

Thank you, Steve, and thank you Mrs. Clinton. Your description of the right way and the wrong way to reform government reminds me of the story about the veterinarian and the taxidermist who became business partners. They had the hardest time deciding what to put on the sign out in front of their office. Finally, they settled on this: "Either way, you get your dog back."

Well, this administration and the Congress are kind of like those two. The Clinton-Gore way is to make government well again. Dole and Gingrich seem to just want to stuff it.

That's the wrong way. Public opinion poll after poll shows that most Americans ***do*** want a smaller government — ***yes***. And we're making it smaller — the smallest it's been since the Kennedy Administration.

But, most Americans don't want to give up on government. Most Americans believe as President Clinton and I believe — government is the way a free people work together to solve their biggest national problems.

But if government does not work well — if it never seems to solve the problems it sets out to solve — problems like crime or poverty, disease or ignorance, threats to our security or to our economy — then Americans loose faith in government. And when we do that, we are loosing confidence in our own ability to work together as a free people.

That is a crisis of confidence we face today. Thirty years ago, when asked if government could be trusted to do the right thing, 75% of Americans said yes. Today, it's less than 20%. Confidence has been lost by Democrats as well as Republicans — by the old and by the young — among all races and creeds — the loss has been across the board.

We have to restore America's faith in government. We have to restore our faith in ourselves. That's why we have to make government work better — not just cost less. That's why President Clinton and I have been reinventing government.

You know, just listening to the First Lady and Dr. Gleason describe what is wrong with health care regulation is like a trip down reinvention memory lane for me. Two years ago, when President Clinton gave me the reinvention job, I found the very same things wrong all over the government: lots of attention to *red tape*, but little interest in *results* — lots of *mistrust* and confrontation, but very little *partnership* and teamwork — long on *rules,* but short on common sense.

And just as the First Lady learned about the real problems, and how to fix them, from physicians like Dr. Gleason and his colleagues who were kind enough to join us today, I've found that the best ideas about how to make government work better and cost less always come from the people on the front lines — people who do the real work day in and day out.

We listened to those people about reinventing the rest of government. And we are listening to you doctors and other medical professionals about how to fix government's role in health care.

The parallels are really striking. Take on-the-job worker safety for example: Government regulation has helped make the American workplace safer over the years. But, our new approach is making big improvements for workers, with fewer costly hassles for business owners. It was started by some front-line workers in Maine, and now, President Clinton has ordered OSHA to take it nation-wide. It is all based on partnership among labor, management, and government with a common goal of healthy workers in a growing economy.

The same kind of results-oriented partnerships are changing things so that the government can protect the environment without using up a forest-worth of paperwork — so that government can ensure the safety and effectiveness of drugs without being such a pain — and the government can enforce trade regulations without holding up shippers or shanghaiing travelers. The list of reforms goes on and on.

President Clinton and I are making that kind of change because we agree with you, and with most other Americans, that government should be in your corner — not in your face. But we don't agree with the majority of Congress that the only solution is a meat ax. In short, we don't need what the butcher ordered — we need what the doctor ordered.

Here are some of the new ideas that we are putting into practice at the Health Care Financing Administration — ideas for a reinvented government that we got from doctors like you here today — and from patients and even from government workers — the people on the front lines.

HCFA **(HICK-fa)** is spending less time writing rules and more time listening to its customers — understanding their problems — reaching agreement on common goals. In other words, their new method is to ***communicate, not dictate***.

HCFA is going to stop mailing its customers reams and reams of bewildering data. If you've ever been on the receiving end of Medicare or Medicaid, you know what I mean. Instead, HCFA will make sure that people get only the information they need, and that they get it in a way that ordinary humans can understand. In other words, they will ***educate, not inundate.***

And, ~~instead of~~ as they ***regulating***, HCFA's going to ***innovate.*** By that, I mean that the government is going to focus more on getting ***better and better results***, which come from innovation. We will stimulate innovation, and reward innovation. We will be paying less and less attention to making sure that processes conform with the regulations — because we believe that ***results*** are more important than red tape.

Let me give you some specific examples:

- Last year, HCFA dropped the irritating rule that doctors had to sign a form every year acknowledging the penalties for cheating on Medicare. But as Dr. Gleason just told us, there is still the so-called "attestation (**a-tess-TA-shun**) form" for each Medicare patient who is being discharged from a hospital. The doctor has to certify that none of the charges are fraudulent before the hospital can send in the claim.

  Now, is that crazy, or what? Did we really think that if the doctor were a crook, he would — now confronted by the intimidating Physician Attestation Form (the very name makes a charlatan shudder) — did we think he would suddenly have a change of heart, and come clean? More to the point, is it the official opinion of the US Government that the vast majority of doctors and hospitals in this country are crooks?

  The correct answer is, "None of the above." And so, we are relegating the "Physician Attestation Form" to the trash can of yesterday's government.

  (Drop the forms into the can.)

  From now on, we will start from an assumption of trust instead of mistrust — the assumption that the vast majority of America's doctors and hospitals are honest.

  By the way, each year, America's doctors had to sign 11 million of those forms. Even if each one only took a minute to look over and sign, that's 200,000 hours of doctor time that can now be devoted to patients instead of paperwork.

  And hospitals will save time and money too. They used to have messengers driving around town with the forms tracking down signatures. One hospital I heard about held an occasional "physician amnesty day" and enticed the doctors with free brownies to come in and sign the forms. Sorry if regulatory reinvention is messing up a good thing there.

- HCFA will also be changing the way they make sure that laboratory tests are accurate. For example, instead of scheduling regular, on-site inspections of *every* lab in America, we will turn attention away from the

labs with solid track records of high quality, and concentrate more on the labs that need improvement. How's that for common sense?

Or this: We will stop wasting money on routine inspections of lab tests that are done by machines that don't make mistakes. We'll count on the time-tested technology unless there is some evidence of a problem.

- And HCFA has come up with better was to ensure that Americans with serious kidney disease get top notch care — ways focused on results rather than red tape. Instead of holding yearly inspections to make sure all the paperwork is in order, we will continually track how the patients are doing. We will let everyone know which facilities produce excellent results. That way, government can help consumers make informed choices.

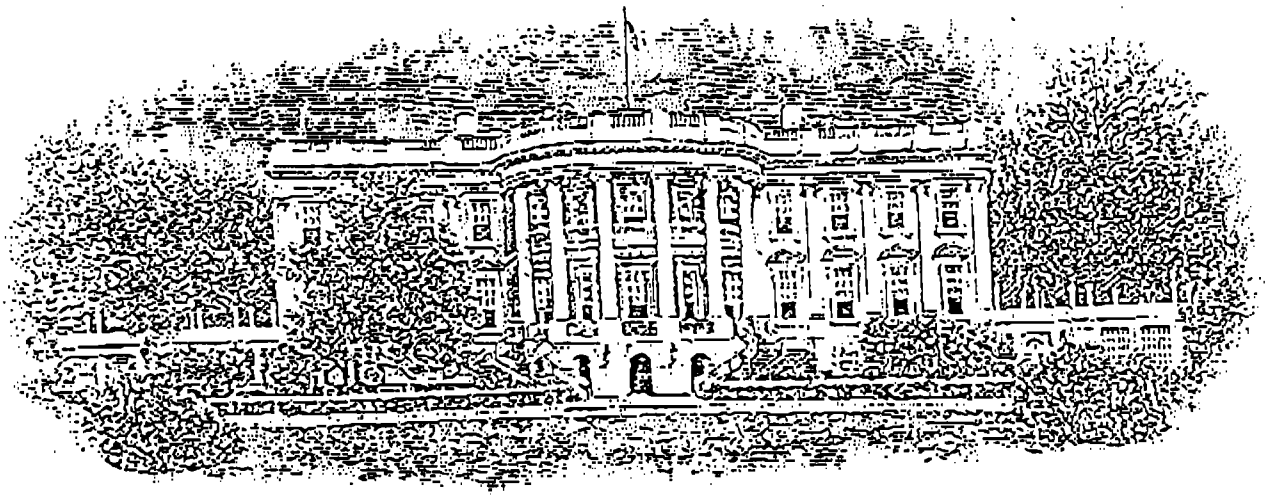
- And for mental disease and retardation — we are cutting out the red tape there too. We want states to use their money for ***first class care*** instead of ***federal second guessing.***

And this is not the end of it. We will keep listening and keep changing and keep restoring faith in government.

As the First Lady pointed out, when it comes to reinventing government, health care is no different from any other national problem: We need faith that we can solve our problems together through government. And to regain that faith, we need to make government work better and cost less.

That's what Clinton and Gore are all about — making government work better and cost less. That is and always will be — the right way.

The White House



DOMESTIC POLICY

FACSIMILE TRANSMISSION COVER SHEET

TO: Jen Klein

FAX NUMBER: 456-2878

TELEPHONE NUMBER: 456-2593

FROM: Jii

TELEPHONE NUMBER: 456-5587

PAGES (INCLUDING COVER): 10

COMMENTS: The 1991 Article & letters.

07/10/95 17:05 ☎ 002

SPECIAL ARTICLE

THE DETERIORATING ADMINISTRATIVE EFFICIENCY OF THE U.S. HEALTH CARE SYSTEM

STEFFIE WOOLHANDLER, M.D., M.P.H., AND DAVID U. HIMMELSTEIN, M.D.

Abstract *Background and Methods.* In 1983 the proportion of health care expenditures consumed by administration in the United States was 60 percent higher than in Canada and 97 percent higher than in Britain. To assess the effects of recent health policy initiatives on the administrative efficiency of health care, we examined four components of administrative costs in the United States and Canada for 1987: insurance overhead, hospital administration, nursing home administration, and physicians' billing and overhead expenses. Most data were provided by the two nations' federal health and statistics agencies, supplemented by state and provincial data and published sources. Because data on physicians' billing costs were limited, we estimated a range for these costs by two methods that rely on different sources of data. All figures are reported in 1987 U.S. dollars.

Results. In 1987 health care administration cost between $96.8 billion and $120.4 billion in the United States, amounting to 19.3 to 24.1 percent of total spending on health care, or $400 to $497 per capita. In Canada, between 8.4 and 11.1 percent of health care spending ($117 to $156 per capita) was devoted to administration. Administrative costs in the United States increased 37 percent in real dollars between 1983 and 1987, whereas in Canada they declined. The proportion of health care spending consumed by administration is now at least 117 percent higher in the United States than in Canada and accounts for about half the total difference in health care spending between the two nations. If health care administration in the United States had been as efficient as in Canada, $69.0 billion to $83.2 billion would have been saved in 1987.

Conclusions. The administrative structure of the U.S. health care system is increasingly inefficient as compared with that of Canada's national health program. Recent health policies with the avowed goal of improving the efficiency of care have imposed substantial new bureaucratic costs and burdens. (N Engl J Med 1991; 324:1253-8.)

MEDICINE is increasingly a spectator sport. Doctors, patients, and nurses perform before an enlarging audience of utilization reviewers, efficiency experts, and cost managers (Fig. 1). A cynic viewing the uninflected curve of rising health care spending might wonder whether the cost-containment experts cost more than they contain; one is reminded of the Chinese proverb "There is no use going to bed early to save candles if the result is twins."

In 1983 the proportion of health care spending consumed by administrative costs in the United States was 60 percent higher than in Canada and 97 percent higher than in Britain.[2] Recent U.S. health policies have increased bureaucratic burdens and curtailed access to care. Yet they have failed to contain overall costs. This study updates and expands estimates of the costs of health administration in North America through 1987.[2] The results demonstrate that the bureaucratic profligacy of the U.S. health care system has increased sharply, while in Canada the proportion of spending on health care consumed by administration has declined.

METHODS

We examined four components of administrative costs in the United States and Canada: insurance overhead, hospital administration, nursing home administration, and physicians' overhead and billing expenses. All estimates are for fiscal year 1987, the most recent year for which complete data were available. Costs are reported in 1987 U.S. dollars, based on the 1987 exchange rate of $1.33 (Canadian) = $1 (U.S.); calculations of per capita spending were based on populations of 243,934,000 in the United States and 25,652,000 in Canada.

Figures on insurance overhead in the United States were obtained from the Health Care Financing Administration.[3] Although nationwide data on the costs of hospital and nursing home administration were not available, the California Health Facilities Commission regularly compiles detailed cost data, based on Medicare cost reports, on that state's hospitals and nursing homes. Four years ago we confirmed that administrative costs in California's health facilities were similar to those in at least two other states.[2] Since then, trends in hospital and nursing home financing and organization in California have paralleled developments in the nation as a whole.[4,5] We computed total hospital administrative costs by summing costs in the following categories: general accounting, patient accounting, credit and collection, admitting, other fiscal services, hospital administration, public relations, personnel department, auxiliary groups, data processing, communications, purchasing, medical library, medical records, medical-staff administration, nursing administration, in-service education, and other administrative services. We excluded costs attributed to research administration, administration of educational programs, printing and duplicating, depreciation, amortization, leases and rentals, insurance, licenses, taxes, central services and supply, other ancillary services, and unassigned costs. We assumed that administration represented the same proportion of total hospital costs in California as nationwide. We derived estimates of nationwide administrative costs for nursing homes from the California data in a similar manner.

Although Canada's 10 provincial health programs differ in some details, they share common structural features that tend to streamline bureaucracy. Each program provides comprehensive coverage for virtually all provincial residents under a single publicly administered plan. Private insurance may cover additional services, but duplication of the public coverage is proscribed; hospitals are paid a lump-sum (global) amount to cover operating expenses, and physicians bill the program directly for all fees.

The Health Statistics Branch of Health and Welfare Canada and Statistics Canada's Canadian Center for Health Information provided unpublished data on nationwide spending for insurance, hospitals, and nursing homes. These data were derived from the provincial governments' reports of their expenditures for insurance administration and from detailed cost reports submitted by hospi-

From the Division of Social and Community Medicine, Department of Medicine, Cambridge Hospital and Harvard Medical School, Cambridge, Mass., and the Public Citizen Health Research Group, Washington, D.C. Address reprint requests to Dr. Himmelstein at 1493 Cambridge St., Cambridge, MA 02139.

07/10/95 17:06 ☎ 003

tals and nursing homes. We computed total hospital administrative costs by summing costs in the following categories: hospital administration ("other"), advertising, association-membership fees, business machines, collection fees, postage, auditing and accounting fees, other professional fees (such as legal fees but excluding medical fees), service-bureau fees, telephone and telegraph, indemnity to board members, travel and convention expenses, medical records and hospital library, and nursing administration. We excluded administrative and support services for educational and research programs, insurance, interest, printing, stationery and office supplies, materiel management, and central supply. Statistics Canada tabulates administrative costs for nursing homes as a single category. These data are less reliable than the hospital figures, since cost reporting by nursing homes is voluntary, and the number of facilities reporting varies substantially from year to year.

We confirmed the accuracy of the Canadian federal data, using more detailed but incomplete data from British Columbia, the Maritimes, Ontario, Quebec, and Saskatchewan[6-10] (and personal communications: Cunningham D, British Columbia Ministry of Health; Lim P, Continuing Care Employee Relations Association of British Columbia; and Davis J, Ontario Ministry of Health). Because these data generally matched the national figures, we have not reported them separately.

Only indirect or incomplete information is available on the billing costs of Canadian and U.S. physicians. We therefore used two different methods to estimate these costs, one based on physicians' reports of their professional expenses and the other on the numbers of employees in physicians' offices. The expense-based method (Method 1) probably overestimates the actual difference in billing costs between the two nations, whereas the personnel-based approach (Method 2) may underestimate the difference.

Our first approach, Method 1, rests on the assumption that the entire difference in physicians' billing and overhead expenses (excluding malpractice premiums[11,12]) between the United States and Canada is attributable to the excess administrative costs borne by American doctors. The American Medical Association (AMA) estimates U.S. physicians' incomes and practice expenses on the basis of the results of a survey of a representative sample of nonfederal, practicing physicians (excluding interns and residents).[12] Revenue Canada tabulates physicians' professional expenses on the basis of tax returns (Rehmer L, Health Information Division, Health and Welfare Canada: personal communication). Because these figures are "distorted, primarily because of the way group practice physicians tend to report expenses" (Rehmer L, Health Information Division, Health and Welfare Canada: personal communication), we used Revenue Canada's corrected tabulation, which included only the 91 percent of physicians who reported professional expenses amounting to between 5 percent and 300 percent of their net incomes. We added to both the U.S. and Canadian figures an estimate of the value of the physicians' time devoted to billing[13] (and Peachey D: personal communication); we assumed that this time was valued at the same rate as other professional activity.

Using Method 2, we also estimated physicians' billing costs on the basis of data on the number of clerical and managerial personnel employed in their offices, as well as the costs of outside billing services. For the United States, we obtained information on physicians' office personnel from data tapes from the Census Bureau's March 1988 Current Population Survey (CPS).[14] Since comparable survey data were unavailable for Canada, we used information from a detailed study of office staffing patterns in the province of Quebec in 1977.[15] These earlier figures were slightly higher than informal current estimates provided by the Ontario Medical Association (Peachey D: personal communication). For both the United States and Canada, we assumed that the total annual cost per employee averaged $35,000 (including wages, benefits, taxes, work space, equipment, telephone, supplies, and other costs attributable to the employee) and that the ratio of clerical workers to physicians (excluding residents) was identical in offices and other settings. We added to both the U.S. and Canadian figures estimates of the value of physicians' personal time spent on billing, calculated as described above. For the United States we added the cost of outside billing services as determined by a recent survey by the AMA.[13]

Finally, to evaluate trends over time, we recalculated the 1987 figures to maintain strict comparability with the less detailed and less complete data for 1983.[3] As in our earlier paper,[2] we estimated physicians' billing and overhead costs by the expense-based method (Method 1). However, we excluded the cost of physicians' time spent on billing because comparable data were unavailable for 1983. In keeping with our earlier method, we included malpractice costs in physicians' overhead expenses but corrected for increases over time in these costs.[11,12,16] For each country we took average total professional expenses in 1987, subtracted the average 1987 malpractice premium, then added the average 1983 malpractice premium (all expressed as a percentage of gross income). The 1983 figures were converted to 1987 dollars with use of the gross-domestic-product price index for each country.[17]

Results

Insurance Overhead

In 1987 private insurance firms in the United States retained $18.7 billion for administration and profits out of total premium revenues of $157.8 billion.[3] Their average overhead costs (11.9 percent of premiums) were considerably higher than the 3.2 percent administrative costs of government health programs such as Medicare and Medicaid ($6.6 billion out of total expenditures of $207.3 billion).[3] Together, administration of private and public insurance programs consumed 5.1 percent of the $500.3 billion spent for health care, or $106 per capita.

The overhead costs for Canada's provincial insurance plans amounted to $235 million (0.9 percent) of the $26.57 billion spent by the plans[17] (and Health Information Division, Health and Welfare Canada: personal communication). The administrative costs of Canadian private insurers averaged 10.9 percent of premiums ($200 million of the $1.83 billion spent for such coverage) (Health Information Division, Health and Welfare Canada: personal communication). Total administrative costs for Canadian health insurance consumed 1.2 percent of health care spending, or $17 per capita.

Hospital Administration

Hospital administration represented 20.2 percent of hospital costs in California in 1987–1988.[18] Extrapolating this figure to the total U.S. hospital expenditures of $194.7 billion in 1987[2] yielded an estimate of $39.3 billion, or $162 per capita, consumed by hospital administration. In Canada, hospital administration cost $1.27 billion, amounting to 9.0 percent of total hospital expenditures of $14.14 billion (Health Information Division, Health and Welfare Canada: personal communication), or $50 per capita.

Nursing Home Administration

The administrative costs in California's nursing homes accounted for 15.8 percent of total revenues in 1987–1988.[19] On the basis of this figure, we estimate that administration cost $6.4 billion of the $40.6 billion spent nationally for nursing home care,[3] or $26 per capita. Canadian nursing homes spent $231 million on administration in 1987–1988, amounting to

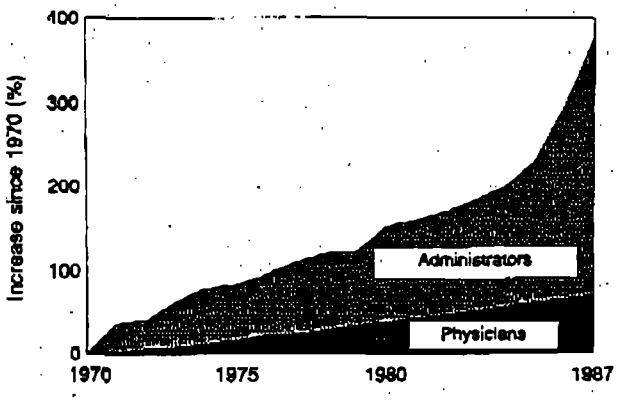


Figure 1. Growth in the Numbers of Physicians and Health Care Administrators from 1970 to 1987.

The data are from *Statistical Abstract of the United States* for these years (Table 64-2, 109th edition).[1] Because of a modification in the Bureau of the Census' definition of "health administrators," the change between 1982 and 1983 is interpolated rather than actual.

13.7 percent of the total expenditures of $1.69 billion (Statistics Canada, Canadian Center for Health Information: personal communication), or $9 per capita.

Physicians' Billing Expense

Method 1

When calculated according to Method 1, U.S. physicians' overhead and billing expenses, excluding malpractice premiums, made up 48.7 percent of their gross professional income[12] — $44.9 billion of the $102.7 billion spent for physicians' services.[3] In addition, physicians spent an average of six minutes on each Medicare and Blue Shield claim.[13] Assuming that the time required to bill other insurers was similar, the average physician spent about 134.4 hours per year (4.4 percent of his or her total professional activity) on billing; this time had a total value of $4.5 billion. Thus, the total value of U.S. physicians' billing and overhead was $49.4 billion, or $203 per capita.

Canadian physicians' professional expenses, excluding malpractice premiums, amounted to $1.99 billion, or 34.4 percent of their gross income (Rehmer L: personal communication). According to the director of professional affairs of the Ontario Medical Association, "The commitment of time to billing . . . is trivial and can be measured in seconds [per claim]" (Peachey D: personal communication). Assuming that the average physician spends 1 percent of his or her professional time on billing, with a total value of $58 million annually, the total cost of physicians' billing and overhead was $2.04 billion, or $80 per capita.

Method 2

The average office-based physician in the United States employed 1.47 clerical and managerial workers (Himmelstein DU, Woolhandler S: unpublished data), at an annual cost of $51,564 per physician, for a total of $20.0 billion. As calculated above (Method 1), the time physicians spent on billing was valued at $4.5 billion. In addition, 13.9 percent of physicians contracted with outside billing firms, at an average annual cost of $23,196 each,[14] for a total of $1.3 billion. Physicians' total billing and clerical expenses amounted to $25.8 billion, or $106 per capita.

The average office-based general practitioner in Quebec employed 0.733 receptionists and secretaries[15] at an annual cost of $25,655 per physician, for a total of $1.0 billion for Canadian physicians. In addition, the time physicians spent on billing was valued at $58 million. Physicians' total billing and clerical expenses were thus $1.06 billion, or $41 per capita.

Total Costs of Administration

Table 1 summarizes the per capita costs of health care administration in the United States and Canada, including physicians' billing and overhead costs as calculated by the two different methods. Overall expenditures for health care administration in the United States totaled $96.8 billion to $120.4 billion ($400 to $497 per capita), accounting for 19.3 to 24.1 percent of the $500.3 billion spent for health care. Canadians spent $3.00 billion to $3.98 billion for health care administration ($117 to $156 per capita), amounting to 8.4 to 11.1 percent of the $35.9 billion spent for health care. The difference of $283 to $341 in the per capita cost of health care administration and billing accounted for 43.5 to 52.5 percent of the total difference in health spending between the two nations. If U.S. health care administration had been as efficient as Canada's, $69.0 to $83.2 billion (13.8 to 16.6 percent of total spending on health care) would have been saved in 1987.

The difference between the United States and Canada in billing and administrative costs has markedly increased since 1983.[2] Insurance overhead in the United States has risen from 4.4 percent to 5.1 percent of total health care spending, whereas insurance overhead in Canada has declined from 2.5 percent to

Table 1. Cost of Health Care Administration in the United States and Canada, 1987.

Cost Category	Spending per Capita*	
	U.S.	Canada
Insurance administration	106	17
Hospital administration	162	50
Nursing home administration	26	9
Physicians' overhead and billing expenses		
Expense-based estimate	203	80
Personnel-based estimate	106	41
Total costs of health care administration†		
High estimate	497	156
Low estimate	400	117

*All costs are expressed in U.S. dollars.

†The high estimate incorporates physicians' administrative costs derived by the expense-based method, and the low estimate costs derived by the personnel-based method.

07/10/95 17:07 ☎ 005

1.2 percent.[2] Hospital administrative costs have risen from 18.3 percent to 20.2 percent of total hospital spending in the United States, whereas in Canada these costs have climbed slightly from 8.0 percent to 9.0 percent.[2] Administrative expenses in U.S. nursing homes rose from 14.4 percent to 15.8 percent of costs, whereas administration's share of total costs rose from 10.5 to 13.7 percent in Canada.[2] Physicians' professional expenses (excluding malpractice premiums) have increased from 41.4 percent to 43.8 percent of gross income in the United States, whereas the Canadian figure declined from 35.5 percent to 34.4 percent.[2]

When we recalculated the 1987 figures to maintain comparability with the less complete 1983 data, we found that U.S. administrative costs rose from 21.9 percent to 23.9 percent of health care spending between 1983 and 1987, whereas in Canada administrative costs declined from 13.7 percent to 11.0 percent.[2] After adjustment for inflation, the divergence was even more striking. The costs of the health care bureaucracy in the United States rose by $32.2 billion (37 percent) between 1983 and 1987, an increase of $118 per capita. Administrative costs in the Canadian health care system fell by $161 million during this period, a decrease of $6 per capita.

Discussion

Most of our analysis is based on well-substantiated data, although in some areas reliable figures are sparse. The comparability of the data on hospital administrative costs in Canada and the United States is uncertain. However, we relied on detailed budgetary categories that appeared closely matched in the two nations. Although data on the administrative costs of health maintenance organizations are limited, they do not appear to differ substantially from those in the U.S. fee-for-service sector.[20-22]

Both of our methods for estimating physicians' billing costs are imprecise. The expense-based method (Method 1) may overstate the difference between the United States and Canada, since it assumes that the entire discrepancy in the proportion of income devoted to professional expenses was accounted for by malpractice premiums, billing, and administration. The personnel-based method (Method 2) may understate the difference because it assumes that aides and other clinical personnel employed in physicians' offices performed no activities related to billing, that the total annual cost per clerical worker was no less in Canada than in the United States, and that Canadian billing operations have not been streamlined since 1977 despite computerization. An official of the Ontario Medical Association estimates that electronic claims submission and reconciliation takes about one sixth as much staff time as paper-based billing (Peachey D: personal communication).

In the United States, clerical and managerial staff accounted for 59.5 percent of the nonphysician employees in doctors' offices in 1988, and 74,700 more were added over the ensuing two years (Himmelstein DU, Woolhandler S: unpublished data). In contrast, technicians and technologists accounted for only 7.3 percent of nonphysician office workers in 1988 and for only 5.7 percent in 1990 (Himmelstein DU, Woolhandler S: unpublished data). In 1988, the staff in a typical U.S. physician's office spent about one hour on each Blue Shield or Medicare claim,[13] at least 20 times more than in Ontario (Peachey D: personal communication; Weinkauf D: personal communication). In a typical practice in Canada, "One person does all the billing, bookkeeping and typing . . . for 8 physicians."[23]

Our estimates omit the administrative costs of union and employer health-benefit programs and the administrative work done by hospital nurses and other nonphysician clinical personnel — all probably greater in the United States than in Canada. Moreover, patients in the United States spend far more time (and anguish) on insurance paperwork than do Canadians; these costs are not reflected in our figures. On the other hand, some argue that funding health services through taxes, as in Canada, erodes productivity throughout the economy by discouraging work and investment — the so-called dead-weight loss.[24] Within the range of tax rates in North America, however, the magnitude, and even existence, of this dead-weight loss is controversial.[25]

The United States spent 37 percent more in real dollars on health administration in 1987 than in 1983.[2] The recent quest for efficiency has apparently amplified inefficiency. Cost-containment programs predicated on stringent scrutiny of the clinical encounter have required an army of bureaucrats to eliminate modest amounts of unnecessary care. Each piece of medical terrain is meticulously inspected except that beneath the inspectors' feet. Paradoxically, the cost-management industry is among the fastest-growing segments of the health care economy and is expected to generate $7 billion in revenues by 1993.[26] The focus on micromanagement has obscured the fundamentally inefficient structure required to implement such policies. In contrast, Canada has evolved simple mechanisms to enforce an overall budget, but it allows doctors and patients wide latitude in deciding how the funds are spent. Reducing our administrative costs to Canadian levels would save enough money to fund coverage for all uninsured and underinsured Americans.[27] Universal comprehensive coverage under a single, publicly administered insurance program is the sine qua non of such administrative simplification.

The fragmented and complex payment structure of the U.S. health care system is inherently less efficient than the Canadian single-payer system. The existence of numerous insurers necessitates determinations

of eligibility that would be superfluous if everyone were covered under a single, comprehensive program. Rather than a single claims-processing apparatus in each region, there are hundreds. Fragmentation also reduces the size of the insured group, limiting savings from economies of scale. Insurance overhead for U.S. employee groups with fewer than 5 members is 40 percent of premiums but falls to 5.5 percent for groups of more than 10,000.[28] Competition among insurers leads to marketing and cost shifting, which benefit the individual insurance firm but raise systemwide costs.

A lack of comprehensiveness in coverage also drives up administrative costs. Copayments, deductibles, and exclusions are expensive to enforce and lead many enrollees to purchase secondary "Medigap" policies. The secondary insurers maintain redundant and expensive bureaucracies.[29]

The efficiency of U.S. health care is further compromised by the extensive participation of private insurance firms whose overhead consumes 11.9 percent of premiums, as compared with 3.2 percent in U.S. public programs.[3] Even the "public" figure reflects the inefficiency of the private firms that process claims for Medicare for an average of $2.74 per claim,[30] whereas Ontario's Ministry of Health processes claims for $0.41 each (Davis J: personal communication). Moreover, the inefficiency of private insurers is not unique to the United States. The small private-insurance sectors of Canada, the United Kingdom, and Germany have overheads of 10.9 percent, 16 percent, and 15.7 percent, respectively.[31,32] A major advantage of public programs in terms of efficiency is their use of existing tax-collection structures, obviating the need for a redundant bureaucracy to collect money for health services. Thus, the overhead in Germany's premium-based, quasi-public sickness funds is between 4.6 percent[33] and 4.8 percent (Kuhn H: personal communication) — considerably higher than the overhead in tax-funded systems.

The scale of waste among private carriers is illustrated by Blue Cross/Blue Shield of Massachusetts, which covers 2.7 million subscribers and employs 6682 workers[34] — more than work for all of Canada's provincial health plans, which together cover more than 25 million people[7-10] (and Davis J: personal communication; Cunningham D: personal communication); 435 provincial employees administer the coverage for more than 3 million people in British Columbia (Cunningham D: personal communication).

The existence of multiple payers in the United States also imposes bureaucratic costs on health care providers. Hospitals must bill several insurance programs with varying and voluminous regulations on coverage, eligibility, and documentation. Moreover, billing on a per-patient basis requires an extensive internal accounting apparatus for attributing costs and charges to individual patients and insurers. In contrast, Canada's single-payer system funds hospitals through global budgets, eliminating almost all hospital billing. The striking administrative efficiency of the Shriners' hospitals in the United States, which bill neither patients nor third parties and devote only 2 percent of their revenues to administration,[35] suggests that payment mechanisms rather than cultural or political milieus determine administrative costs. Here, too, the European experience parallels North America's. British hospitals that are assigned global budgets devote 6.9 percent of spending to administration,[36] but those paid on a per-patient basis (such as Humana's Wellington Hospital in London) spend 18 percent.[37]

The synchronous growth of bureaucratic profligacy and unmet health needs is reminiscent of Dickens' somber tale of six poor travelers who were relegated to outbuildings when the hostel built for them was fully occupied by its charitable administrators.

> I found, too, that about a thirtieth part of the annual revenue was now expended on the purposes commemorated in the inscription over the door; the rest being handsomely laid out in Chancery, law expenses, collectorship, receivership, poundage, and other appendages of management, highly complimentary to the importance of the six Poor Travellers.[38]

The house of medicine is host to a growing array of specialists in fields unconnected to healing. At its present rate of growth, administration will consume a third of spending on health care 12 years hence, and half of the health care budget in the year 2020.

We are indebted to Mr. Lothar Rehmer, Ms. Judith Dowler, Dr. Jane Fulton, and Mr. Gilles Fortin for providing much of the raw data on Canadian health spending and to Dr. David H. Bor for his invaluable advice.

References

1. Bureau of the Census. Statistical abstract of the United States. 102nd–109th eds. Washington, D.C.: Government Printing Office, 1981–1989.
2. Himmelstein DU, Woolhandler S. Cost without benefit: administrative waste in U.S. health care. N Engl J Med 1986; 314:441-5.
3. Letsch SW, Levit KR, Waldo DR. National health expenditures, 1987. Health Care Financ Rev 1988; 10(2):109-22.
4. American Hospital Association. Hospital statistics: 1984 ed. Chicago: American Hospital Association, 1984.
5. *Idem*. Hospital statistics: 1988 ed. Chicago: American Hospital Association, 1988.
6. Hospital statistics 1986–1987. Toronto: Queen's Printer, 1987.
7. Ontario Ministry of Health. Annual report 1988–89. Kingston: Ontario Ministry of Health, 1989.
8. Regie de L'assurance-maladie du Quebec. Rapport Annual 1986–1987. Quebec: Government of Quebec, 1987:30 pp.
9. Saskatchewan Medical Care Insurance Commission. Annual report 1985–86. Regina: Government of Saskatchewan, 1986.
10. Nova Scotia Medical Services Insurance. Annual statistical tables: fiscal year 1985–86. Halifax: Government of Nova Scotia, 1986:3.
11. Canadian Medical Protective Association (CMPA) membership fees, 1971–1990. Toronto: Canadian Medical Association, 1989.
12. Gonzalez ML, Emmons DW, eds. Socioeconomic characteristics of medical practice 1989. Chicago: American Medical Association, 1989.
13. AMA Center for Health Policy Research. The administrative burden of health insurance on physicians. SMS Report 1989; 3(2):2-4.
14. Bureau of the Census. Current population survey, March 1988: technical documentation. Washington, D.C.: Department of Commerce, 1988.
15. Berry C, Brewster JA, Held PJ, Kehrer BH, Manheim LM, Reinhardt U. A study of the responses of Canadian physicians to the introduction of universal medical care insurance: the first five years in Quebec. Princeton, N.J.: Mathematica Policy Research, 1978.

07/10/95 17:08 ☎ 007

renal tubules. This is usually accomplished by the infusion of solutions containing 5 percent dextrose, potassium, and 50 to 100 mmol of sodium bicarbonate per liter. While administering ondansetron with the use of this solution, we noted the faint appearance of a cloudy precipitate in the intravenous tubing.

To assess this, we prepared a solution of ondansetron (0.32 mg per milliliter) in 5 percent dextrose and water, and a solution of 5 percent dextrose with 20 mmol of potassium chloride and 50 mmol of sodium bicarbonate per liter. At room temperature (24°C) the pH values of the ondansetron solution and the bicarbonate solution were 4.0 and 8.6, respectively. When we combined 5 ml of each solution, a white precipitate formed immediately, and it became more prominent during the first minute. The pH of this solution was 7.8. We had to titrate this solution with hydrochloric acid to a pH of 6.2 before all of the crystals dissolved. When we titrated the solution of ondansetron (0.32 mg per milliliter) with the bicarbonate solution, a visible precipitate in the test tube first formed when the pH was 7.0.

In summary, we wish to call the attention of physicians, nurses, and pharmacists to the instability of concentrated solutions of ondansetron in an alkaline environment. To prevent the precipitation of ondansetron in the intravenous tubing of a patient receiving an alkaline solution, the access line should be flushed both before and after the infusion.

PAUL F. JAROSINSKI, P.D.
National Institutes of Health

STEVEN HIRSCHFELD, M.D., PH.D.
Bethesda, MD 20892 National Cancer Institute

1. Cubeddu LX, Hoffmann IS, Fuenmayor NT, Finn AL. Efficacy of ondansetron (GR 38032F) and the role of serotonin in cisplatin-induced nausea and vomiting. N Engl J Med 1990;322:810-6.
2. Marty M, Pouillart P, Scholl S, et al. Comparison of the 5-hydroxytryptamine$_3$ (serotonin) antagonist ondansetron (GR 38032F) with high-dose metoclopramide in the control of cisplatin-induced emesis. N Engl J Med 1990; 322:816-21.

The above letter was referred to Glaxo Inc. (the maker of ondansetron), which offers the following reply:

To the Editor: Drs. Jarosinski and Hirschfeld describe the incompatibility of ondansetron with sodium bicarbonate used to alkalinize the urine, in this instance before high-dose methotrexate therapy. Their letter illustrates the importance of determining the compatibility of combinations of drugs before the drugs are administered.

Sodium bicarbonate (pH, 7.4 to 8.5) is known to be incompatible with acidic drugs.[1] Thus, Jarosinski and Hirschfeld might have anticipated the precipitation they describe if they had noted that the pH of ondansetron hydrochloride (Zofran injection) is 3.3 to 4.0.[2-4] A recently published study by Trissel et al.[5] evaluated the physical compatibility of ondansetron with 80 drugs commonly given to patients with cancer. The results indicated that ondansetron tends to be incompatible with drugs that have alkaline pH values.

Flushing is always a safe alternative when the compatibility of solutions of two (or more) drugs has not been established. In this case, ondansetron and sodium bicarbonate could have been administered through the same line with adequate flushing, as suggested by the authors.

Finally, when published information is not available, the manufacturer may be a helpful source of unpublished information about the compatibility of different drugs.

JANET FOX, PHARM.D.
Research Triangle Park, MARTHA IKEDA, PHARM.D.
NC 27709 Glaxo Inc. Research Institute

1. USP DI. Drug information for the health care provider. 11th ed. Rockville, Md.: United States Pharmacopeial Convention, 1991.
2. Product information for Zofran® injection. Research Triangle Park, N.C.: Glaxo, 1991.
3. Trissel LA. Handbook on injectable drugs. 6th ed. Suppl. Bethesda, Md.: American Society of Hospital Pharmacists, 1991.
4. Leak RE, Woodford JD. Pharmaceutical development of ondansetron injection. Eur J Cancer Clin Oncol 1989;25:Suppl 1:S67-S69.
5. Trissel LA, Tramonte SM, Grilley BJ. Visual compatibility of ondansetron hydrochloride with selected drugs during simulated Y-site injection. Am J Hosp Pharm 1991;48:988-92.

CUTANEOUS SEEDING OF GALLBLADDER CANCER AFTER LAPAROSCOPIC CHOLECYSTECTOMY

To the Editor: A 58-year-old woman was hospitalized with a two-month history of pain in the right hypochondrium. Ultrasonography demonstrated a contracted gallbladder containing a stone. Endoscopic retrograde cholangiography showed no stones in the common bile duct. Laparoscopic cholecystectomy was done. The gallbladder was dissected from the liver with cautery and removed through a small incision in the left hypochondrium, as described by Perissat et al.[1] The incision track had to be enlarged because the gallbladder contained a stone that was 3 cm in diameter and the wall of the gallbladder was thickened.

The patient recovered quickly and was discharged. Histologic examination of the gallbladder showed chronic cholecystitis as well as an unexpected adenocarcinoma invading the serosa. Three months later, as radiotherapy on the gallbladder area was being initiated, the patient was found to have a painful subcutaneous nodule at the site of the incision in the left hypochondrium. No other skin nodules were present. Abdominal ultrasonography and CT scanning showed no other tumor masses or ascites. The nodule was excised; histologic examination revealed adenocarcinoma. The histologic findings were identical to those of the resected gallbladder carcinoma. Four months later, the patient was alive, but had recurrent cancer.

It appears reasonable to assume that this patient's skin nodule was due to the dissemination of cancer cells in the track through which the carcinomatous gallbladder was removed. Such a complication was not described in two large series of laparoscopic cholecystectomies.[2,3] The use of a cellophane gallbladder bag initially designed to prevent the leakage of bile or gallstones into the peritoneal cavity could prevent this complication.

FRANÇOIS DROUARD, M.D.
Saint-Quentin 02321, France Centre Hospitalier Général

JACQUES DELAMARRE, M.D.
JEAN-PIERRE CAPRON, M.D.
Amiens 80054, France Centre Hospitalier Universitaire

1. Perissat J, Collet D, Belliard R, Dost C, Bikandou G. Cholécystectomie par laparoscopie: la technique opératoire: les résultats des 100 premières observations. J Chir (Paris) 1990;127:347-55.
2. The Southern Surgeons Club. A prospective analysis of 1518 laparoscopic cholecystectomies. N Engl J Med 1991;324:1073-8.
3. Cuschieri A, Dubois F, Mouiel J, et al. The European experience with laparoscopic cholecystectomy. Am J Surg 1991;161:385-7.

ADMINISTRATIVE EFFICIENCY OF THE U.S. HEALTH CARE SYSTEM

To the Editor: Woolhandler and Himmelstein (May 2 issue)* suggest that an excessive and inefficient administrative structure is the villain behind this nation's health care crisis. They arrive at this conclusion by comparing health care expenses in Canada and the United States. To make the comparison, the authors draw on highly questionable data and extrapolations that are precariously broad — for example, data on administrative costs that are outdated, not necessarily representative, and based on incomplete reports and personal communications. The authors use administrative-cost data for hospitals and nursing homes in California as a basis for extrapo-

*Woolhandler S, Himmelstein DU. The deteriorating administrative efficiency of the U.S. health care system. N Engl J Med 1991;324:1253-8.

07/10/95 17:09 ☎ 008

lation nationwide, assuming little variation in health care costs and practices in the United States. Clearly, their conclusions are overly simplistic.

As a member of the *House Ways and Means Committee*, I recently attended five days of committee hearings and a three-day committee seminar devoted solely to health care costs and issues of access. Expert after expert told the committee how much the United States spends on health care and roughly how much of the cost results from price inflation, the higher intensity and volume of services, and an aging population. However, no expert could adequately quantify the factors driving the increasing costs of hospital and physician care.

Physicians and hospital managers have shown that medical liability, redundant government requirements, and an excessive burden of paperwork are making health care more expensive than it needs to be. Researchers report that too many health services are ordered unnecessarily or inappropriately. In addition, hospitals and physicians in every community seem to have a "keep up with the Joneses" attitude, which results in overbuilding and excessive diffusion of expensive technology.

Policy makers in Congress and the private sector need to know the extent and effects of these and other factors that increase costs. Only then can problems be defined realistically and appropriate policies developed to address inefficiencies.

Frankly, the Canadian model that Woolhandler and Himmelstein advocate for this country is not so enticing. Rates of growth in per capita expenses in Canada and the United States during the past decade are comparable, despite the use of price and budget controls in Canada. Furthermore, examples abound of long queues and lack of access to sophisticated medical care in Canada. Before we rush to replicate the Canadian system, we need to examine and understand its problems.

BILL ARCHER
U.S. House of Representatives
Washington, DC 20515

To the Editor: Although the study by Woolhandler and Himmelstein is consistent with the self-evident concept that a single-payer health care system has lower administrative costs than a multipayer system, it fails to support their conclusions that the Canadian-style approach is unique or necessary for cost saving, or that such saving improves efficiency.

The authors claim to use "well-substantiated data," but they disclose that their hospital data are from only one state, allege them to parallel those for two other states,[1] and then assume that they describe all hospitals serving the rest of the U.S. population. The overhead of nursing homes in California alone is extrapolated to the entire United States without any support. An analysis based on assumption and extrapolation is intrinsically limited.

Even so, labeling a comparison of the U.S. and Canadian systems an "efficiency study" twists the very concept of efficiency. One system is more efficient than another if it produces more or better output for equal input or if it produces equal output for less input. The authors imply that the Canadian system produces the same product with less overhead. But the literature suggests that the Canadian system of health care produces long waits for major surgery,[2,3] extended lengths of stay,[4] and a limited choice of services.[5] Such a system can result in private funding for up to 17 percent of all elective surgery, 70 percent of hospice care, and virtually all nursing home beds.[6] Currently, 3500 residents of Ontario are choosing the United States for drug and alcohol treatment alone,[7] and the costs of the exodus from Ontario for all types of care increased 45 percent in 1990.[7] Publicly administered programs certainly result in a different product, and one that may result in the hidden administrative costs of prolonged morbidity.

U.S. citizens surely prefer freedom to choose from a wider range of services that are conveniently available, even at higher cost, to the uniform, choiceless, government-operated system the authors support. Even if the opposite is true, the authors provide no support for concluding that alternative actions cannot save costs. Without changing the basic nature of our health care system, federal legislation could reduce administrative costs caused by our tort system and state-to-state variation in insurance benefits. In sum, the challenge for the United States is not to change our apple into their orange, but to make our apple better.

RICHARD LAUVE, M.D.
Louisiana State University
Medical Center
New Orleans, LA 70112

HUGH W. LONG, PH.D.
Tulane University
New Orleans, LA 70118

1. Himmelstein DU, Woolhandler S. Cost without benefit: administrative waste in U.S. health care. N Engl J Med 1986;314:441-5.
2. Iserr JM. A comparison of expenditures for physicians' services in the United States and Canada. N Engl J Med 1991;324:566-7.
3. Breo DL. Universal Medicare: the Canadian experience. American Medical News. March 10, 1989:3, 38, 39.
4. Schieber GJ, Poullier JP. International health spending and utilization trends. Health Aff (Millwood) 1988;7(4):105-12.
5. Friedman EA. Treatment of end-stage renal disease in Canada. N Engl J Med 1991;324:1067-8.
6. Lister J. Proposals for reform of the British National Health Service. N Engl J Med 1989;320:877-80.
7. Borsellio M. U.S. hospitals, doctors milking 'Canadian cash cows.' Medical Post. January 29, 1991:16.

To the Editor: Many of the figures used by Woolhandler and Himmelstein are based on personal communications that no reader can verify independently. The authors assume that administrative costs are overhead costs, so they count the costs of supplies, rent, equipment, and professional-liability insurance as if they were administrative expenses that would disappear in a one-payer scheme of national health insurance. The appropriate method of cost analysis is marginal cost analysis, or what accountants call differential cost analysis. Even if one accepts that American physicians spend about 44 percent of their gross income on administrative costs, the savings in moving to a universal one-payer system would be considerably less. The costs of operating a physician's office and of utilities, supplies, and rent cannot all be counted as administrative waste in the American health care system.

Furthermore, the figures for physicians' administrative expenses in the United States are probably overstated, because the data were reported by physicians to the American Medical Association (AMA). The Canadian figures were from the tax records. The cost analysis for the hospital sector represents even more of a comparison between apples and oranges. It is a surprise that the authors selected California hospitals to serve as their yardstick of hospital administrative expenses in the United States. With more carriers of commercial insurance doing business and because of competitive-bidding programs, hospital administrative costs are higher in California than elsewhere in the United States. The figures given for the Canadian health care system are low estimates, for several reasons: the education department pays for teaching-hospital expenses that are not included in the health budget, Canadian government officials do not record indirect administrative expenses, such as that of processing claims, and the authors do not consider the additional costs of collecting more revenue through the tax system.

STEVEN R. EASTAUGH, SC.D.
George Washington University, School of Business
JANET A. EASTAUGH, M.D.
Providence Hospital
Washington, DC 20008

To the Editor: It is essential that we continue to minimize the administrative costs of health care. However, Woolhandler and Himmelstein overstate the administrative load in the U.S. health care system and understate it in the Canadian system. First, insurance overhead includes local, state, and federal taxes that would have to be replaced were the United States to adopt a Canadian health care system. Consequently, the article overestimates the administrative burden of insurance in the United States by about 15

07/10/95 17:10 ☎ 009

percent. Second, the U.S. insurance overhead includes the cost of capital, whereas the Canadian government's borrowing costs are excluded. Furthermore, under the authors' Method 1, the bulk of the difference in physicians' administrative costs is derived from the acceptance of an AMA allocation of 44 percent of physicians' gross income to "overhead and billing," as compared with 34 percent in "professional expenses" for Canadian physicians. Aside from differences in the definitions of these two terms, the authors appear to exclude differences in the costs of labor, supplies, medical equipment, and rent, and the greater availability of expensive technology in the United States, instead treating them all as administrative expenses lumped with billing and other expenses peculiar to the payment system.

In addition, the authors' estimates that physicians spend six minutes and clerical staff spend one hour on each claim are based on a single self-reported survey, one that would probably not be supported by a time-and-motion study. Moreover, the authors do not address the implicit costs associated with the obligation of Canadian physicians and hospital administrators to allocate limited funds among the patients with the most critical needs. The commitment of physicians' time to managing waiting lines is not trivial. Finally, the authors' use of the concept of the exchange rate to normalize prices, rather than the more widely accepted concept of purchasing-power parity in currency conversion (which takes into account the real purchasing power of countries) overstates the true difference in administrative costs.

Although government monopolies can limit marketing and billing expenses, Woolhandler and Himmelstein appear to have seriously overestimated what these expenses might be in the U.S. health care system. Government monopolies can also extract substandard prices from sellers of goods and services on a temporary basis, and can limit investment in expensive forms of technology and therefore access to them.

EDMUND F. KELLY
Aetna
Hartford, CT 06156

To the Editor: Woolhandler and Himmelstein assert that physicians' clerical staffs spend one hour per insurance claim. AMA data show that physicians average about 120 patient visits per week,[1] most of which generate a claim. If one accepts the authors' statement that an average physician employs 1.47 clerical personnel, each clerical employee would be required to work more than 80 hours per week processing claims. Common sense tells us this is unlikely.

In addition, the authors state that doctors spend 6 minutes per claim, which would mean they would have to spend more than 12 hours per week personally processing claims. However, AMA data show that physicians spend an average of about 53 hours per week on all activities involving patients, including 49 hours in direct care.[1] If this is so, physicians in reality spend only 4 hours per week on other activities, such as administration — far less than the 12 hours of claims-related activities estimated by Himmelstein and Woolhandler.

The authors were also unaware of, or just ignored, other important data. According to the Congressional Budget Office, from 1980 to 1987, per capita health costs increased faster in Canada than in the United States (by 38 percent vs. just over 33 percent).[2]

Finally, the authors glaringly ignore important inherent differences between the two countries, such as the greater investment in quality assurance in the United States, the litigious nature of U.S. society, and major social and demographic differences in such areas as income, social and ethnic characteristics, language, expectations, and problems associated with the crime rate and drug abuse.

MILFORD C. MALONEY, M.D.
American Society of Internal Medicine
Washington, DC 20005

1. Gonzalez ML, ed. Socioeconomic characteristics of medical practice, 1990/1991. Chicago: American Medical Association, 1991.
2. Langwell KM. Rising health care costs: causes, implications, and strategies. Washington, D.C.: Government Printing Office, 1991.

The above letters were referred to the authors of the article in question, who offer the following reply:

To the Editor: We used data on administrative costs for California hospitals because they are the only relevant published figures, and there is good evidence that they are representative of the nation. Four years before conducting the present study, we confirmed that the administrative costs of California hospitals were almost identical to those in Florida and Texas,[1] and the representativeness of these earlier data was substantiated by comparison with data from five additional states.[2] Since then, the use of the diagnosis-related-group system has attenuated local differences in hospital administration, and changes in California's staff-to-bed ratio, costs, and length of stay are virtually identical to those nationwide.[3,4]

Archer considers our 1987 data outdated. More recent, though fragmentary, figures indicate further deterioration in administrative efficiency. The overhead for private insurance climbed 20 percent in 1989 and is projected to reach $45 billion in 1991, as compared with our figure of $18.7 billion for 1987.[5]

Privately funded care is rare in Canada, contrary to the misleading British statistics that Leave and Long cite. Canadians report fewer nonfinancial barriers to care than Americans, visit doctors more often, have more procedures and hospital days, live longer, have a freer choice of providers, and are more satisfied with their care, while spending about $1,000 less per capita on it.[6-8] About half this difference is accounted for by bureaucratic costs. Demography and accounting practices explain only a tiny fraction.[9] Alcohol and tobacco cause the vast majority of illnesses related to substance abuse in both nations, and this abuse is more prevalent in Canada.[10] At any given level of health spending, Canada's system produces more care and less paper.

Contrary to the Eastaughs' assertions (and as described in our Methods section), we treated as administrative excess only the portions of physicians' overhead that exceeded the comparable Canadian figure; we excluded malpractice premiums and educational expenses and included claims-processing costs in Canada. The overhead costs of collecting more revenues through the existing apparatus of the Internal Revenue Service are negligible. These correspondents speculate that physicians overstate their overhead in confidential surveys but not when filing tax returns. We doubt it.

Kelly would subtract taxes from insurance overhead, but he neglects to add income earned by insurance companies from invested premiums. If both adjustments are made, our estimate changes little. Using purchasing-power parities would not change the proportion of health costs devoted to administration and would decrease our dollar estimates of potential savings by only 4 percent. There is no evidence that an observational study of physicians' billing would contradict the data in the AMA survey or that Canadians spend much time managing waiting lines. In contrast, the administrative work of patients, nurses, and social workers in the United States, who were excluded from our analysis, is substantial.

We estimated that physicians spend 2.6 hours per week on claims-related activities, not the 12 hours that Dr. Maloney attributes to us. He misinterprets the AMA data. The average physician spends 58 hours per week on professional activities, including administration.[11] The 53-hour figure includes only "direct patient care and activities related to patient care such as interpreting laboratory tests and consulting with other physicians."[11] Although physicians average 120 patient visits per week, the number of insurance claims is much lower. Physicians sometimes collect directly from patients, offer free care, or bill for several visits in a single claim. Our estimates of time spent in billing activities use AMA data collected as part of the larger survey Maloney cites, and are fully consistent with it.

Every personal communication cited in our paper was obtained in writing and forwarded to the editors of the *Journal*.

Even if every assertion made by our critics were credible, the potential administrative savings from implementing a Canadian-style system in the United States would still exceed 10 percent of health spending. The General Accounting Office recently estimated this savings at $67 billion in the first year alone and concluded, "If the United States were to shift to a system of universal coverage and

07/10/95 17:11 ☎ 010

a single payer, as in Canada, the savings in administrative costs would be more than enough to offset the expense of universal coverage."[6]

DAVID U. HIMMELSTEIN, M.D.
STEFFIE WOOLHANDLER, M.D., M.P.H.
2957 Tilden St., N.W.
Washington, DC 20008

1. Himmelstein DU, Woolhandler S. Cost without benefit: administrative waste in U.S. health care. N Engl J Med 1986;314:441-5.
2. Watt JM, Derzon RA, Renn SC, Schramm CJ, Hahn JS, Pillari GD. The comparative economic performance of investor-owned chain and not-for-profit hospitals. N Engl J Med 1986;314:89-96.
3. American Hospital Association. Hospital statistics. 1984 ed. Chicago: American Hospital Association, 1984.
4. *Idem.* Hospital statistics. 1988 ed. Chicago: American Hospital Association, 1988.
5. Department of Commerce. U.S. industrial outlook, 1991. Washington, D.C.: Government Printing Office, 1991.
6. General Accounting Office. Canadian health insurance: lessons for the U.S. Washington, D.C.: Government Printing Office, 1991. (GAO/HRD-91-90.)
7. Fuchs VR, Hahn JS. How does Canada do it? A comparison of expenditures for physicians' services in the United States and Canada. N Engl J Med 1990;323:884-90.
8. Blendon RJ. Three systems: a comparative survey. Health Manage Q 1989;11:2-19.
9. Waldo DR, Sonnefeld ST. U.S./Canadian health spending: methods and assumptions. Health Aff (Millwood) 1991;10(2):159-64.
10. National Center for Health Statistics, Stephens T, Schoenborn CA. Adult health practices in the United States and Canada. Vital and health statistics. Series 5, No. 3. Washington, D.C.: Government Printing Office, 1988. (DHHS publication no. (PHS)88-1479.)
11. Gonzalez ML, ed. Socioeconomic characteristics of medical practice, 1990/1991. Chicago: American Medical Association, 1991.

Letters to the Editor should be typed double-spaced (including references) with conventional margins. The length of the text is limited to 40 typewritten lines (excluding references). Abbreviations should not be used.

BOOK REVIEWS

UNDERSTANDING AND DIAGNOSING PEDIATRIC HEART DISEASE

By David W. Sapire. 197 pp., illustrated. Norwalk, Conn., Appleton and Lange, 1991. $35.

Heart disease in young patients often creates anxiety in physicians during their training and later in practice. Part of this fear is based on the mystique of the heart, part is due to the possibility of a life-threatening situation, and part is related to complex and ever-changing descriptions of clinical findings and therapeutic strategies. Sapire endeavors "to remove some of the mystery" of heart disease in infants and young children by providing a simplified, basic approach to clinical pediatric cardiology. The book is not intended as a reference source for the extensive variety of malformations and problems encountered in the practice of pediatric cardiology, but rather as a starting point for examining the infant and young child with suspected heart disease. To a large extent, the author has achieved his goal.

The first 5 of the book's 10 chapters are largely devoted to describing the pathophysiologic basis of the clinical findings in patients with congenital heart lesions. The next three chapters cover physical examination, electrocardiography, and roentgenology. Many clinical pearls regarding cardiologic physical diagnosis are included. The chapter on common conditions encountered in the practice of cardiology is short but surprisingly complete and interspersed with brief but helpful descriptions of hemodynamic pathophysiology. For the uninitiated, the final chapter describes current surgical management of simple and complex congenital malformations.

The book is clearly written and concise but reasonably comprehensive. Physical diagnosis, clinical descriptions, and basic noninvasive techniques are presented in an easy-to-understand format. The book is amply illustrated with diagrams that clarify and enhance the text. The references are limited to classic standard textbooks of pediatric cardiology, and the bibliography is extensive for a book of this length. Errors are rare.

Although this work purports to be a basic and simplified textbook on pediatric heart disease, most of it covers congenital cardiac malformations. Arrhythmias, Kawasaki disease, cardiomyopathies, and rheumatic fever receive little or no attention. Functional murmurs, which constitute the basis for 30 to 50 percent of referrals in outpatient cardiology, are dealt with in only a few short sentences. The clinical presentation of cyanotic spells due to the tetralogy of Fallot is inadequately described. The book suggests that intravenous propranolol is the indicated and definitive treatment for all such spells, a statement that would be disputed by many cardiologists. Other shortcomings are probably related to the experience of the author. For instance, Sapire suggests that the prognosis of the patient in whom an interrupted aortic arch is promptly repaired is good. This statement is true if posterior malalignment of the outlet septum, with resultant subaortic stenosis, is not present. Also, in many institutions, the mortality rate for the arterial-switch procedure for simple transposition of the great vessels is equal to or lower than the rate for the atrial switch. Cardiac transplantation as a therapeutic option is not discussed in any chapter. Finally, if the primary purpose of this book is to simplify the diagnosis and management of heart disease in the young, the inclusion of vectorcardiography, a complex subject at best, is somewhat paradoxical.

Despite the limitations discussed above, this book can be recommended to young physicians as an introductory textbook of pediatric cardiology. Practicing physicians who wish to be reacquainted with the basic principles of diagnostic cardiology may also find it helpful. Physicians who do avail themselves of the clearly presented approach to the diagnostic techniques discussed by Sapire may "call the cardiologist" a little less often.

J. PETER HARRIS, M.D.
University of Rochester
Medical Center
Rochester, NY 14642

FETAL HEART RATE MONITORING

Second edition. By Roger K. Freeman, Thomas J. Garite, and Michael P. Nageotte. 230 pp., illustrated. Baltimore, Williams and Wilkins, 1991. $48.

Intrapartum electronic monitoring of the fetal heart rate was introduced with great enthusiasm in the early 1970s. It was hoped that with the ability to recognize intrapartum fetal asphyxia and to intervene in a timely fashion, the incidence of neurologic injury to the fetus would be substantially reduced. Specifically, most cases of cerebral palsy were thought to arise during the intrapartum period, and it was hoped that this considerable source of morbidity could essentially be eliminated. Electronic monitoring was quickly adopted, and it became a standard of care by the end of the 1970s. During that decade, hundreds of publications documented associations between various patterns of the fetal heart rate and intrapartum events, medications, and interventions. Residency training programs scheduled weekly monitoring rounds at which "interesting tracings" were intently studied. Barely a whisper of dissent questioning the validity of the technique was heard.

During the 1980s, the utility of the technique was tested in randomized, controlled clinical trials. The first few trials that found no benefit from intrapartum monitoring were criticized for their small size. As such trials grew in size, including one involving almost 35,000 patients that was presented in the *Journal*, and still no benefit was found, they were criticized because they were conducted in term infants at low risk. In 1990 the results of neurologic evaluations of nearly 200 subjects in a randomized, controlled trial comparing

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

Reinventing

HEALTH CARE

Regulations

PRESIDENT BILL CLINTON
VICE PRESIDENT AL GORE

JULY 1995

TO: Hillary Rodham Clinton
FROM: Jennifer Klein J.K.
DATE: 7/12/95
RE: Press Clips on Regulatory Reform Event

I wanted to be sure you saw these. Media Affairs is putting together a comprehensive packet of press clips, but I thought you might be interested in what I've seen so far.

s 'urn In

'ag, Room for 36 Students

's a
hem
s of
and
sion
pro-
out
has
blic
the
pri-
ı of
and
Fu-
and
$6
as
and
ling
and
to
the
the
be
ure

would place the dorm's construction costs at higher than those of even the most expensive college residence halls, according to a survey by American School and University magazine. The survey of college dorms constructed in 1993 showed that the median per-resident cost was $25,991 and that the most expensive dorm had a per-resident cost of $63,889.

Raines defended the expense of the page dorm and school, saying that a lot of work, including landscaping and removal of underground storage tanks, had to be done to prepare the building for renovation. "It's nothing fancy about the building," he said. "It's simply a dorm."

The construction of a new Senate page dorm was authorized by Congress in 1992 and again in July 1993 after an earlier site became unavailable.

An aide to Senate Appropriations Committee Chairman Mark O. Hatfield (R-Ore.) said the Senate was forced to find a facility for its pages because the House had informed the body that it could no longer house Senate pages in its dorms. The House provides separate accommodations for its pages. "Certainly the acquisition was expensive," the aide said, "but it doesn't appear the Senate had any other choice."

But even liberal Democrats, when told the price tag, expressed concern. "Is that what it cost?" said Sen. Paul D. Wellstone (D-Minn.). Though he cautioned he did not know the circumstances surrounding the project, Wellstone added: "In this day and age, unless there was no other choice, it's better not to go [illegible] with that type of expansion.

Latest 'Reinventing' Proposals Take Aim at Health Forms

Gore, First Lady Announce Streamlining Plan

By Spencer Rich
Washington Post Staff Writer

"You don't have to fill this out, it's gone, it's history," Vice President Gore told an audience of physicians and reporters yesterday as he pointed to a pile of "physician attestation" forms splayed out at a White House news conference.

Gore and first lady Hillary Rodham Clinton used the attestation forms as an example of needless paperwork and announced a new round of "reinventing government" proposals for the Health Care Financing Administration (HCFA), which runs the giant Medicare and Medicaid programs.

Clinton said the proposals would help "simplify the health care system" by cutting a forest of "unnecessary regulatory burdens," and would "free doctors, hospitals and other health care providers" to spend more time at patients' bedsides instead of filling out forms.

Steve Gleason, a physician who heads the National Health Policy Council and who worked on the proposals, said "attestation forms"—required from doctors when they discharge Medicare patients—are essentially briefer versions of case discharge summaries already required. Eliminating them will save hospitals $136.8 million a year, he said.

Another proposal to cut paperwork, Gore said, would require firms that insure government workers and retirees in the Federal Employee Health Benefits Program to use the same doctor payment forms as in Medicare, and so simplify billing.

Another proposal would eliminate annual assessments required by both Medicare and Medicaid for mentally ill and retarded nursing home patients. One is enough, officials said.

Another proposed rule would give states more power to approve training programs for aides offered by nursing homes, even if the institution has been sanctioned for various failings.

The proposals released by Gore and the first lady also would ease paperwork and monitoring requirements for laboratories in clinics and doctor's offices and require less frequent on-site inspections of labs that have records as "excellent performers."

Gore said that rather than focusing on how facilities provide services and meet regulations, HCFA will focus on the quality of care. For example, he said, the agency might focus on how well a facility cleaned the blood of dialysis patients rather than checking every employee's job performance.

Officials could not estimate how much the proposals would save overall.

THE WASHINGTON POST
WEDNESDAY, JULY 12, 1995

The Daniel Webster Page Dorm, a former funeral home on Capitol Hill, has some senators concerned about its cost.

Clinton Extends Full Diplomatic Relations to Vietnam (Washn) By Susan Page= (c) 1995, Newsday=

WASHINGTON Calling on the nation to heal the fractures that persist over Vietnam, President Clinton Tuesday extended full diplomatic relations to Hanoi and opened the door to expanded economic and political ties between the one-time enemies.

``This moment offers us the opportunity to bind up our own wounds,'' the president told an invited audience of officials and veterans. ``They have resisted time for too long. We can now move on to common ground. Whatever divided us before, let us consign to the past.''

The East Room provided a tableau of some of those divisions: Clinton, who as a young man maneuvered to avoid serving in Vietnam, was flanked by Sen. John McCain, R-Ariz., a former Navy pilot who spent nearly six years in a prisoner-of-war camp in Vietnam, and Sen. John Kerry, D-Mass., who was decorated for his service in Vietnam and returned home to help lead anti-war protests.

But the leaders of the American Legion and the National League of Families of American Prisoners and Missing in Southeast Asia pointedly left the White House before the ceremony. Earlier, at a private Cabinet Room meeting, they told Clinton that Hanoi had failed to cooperate fully in settling the 1,618 cases of those missing and would be even less likely to respond now.

And in Albany, N.Y., the disabled Vietnam veteran who heads the New York state Division of Veterans' Affairs called Clinton's decision ``a betrayal to the American people.''

``It's even more shocking to me that a president who refused to go to Vietnam when called is now apparently leading the charge of big business to bring us back there in 1995,'' said John Behan, who as a Marine sergeant lost both legs in Vietnam. Behan called it ``a betrayal to the American people ... but most of all it's a betrayal to the POW families.''

Clinton, however, argued that Hanoi had intensified its efforts to account for those missing in action since he lifted the economic embargo against Vietnam last year. He said he would send another delegation to Vietnam this year to pursue the issue, especially 55 high-priority ``discrepancy'' cases in which U.S. servicemen were last seen alive in North Vietnam.

Secretary of State Warren Christopher also will visit Vietnam early next month to discuss MIAs as well as democratic and economic reforms. Some U.S. policy-makers have supported stronger ties to Vietnam as a counterweight to China in the region.

Congressional critics of Clinton's decision among them Senate Majority Leader Bob Dole, R-Kan. have vowed to try to block funds for an embassy or other diplomatic activities in Vietnam. But McCain, who has been the most forceful advocate of better diplomatic relations, said the measure probably could not pass the Senate and in any case would not survive a presidential veto.

Clinton's announcement, while important symbolically, has limited immediate effect. The United States and Vietnam will exchange ambassadors, and the building that now houses the U.S. liaison office in Hanoi will become the U.S. Embassy. (Washington has normal ties with Cambodia and Laos, where the search continues for MIAs.)

But with full diplomatic relations, Hanoi can apply for most-favored-nation trading status, which would enable Vietnamese products to be imported to the United States with the lowest possible tariffs. A U.S. interagency task force will now determine if U.S. businesses that want to invest in Vietnam can receive loans and guarantees through the Export-Import Bank and the Overseas Private Investment Corp.

The political controversy is likely to be short-lived, most analysts predicted. A CNN/USA Today/Gallup Poll published Tuesday showed Americans by a more than 2-1 ratio supported normalizing relations.

(Optional add end)

``Sure there's going to be some negative fallout, but I would say that the general tenor of the time is that the war is long over,'' said Stephen Hess, who worked on the Eisenhower and Nixon White House staffs and is now associated with the Brookings Institution think tank. ``The world is just so utterly different than it was.''

But Colleen Shine, whose father, an Air Force pilot, disappeared in Vietnam about a month before the Paris Peace Treaty was signed, disagreed.

``A lot of people said, `It's been 20 years,' '' Shine, a member of the board of the National League of Families, said in an interview after the meeting with Clinton. ``But I tell you, when I heard there were Bosnian air strikes this morning, all I could think was, I hope no American families were affected.''

Hillary Clinton, Al Gore Take New Stab at Reforming Health Care By Dena Bunis= (c) 1995, Newsday=

First lady Hillary Rodham Clinton obviously hasn't lost her zeal for health care reform. Tuesday she joined Vice President Al Gore in announcing changes that they said would mean doctors and nurses spend more time ministering to patients and less time filling out forms.

The changes, which will be made in the Medicare and Medicaid programs, come as the Republican-controlled Congressllis contemplating record-setting cutbacks in spending on those two federal programs.

``We can simplify the system and regulate the right way, without compromising quality,'' Clinton told about 80 doctors and nurses at the White House.

She chastised the Republican majority for proposing to ``take deep Medicare cuts to pay for tax breaks for the wealthiest Americans.'' Party leaders say they want to help reduce the deficit and provide middle-class tax relief by cutting $452 billion from Medicare and Medicaid over the next seven years. The Clinton administration's budget would cut half that.

For the Clinton administration, the beauty of the regulatory measures announced Tuesday is that they can be accomplished by the stroke of an executive pen and do not need legislative approval.

Bruce Vladeck, head of the Health Care Finance Administration, which has control over Medicare and Medicaid, told reporters that some of the changes will begin immediately and others are to be phased in over a number of years,

Gore, who is the administration's point person in its efforts to trim bureaucracy, zeroed in on several changes, including one that would eliminate a form physicians must sign for each Medicare patient discharged from a hospital. The form certifies the accuracy of diagnoses and procedures.

``From now on, we will start with trust instead of mistrust,'' said Gore. ``We'll start from the assumption that the vast majority of America's doctors and hospitals are honest people and reputable institutions, not dens of thieves.''

That change alone, federal officials estimated, would save the health care system about $136 million a year, with each hospital in the country saving $22,500 a year.

The government will also begin looking, for example, at

clinical laboratories that exhibit poor performance rather than reviewing all labs. It will change the focus of regulations at such facilities as nursing homes and kidney dialysis centers to concentrate on measuring the effectiveness of the treatment rather than the processes followed to provide the treatment.

``This is a revolution in the making," said Mary Mundinger, dean of the Columbia University School of Nursing, who was at the White House briefing. ``In one stroke of the pen, what this administration has done is change regulations for 74 million Americans under Medicaid and Medicare to begin to look at patient welfare instead of professional process."

(Begin optional trim)

Medicare advocates know that the savings from this regulatory reform pale by comparison with the $270 billion over seven years that Republicans want to slice from the program.

``We're faced with a diminishing resource and given that there's not enough money to do everything, we should spend it mostly on the bad apples and where the problems are," said John Rother, chief lobbyist for the American Association of Retired Persons, which is waging a campaign to moderate the proposed health care cuts. ``If it saves time and hassles, it's probably worth doing," Rother said.

The AARP Tuesday released a nationwide public opinion poll that showed that nine out of 10 respondents said Medicare and Social Security are the two federal programs for retirees that are linchpins of economic security and independence. Rother said his group will undertake a massive education plan among the public and for lawmakers about the impact of the proposed cuts.

(End optional trim)

Health Care Finance Administration officials acknowledged Tuesday that many of the changes will be slow in coming, taking effect only as the medical community hammers out agreements on what constitutes a fair assessment of the outcome of a treatment.

``Out general strategy is that as outcome measures become available, we will begin to use them and we will replace measures we are now using that are proxies for outcomes," said Barbara Gagel, director of the Health Care Finance Administration's bureau of health standards and quality.

In the case of kidney dialysis, for example, a recently agreed-upon standard for impurities in patients' blood will eventually replace information from patients' charts as the indicator as to whether Medicare money is being appropriately spent.

Clinton Extends Full Diplomatic Relations to Vietnam (Washn) By Susan Page= (c) 1995, Newsday=

WASHINGTON Calling on the nation to heal the fractures that persist over Vietnam, President Clinton Tuesday extended full diplomatic relations to Hanoi and opened the door to expanded economic and political ties between the one-time enemies.

``This moment offers us the opportunity to bind up our own wounds,'' the president told an invited audience of officials and veterans. ``They have resisted time for too long. We can now move on to common ground. Whatever divided us before, let us consign to the past.''

The East Room provided a tableau of some of those divisions: Clinton, who as a young man maneuvered to avoid serving in Vietnam, was flanked by Sen. John McCain, R-Ariz., a former Navy pilot who spent nearly six years in a prisoner-of-war camp in Vietnam, and Sen. John Kerry, D-Mass., who was decorated for his service in Vietnam and returned home to help lead anti-war protests.

But the leaders of the American Legion and the National League of Families of American Prisoners and Missing in Southeast Asia pointedly left the White House before the ceremony. Earlier, at a private Cabinet Room meeting, they told Clinton that Hanoi had failed to cooperate fully in settling the 1,618 cases of those missing and would be even less likely to respond now.

And in Albany, N.Y., the disabled Vietnam veteran who heads the New York state Division of Veterans' Affairs called Clinton's decision ``a betrayal to the American people.''

``It's even more shocking to me that a president who refused to go to Vietnam when called is now apparently leading the charge of big business to bring us back there in 1995,'' said John Behan, who as a Marine sergeant lost both legs in Vietnam. Behan called it ``a betrayal to the American people ... but most of all it's a betrayal to the POW families.''

Clinton, however, argued that Hanoi had intensified its efforts to account for those missing in action since he lifted the economic embargo against Vietnam last year. He said he would send another delegation to Vietnam this year to pursue the issue, especially 55 high-priority ``discrepancy'' cases in which U.S. servicemen were last seen alive in North Vietnam.

Secretary of State Warren Christopher also will visit Vietnam early next month to discuss MIAs as well as democratic and economic reforms. Some U.S. policy-makers have supported stronger ties to Vietnam as a counterweight to China in the region.

Congressional critics of Clinton's decision among them Senate Majority Leader Bob Dole, R-Kan. have vowed to try to block funds for an embassy or other diplomatic activities in Vietnam. But McCain, who has been the most forceful advocate of better diplomatic relations, said the measure probably could not pass the Senate and in any case would not survive a presidential veto.

Clinton's announcement, while important symbolically, has limited immediate effect. The United States and Vietnam will exchange ambassadors, and the building that now houses the U.S. liaison office in Hanoi will become the U.S. Embassy. (Washington has normal ties with Cambodia and Laos, where the search continues for MIAs.)

But with full diplomatic relations, Hanoi can apply for most-favored-nation trading status, which would enable Vietnamese products to be imported to the United States with the lowest possible tariffs. A U.S. interagency task force will now determine if U.S. businesses that want to invest in Vietnam can receive loans and guarantees through the Export-Import Bank and the Overseas Private Investment Corp.

The political controversy is likely to be short-lived, most analysts predicted. A CNN/USA Today/Gallup Poll published Tuesday showed Americans by a more than 2-1 ratio supported normalizing relations.

(Optional add end)

``Sure there's going to be some negative fallout, but I would say that the general tenor of the time is that the war is long over,'' said Stephen Hess, who worked on the Eisenhower and Nixon White House staffs and is now associated with the Brookings Institution think tank. ``The world is just so utterly different than it was.''

But Colleen Shine, whose father, an Air Force pilot, disappeared in Vietnam about a month before the Paris Peace Treaty was signed, disagreed.

``A lot of people said, `It's been 20 years,' '' Shine, a member of the board of the National League of Families, said in an interview after the meeting with Clinton. ``But I tell you, when I heard there were Bosnian air strikes this morning, all I could think was, I hope no American families were affected.''

Hillary Clinton, Al Gore Take New Stab at Reforming Health Care By Dena Bunis= (c) 1995, Newsday=

First lady Hillary Rodham Clinton obviously hasn't lost her zeal for health care reform. Tuesday she joined Vice President Al Gore in announcing changes that they said would mean doctors and nurses spend more time ministering to patients and less time filling out forms.

The changes, which will be made in the Medicare and Medicaid programs, come as the Republican-controlled Congressllis contemplating record-setting cutbacks in spending on those two federal programs.

``We can simplify the system and regulate the right way, without compromising quality,'' Clinton told about 80 doctors and nurses at the White House.

She chastised the Republican majority for proposing to ``take deep Medicare cuts to pay for tax breaks for the wealthiest Americans.'' Party leaders say they want to help reduce the deficit and provide middle-class tax relief by cutting $452 billion from Medicare and Medicaid over the next seven years. The Clinton administration's budget would cut half that.

For the Clinton administration, the beauty of the regulatory measures announced Tuesday is that they can be accomplished by the stroke of an executive pen and do not need legislative approval.

Bruce Vladeck, head of the Health Care Finance Administration, which has control over Medicare and Medicaid, told reporters that some of the changes will begin immediately and others are to be phased in over a number of years,

Gore, who is the administration's point person in its efforts to trim bureaucracy, zeroed in on several changes, including one that would eliminate a form physicians must sign for each Medicare patient discharged from a hospital. The form certifies the accuracy of diagnoses and procedures.

``From now on, we will start with trust instead of mistrust,'' said Gore. ``We'll start from the assumption that the vast majority of America's doctors and hospitals are honest people and reputable institutions, not dens of thieves.''

That change alone, federal officials estimated, would save the health care system about $136 million a year, with each hospital in the country saving $22,500 a year.

The government will also begin looking, for example, at

clinical laboratories that exhibit poor performance rather than reviewing all labs. It will change the focus of regulations at such facilities as nursing homes and kidney dialysis centers to concentrate on measuring the effectiveness of the treatment rather than the processes followed to provide the treatment.

``This is a revolution in the making," said Mary Mundinger, dean of the Columbia University School of Nursing, who was at the White House briefing. ``In one stroke of the pen, what this administration has done is change regulations for 74 million Americans under Medicaid and Medicare to begin to look at patient welfare instead of professional process."

(Begin optional trim)

Medicare advocates know that the savings from this regulatory reform pale by comparison with the $270 billion over seven years that Republicans want to slice from the program.

``We're faced with a diminishing resource and given that there's not enough money to do everything, we should spend it mostly on the bad apples and where the problems are," said John Rother, chief lobbyist for the American Association of Retired Persons, which is waging a campaign to moderate the proposed health care cuts. ``If it saves time and hassles, it's probably worth doing," Rother said.

The AARP Tuesday released a nationwide public opinion poll that showed that nine out of 10 respondents said Medicare and Social Security are the two federal programs for retirees that are linchpins of economic security and independence. Rother said his group will undertake a massive education plan among the public and for lawmakers about the impact of the proposed cuts.

(End optional trim)

Health Care Finance Administration officials acknowledged Tuesday that many of the changes will be slow in coming, taking effect only as the medical community hammers out agreements on what constitutes a fair assessment of the outcome of a treatment.

``Out general strategy is that as outcome measures become available, we will begin to use them and we will replace measures we are now using that are proxies for outcomes," said Barbara Gagel, director of the Health Care Finance Administration's bureau of health standards and quality.

In the case of kidney dialysis, for example, a recently agreed-upon standard for impurities in patients' blood will eventually replace information from patients' charts as the indicator as to whether Medicare money is being appropriately spent.

LEVEL 1 - 16 OF 25 STORIES

Copyright 1995 Newsday, Inc.
Newsday

July 12, 1995, Wednesday, CITY EDITION

SECTION: NEWS; Pg. A15

LENGTH: 425 words

HEADLINE: A New Stab At Reforming Health Care

BYLINE: By Dena Bunis. STAFF WRITER

BODY:

First Lady Hillary Rodham Clinton obviously hasn't lost her zeal for health-care reform. Yesterday she joined Vice President Al Gore in announcing changes that they said would mean doctors and nurses spend more time ministering to patients and less time filling out forms.

The changes, which will be made in the Medicare and Medicaid programs, come as the Republican-controlled Congress is contemplating record-setting cutbacks in spending on those two federal programs.

"We can simplify the system and regulate the right way, without compromising quality," Clinton told about 80 doctors and nurses at the White House.

The first lady chastised the Republican majority for proposing to "take deep Medicare cuts to pay for tax breaks for the wealthiest Americans." Party leaders say they want to help reduce the deficit and provide middle-class tax relief by cutting $ 452 billion from Medicare and Medicaid over the next seven years. The Clinton administration's budget would cut half that.

For the Clinton administration, the beauty of the regulatory measures announced yesterday is that they can be accomplished by the stroke of an executive pen and do not need legislative approval.

Bruce Vladeck, head of the Health Care Finance Administration, which has control over Medicare and Medicaid, told reporters that some of the changes will begin immediately and others are to be phased in over a number of years.

Gore, who is the administration's point person in its efforts to trim bureaucracy, zeroed in on several changes, including one that would eliminate a form physicians must sign for each Medicare patient discharged from a hospital. The form certifies the accuracy of diagnoses and procedures.

That change alone, federal officials estimated, would save the health-care system about $ 136 million a year.

The government will also begin looking, for example, at clinical laboratories that exhibit poor performance rather than reviewing all labs. It will change the focus of regulations at such facilities as nursing homes and kidney dialysis centers to concentrate on measuring the effectiveness of the treatment rather than the processes followed to provide the treatment.

LEXIS·NEXIS® LEXIS·NEXIS® LEXIS·NEXIS®

A member of the Reed Elsevier plc group

"This is a revolution in the making," said Mary Mundinger, dean of the Columbia University School of Nursing, who was at the White House briefing. "In one stroke of the pen, what this administration has done is change regulations for 74 million Americans under Medicaid and Medicare to begin to look at patient welfare instead of professional process."

GRAPHIC: AP Photo-Hillary Rodham Clinton while making announcement at Old Executive Office Building.

LANGUAGE: ENGLISH

LOAD-DATE: July 12, 1995

LEXIS·NEXIS® LEXIS·NEXIS® LEXIS·NEXIS®

A member of the Reed Elsevier plc group

LEVEL 1 - 12 OF 25 STORIES

Copyright 1995 McClatchy Newspapers, Inc.
The Fresno Bee

July 12, 1995 Wednesday, HOME EDITION

SECTION: BUSINESS, Pg. C1, BUSINESS BRIEFING

LENGTH: 665 words

BYLINE: Bee Staff And News Services

BODY:

The markets

Stock prices fell back Tuesday as profit-taking knocked the market off its lofty perch. The dollar advanced, gold rose, and bond prices fell.

Sierra On-Line expands series

Roger Wilco, the main character in Sierra On-Line Inc.'s popular computer game series "Space Quest," goes where no man has gone before in the just released "Space Quest 6: Roger Wilco in the Spinal Frontier." The Bellevue, Wash.-based Sierra On-Line on Tuesday rolled out a Windows/DOS CD-ROM version of this adventure series, which was first introduced in 1986 and has sold more than 1 million units. In this latest installment, created at Sierra On-Line's Oakhurst division, Roger Wilco is shrunk down to microscopic proportions and injected into the bloodstream of a fellow crew member, exploring such frontiers as the stomach, pancreas and gall bladder. The CD-ROM has a retail price of $ 54.95. A MacIntosh version is expected to be released later this summer.

Albertson's opens fourth Fresno store

Albertson's today opens its fourth store in Fresno at 6055 N. Figarden Ave. The 49,273-square-foot store is a combination food and drug store with such specialty departments as a bakery, photo developing center and video rental section. Kreg Elkins has been named store director for the new location, which hopes to serve the growing development in northwest Fresno. The Boise, Idaho-based Albertson's is the fourth-largest supermarket chain in the country.

Burger King chain gets new CEO

MIAMI -- Burger King, the world's No. 2 fast-food chain, named food industry veteran Robert C. Lowes as chief executive officer. Lowes, 49, was previously chief executive of GrandMet Foods Europe, which along with Miami-based Burger King is a unit of Britain's Grand Metropolitan PLC. Lowes said Tuesday his top priority will be adding to Burger King's 7,800 franchises worldwide. Lowes has spent 15 years in the food business, working at H.J. Heinz, General Foods and Philip Morris before joining GrandMet in 1989.

Salomon projects $ 65 million loss

NEW YORK -- Salomon Inc., the big Wall Street bond-trading firm, shocked investors Tuesday by projecting it lost $ 65 million in the second quarter, far worse than expected by many analysts. The news sent Salomon stock tumbling nearly 9 percent, dropping $ 3.62 1/2 to $ 37.25 Tuesday.

LEXIS®-NEXIS® LEXIS®-NEXIS® LEXIS®-NEXIS®

A member of the Reed Elsevier plc group

The Fresno Bee, July 12, 1995

Consumer debt pace slows in May

WASHINGTON -- Consumers ran up debt in May at a slightly slower pace than the previous month, although borrowing for car-buying jumped sharply. The Federal Reserve said Tuesday that consumer credit -- growing for the 24th straight month -- swelled by $ 11.5 billion in May, an annual rate of 14.6 percent.

Medicare form for doctors scrapped

WASHINGTON -- Declaring that hospitals are not "dens of thieves" and physicians are not crooks, Vice President Al Gore said the Clinton administration is scrapping a form doctors had to sign before Medicare would pay patients' hospital bills. The move will save physicians 200,000 hours of time each year, eliminate 11 million forms, save hospitals $ 137 million and help them collect up to 30 days faster from Medicare, Gore said Tuesday.

MCA chairman relinquishes control

LOS ANGELES -- MCA's Lew Wasserman, the gentle giant of Hollywood's power structure, has relinquished control of the international entertainment empire he built from a dance band booking agency. Edgar Bronfman Jr., whose Seagram Co. bought 80 percent of MCA last month, said Tuesday that Wasserman would move from MCA chairman to chairman emeritus and join Seagram's board of directors.

Merck & Co. funds racial diversity

WASHINGTON -- Merck & Co. Inc. will fund a $ 20 million program designed to increase the number of African-American university students who pursue science careers over the next decade. The New Jersey-based drug company said Tuesday that the program will bolster racial diversity and enable the United States to maintain its scientific edge over other countries.

GRAPHIC: Associated Press
Pressure-sensitive. Pasadena-based Avery Dennison printed the Peaches and Pear self-adhesive stamps, released by the U.S. Postal Service in Reno, Nev. Robert C. Lowes

LOAD-DATE: July 13, 1995

LEXIS·NEXIS® LEXIS·NEXIS® LEXIS·NEXIS®
A member of the Reed Elsevier plc group

LEVEL 1 - 23 OF 25 STORIES

Copyright 1995 The Washington Post
The Washington Post

July 12, 1995, Wednesday, Final Edition

SECTION: A SECTION; Pg. A17; THE FEDERAL PAGE

LENGTH: 395 words

HEADLINE: Latest 'Reinventing' Proposals Take Aim at Health Forms; Gore, First Lady Announce Streamlining Plan

BYLINE: Spencer Rich, Washington Post Staff Writer

BODY:

"You don't have to fill this out, it's gone, it's history," Vice President Gore told an audience of physicians and reporters yesterday as he pointed to a pile of "physician attestation" forms splayed out at a White House news conference.

Gore and first lady Hillary Rodham Clinton used the attestation forms as an example of needless paperwork and announced a new round of "reinventing government" proposals for the Health Care Financing Administration (HCFA), which runs the giant Medicare and Medicaid programs.

Clinton said the proposals would help "simplify the health care system" by cutting a forest of "unnecessary regulatory burdens," and would "free doctors, hospitals and other health care providers" to spend more time at patients' bedsides instead of filling out forms.

Steve Gleason, a physician who heads the National Health Policy Council and who worked on the proposals, said "attestation forms" -- required from doctors when they discharge Medicare patients -- are essentially briefer versions of case discharge summaries already required. Eliminating them will save hospitals $ 136.8 million a year, he said.

Another proposal to cut paperwork, Gore said, would require firms that insure government workers and retirees in the Federal Employee Health Benefits Program to use the same doctor payment forms as in Medicare, and so simplify billing.

Another proposal would eliminate annual assessments required by both Medicare and Medicaid for mentally ill and retarded nursing home patients. One is enough, officials said.

Another proposed rule would give states more power to approve training programs for aides offered by nursing homes, even if the institution has been sanctioned for various failings.

The proposals released by Gore and the first lady also would ease paperwork and monitoring requirements for laboratories in clinics and doctor's offices and require less frequent on-site inspections of labs that have records as "excellent performers."

Gore said that rather than focusing on how facilities provide services and meet regulations, HCFA will focus on the quality of care. For example, he

LEXIS·NEXIS® LEXIS·NEXIS® LEXIS·NEXIS®

A member of the Reed Elsevier plc group

said, the agency might focus on how well a facility cleaned the blood of dialysis patients rather than checking every employee's job performance.

Officials could not estimate how much the proposals would save overall.

LANGUAGE: ENGLISH

LOAD-DATE: July 12, 1995

LEXIS·NEXIS® LEXIS·NEXIS® LEXIS·NEXIS®
A member of the Reed Elsevier plc group

LEVEL 1 - 6 OF 25 STORIES

Copyright 1995 Globe Newspaper Company
The Boston Globe

July 12, 1995, Wednesday, City Edition

SECTION: NATIONAL/FOREIGN; Pg. 4

LENGTH: 26 words

HEADLINE: HAPPY TALK;
STORY IN CAPTION

BODY:
Hillary Rodham Clinton and Vice President Al Gore share a laugh yesterday in Washington at an announcement of Medicare regulatory reforms. / AP PHOTO

GRAPHIC: PHOTO

LANGUAGE: ENGLISH

LOAD-DATE: July 13, 1995

LEXIS®-NEXIS® LEXIS®-NEXIS® LEXIS®-NEXIS®

A member of the Reed Elsevier plc group

LEVEL 1 - 8 OF 25 STORIES

Copyright 1995 Charleston Newspapers
The Charleston Gazette

July 12, 1995, Wednesday

SECTION: News; Pg. P3A

LENGTH: 498 words

HEADLINE: MEDICARE RED TAPE CUT FOR DOCTORS, HOSPITALS

BODY:

WASHINGTON (AP) _ Declaring that hospitals are not "dens of thieves" and physicians are not crooks, Vice President Al Gore said the Clinton administration is scrapping a form doctors had to sign before Medicare would pay patients' hospital bills.

The move will save physicians 200,000 hours of time each year, eliminate 11 million forms, save hospitals $ 137 million and help them collect up to 30 days faster from Medicare, Gore said Tuesday.

Hospitals often had to hunt physicians down to sign the "attestation form" certifying the accuracy of each patient's diagnoses and procedures, even though it duplicated information on the patient's charts.

At a White House event with Hillary Rodham Clinton and health officials, Gore called the old requirement crazy.

"If the doctor were a crook, do we really think" that signing a form would stop them? the vice president asked. He joked that the very name of the physician attestation form "makes a charlatan shudder."

"From now on, we will start with trust instead of mistrust," he said. "We'll start from the assumption that the vast majority of America's doctors and hospitals are honest people and reputable institutions, not dens of thieves."

LEXIS-NEXIS® LEXIS-NEXIS® LEXIS-NEXIS®

A member of the Reed Elsevier plc group

The Charleston Gazette, July 12, 1995

The Health Care Financing Administration, which runs Medicare and the federal side of Medicaid, will take other steps to cut red tape and ease the regulatory burden on doctors, hospitals, laboratories and nursing homes.

They include:

Easing clinical laboratory inspection requirements, especially for physicians' in-office labs and those that perform simple, automated tests. Rep. Bill Archer, R-Texas, chairman of the House Ways and Means Committee, has proposed exempting physician office labs entirely from inspections.

Revising rules for hospitals, home health agencies and kidney dialysis centers to focus on outcomes instead of procedural requirements.

. Requiring all health insurers that cover federal workers and their families to adopt the common Medicare claim form.

. Proposing legislation to eliminate a redundant annual reassessment of each mentally ill or retarded resident in nursing homes.

Jim Stacey, a spokesman for the American Medical Association, said eliminating the attestation forms was "a good step forward." The AMA is still looking for further relief from the clinical lab rules, he said.

Mrs. Clinton criticized the Republican proposals to save $ 452 billion from Medicare and Medicaid over seven years. President Clinton has proposed $ 180 billion in savings.

She charged that under GOP plans to convert Medicaid to a block grant to the states, "Seven million children and nearly 1 million

LEXIS®-NEXIS® LEXIS®-NEXIS® LEXIS®-NEXIS®
A member of the Reed Elsevier plc group

elderly and disabled Americans would lose coverage, and millions more would risk losing vital services like nursing-home care."

The right way to control health-care costs "is to improve and strengthen these programs and make them more efficient," she said

LOAD-DATE: July 12, 1995

LEXIS®·NEXIS® LEXIS®·NEXIS® LEXIS®·NEXIS®

A member of the Reed Elsevier plc group

LEVEL 1 - 9 OF 25 STORIES

Copyright 1995 Chicago Sun-Times, Inc.
Chicago Sun-Times

July 12, 1995, WEDNESDAYWEDNESDAY, SXSSXS

SECTION: NWSNWS; NATION BRIEFS; Pg. 2520

LENGTH: 743 words

HEADLINE: Medicare Form Eliminated

DATELINE: WASHINGTON

BODY:

The White House on Tuesday eliminated a Medicare insurance form detested by doctors.

First lady Hillary Rodham Clinton announced the change with Vice President Al Gore, who has been leading the "Reinventing Government" drive for greater efficiency.

Doctors will no longer have to fill out the "Physician Attestation Form," in which they have to affirm that they told the truth on the other hospital discharge forms for Medicare.

Eliminating these 11 million forms a year will save about $ 137 million, or $ 22,500 for an average hospital, officials said. It will save about 6.1 million hours of work, most done by administrative or clerical staff.

The Republican Congress wants to cut $ 270 billion out of projected Medicare spending by 2002. President Clinton's proposals would halve those cuts.NAT12.0AD$ TEMP$ PAPER:CHICAGO SUN-TIMES

Jury Selection Starts in Polly Klaas Murder

Jury selection began in Santa Rosa, Calif., for the trial of Richard Allen Davis, the man accused of killing 12-year-old Polly Klaas, who was abducted Oct. 1, 1993, from a slumber party. The pool of 8,500 potential jurors is eight times larger than that in the O.J. Simpson trial, and jury selection is expected to last four months. Superior Court Judge Lawrence Antolini says he doesn't want to sequester the jury but wants to avoid problems plaguing the Simpson case.

FBI Agent Wounded in Training

An FBI agent was wounded in the finger during firearms training at the FBI Academy in Quantico, Va., -- the second accidental shooting there since Friday, the FBI announced. The agent was treated at a nearby hospital and released. On Friday, two trainees were wounded by a single bullet when a firearm accidentally discharged.

Senate Pages Have Costly New Home

It has cost taxpayers $ 6 million to turn an old Capitol Hill funeral home into a new dormitory for 30 or so Senate pages -- the high school students who deliver senators' messages. At more than $ 142,000 per resident, the

LEXIS·NEXIS® LEXIS·NEXIS® LEXIS·NEXIS®

A member of the Reed Elsevier plc group

dorm -- which has classrooms, computer facilities and an infirmary -- is among the nation's most expensive, according to American School & University magazine.

Affirmative Action Review Due Next Week

President Clinton said he would announce results of his long-awaited review of federal affirmative action programs July 19. Clinton said in February that he intended to review affirmative action. The review has caused anxiety among members of the Congressional Black Caucus, many of whose members vehemently oppose changing or limiting affirmative action programs aimed at redressing racial imbalance in access to jobs, education and other opportunities.

Jury Selection Starts in Polly Klaas Murder

Jury selection began in Santa Rosa, Calif., for the trial of Richard Allen Davis, the man accused of killing 12-year-old Polly Klaas, who was abducted Oct. 1, 1993, from a slumber party. The pool of 8,500 potential jurors is eight times larger than that in the O.J. Simpson trial, and jury selection is expected to last four months. Superior Court Judge Lawrence Antolini says he doesn't want to sequester the jury but wants to avoid problems plaguing the Simpson case.

FBI Agent Wounded in Training

An FBI agent was wounded in the finger during firearms training at the FBI Academy in Quantico, Va., -- the second accidental shooting there since Friday, the FBI announced. The agent was treated at a nearby hospital and released. On Friday, two trainees were wounded by a single bullet when a firearm accidentally discharged.

Senate Pages Have Costly New Home

It has cost taxpayers $ 6 million to turn an old Capitol Hill funeral home into a new dormitory for 30 or so Senate pages -- the high school students who deliver senators' messages. At more than $ 142,000 per resident, the dorm -- which has classrooms, computer facilities and an infirmary -- is among the nation's most expensive, according to American School & University magazine.

Affirmative Action Review Due Next Week

President Clinton said he would announce results of his long-awaited review of federal affirmative action programs July 19. Clinton said in February that he intended to review affirmative action. The review has caused anxiety among members of the Congressional Black Caucus, many of whose members vehemently oppose changing or limiting affirmative action programs aimed at redressing racial imbalance in access to jobs, education and other opportunities.

GRAPHIC: REUTERS

LANGUAGE: English

LN-ACC-NO: NAT12.0AD071995

LOAD-DATE: July 12, 1995

LEXIS·NEXIS® LEXIS·NEXIS® LEXIS·NEXIS®

A member of the Reed Elsevier plc group

BC HEALTH-MEDICARE

Doctors get relief on Medicare paperwork

WASHINGTON, July 11 (Reuter) - The White House salvaged a strand of health care reform Tuesday, saying it had elminated a form detested by doctors and was streamlining other regulations in the federal Medicare programme.

First lady Hillary Rodham Clinton announced the change alongside Vice President Al Gore, who has been leading the ''Reinventing Government'' drive for greater efficiency.

Doctors will no longer have to fill out the ''Physician Attestation Form,'' in which they have to affirm that they told the truth on the other hospital discharge forms for Medicare.

Eliminating these 11 million forms a year will save about $137 million dollars, or $22,500 for an average hospital, officials said. It will save about 6.1 million hours of work, most done by administrative or clerical staff.

That is a tiny drop in the Medicare budget. The Republican Congress wants to cut $270 billion out of projected Medicare spending by the year 2002 and President Clinton's proposals would halve those cuts.

Gore said health officials were also moving to standardise other paperwork, eliminate some inspections of laboratories with good performance histories and re-orient other regulations to emphasise outcomes and results instead of micromanaging and measuring processes and procedures.

Mrs. Clinton echoed the president's criticisms of the Republican approach to Medicare. ''Deep Medicare cuts to pay for tax breaks for the wealthiest Americans is the wrong way,'' she said.

The American Association of Retired Persons Tuesday released another poll showing strong public support in all age groups for Medicare and Social Security. Nearly nine out of 10 people said the two federal programmes for retirees are linchpins of economic security and independence.

REUTER

**** filed by:RB--(--) on 07/11/95 at 15:42EDT ****
**** printed by:WHPR(JSIL) on 07/12/95 at 16:06EDT ****

(UPI Spotlight)
Clinton moves to cut health paperwork

WASHINGTON, July 11 (UPI) The Clinton administration (Tuesday) announced a new series of regulatory reforms affecting the health care industry. The reforms, announced at the White House by Vice President Al Gore and first lady Hillary Rodham Clinton, are designed to cut costs and improve treatment through such changes as eliminating the need for a hospital release form for each Medicare patient, and moving toward the use of a standardized claim for for all federal health care programs.

**** filed by:UPI-(us) on 07/11/95 at 13:10EDT ****
**** printed by:WHPR(JSIL) on 07/12/95 at 16:07EDT ****

Date: 07/12/95 Time: 08:39

Medicare Red Tape Cut for Doctors, Hospitals

WASHINGTON (AP) Mercy Hospital in Des Moines, Iowa, spent $158,000 in a single year complying with a Medicare requirement that physicians sign a special form each time a patient was discharged.

Mercy figures its doctors and their staffs spent 927 hours filling out the forms. Nine clerical workers in the hospital's medical records office logged 6,100 hours.

No more, Vice President Al Gore promised on Tuesday.

The Clinton administration is eliminating the ''Physician Attestation'' form entirely, because it duplicates information already on the patients' discharge records.

The move will save Mercy and 5,000 other hospitals an estimated $137 million, and spare physicians 200,000 hours of busy work, Gore and other Clinton health officials said.

''Eliminating this form is a very important step on our road to recovery from bureaucracy,'' said Dr. Steven Gleason, a Des Moines physician who chairs the National Health Policy Council, which recommended the move.

Gore called the old requirement ''crazy,'' saying it was supposed to keep doctors and hospitals from padding patients' bills.

But ''if the doctor were a crook, do we really think ... that this doctor'' confronted by the form ''would suddenly have a change of heart and say, 'Ahaaa! I'm going to come clean now! It's all over!'' the vice president remarked. He joked that ''the very name'' of the physician attestation form ''makes a charlatan shudder.''

''From now on, we will start with trust instead of mistrust,'' Gore said. ''We'll start from the assumption that the vast majority of America's doctors and hospitals are honest people and reputable institutions, not dens of thieves.''

Hillary Rodham Clinton, who joined Gore at a White House event heralding the deregulatory drive, said doctors now are ''overburdened by paperwork, red tape and needless regulations.''

It will take the Health Care Financing Administration until September to publish a rule formally discarding the physician attestation form, but HCFA Administrator Bruce C. Vladeck and Office of Management and Budget regulatory chief Sally Katzen said doctors can stop signing them today.

HCFA will take other steps to cut red tape, including:

Easing clinical laboratory inspection requirements, especially for physicians' in-office labs and those that perform simple, automated tests. Rep. Bill Archer, R-Texas, chairman of the House Ways and Means Committee, has proposed exempting physicians' office labs from inspections.

Revising rules for hospitals, home health agencies and kidney dialysis centers to focus on outcomes instead of procedural requirements.

With the dialysis centers, Katzen said, the aim is ''to check and see whose patients are improving consistently, rather than

concentrating on the staff's credentials and whether all the paperwork is neat and tidy.''

Requiring all health insurers that cover federal workers and their families to adopt the common Medicare claim form.

Proposing legislation to eliminate a redundant annual reassessment of each mentally ill or retarded resident in nursing homes.

APNP-07-12-95 0845EDT

AM-Doctors-Red Tape,0527
Medicare Red Tape Cut for Doctors, Hospitals
Eds: Also moving on general news wires.
By CHRISTOPHER CONNELL= Associated Press Writer=

WASHINGTON (AP) Declaring that hospitals are not ''dens of thieves'' and physicians are not crooks, Vice President Al Gore said the Clinton administration is scrapping a form doctors had to sign before Medicare would pay patients' hospital bills.

The move will save physicians 200,000 hours of time each year, eliminate 11 million forms, save hospitals $137 million and help them collect up to 30 days faster from Medicare, Gore said Tuesday.

Hospitals often had to hunt physicians down to sign the ''attestation form'' certifying the accuracy of each patient's diagnoses and procedures, even though it duplicated information on the patient's charts.

At a White House event with Hillary Rodham Clinton and health officials, Gore called the old requirement crazy.

''If the doctor were a crook, do we really think'' that signing a form would stop them? the vice president asked. He joked that the very name of the physician attestation form ''makes a charlatan shudder.''

''From now on, we will start with trust instead of mistrust,'' he said. ''We'll start from the assumption that the vast majority of America's doctors and hospitals are honest people and reputable institutions, not dens of thieves.''

The Health Care Financing Administration, which runs Medicare and the federal side of Medicaid, will take other steps to cut red tape and ease the regulatory burden on doctors, hospitals, laboratories and nursing homes.

They include:

Easing clinical laboratory inspection requirements, especially for physicians' in-office labs and those that perform simple, automated tests. Rep. Bill Archer, R-Texas, chairman of the House Ways and Means Committee, has proposed exempting physician office labs entirely from inspections.

Revising rules for hospitals, home health agencies and kidney dialysis centers to focus on outcomes instead of procedural requirements.

Requiring all health insurers that cover federal workers and their families to adopt the common Medicare claim form.

Proposing legislation to eliminate a redundant annual reassessment of each mentally ill or retarded resident in nursing homes.

Jim Stacey, a spokesman for the American Medical Association, said eliminating the attestation forms was ''a good step forward.'' The AMA is still looking for further relief from the clinical lab rules, he said.

Mrs. Clinton criticized the Republican proposals to save $452 billion from Medicare and Medicaid over seven years. President Clinton has proposed $180 billion in savings.

She charged that under GOP plans to convert Medicaid to a block grant to the states, ''Seven million children and nearly 1 million elderly and disabled Americans would lose coverage, and millions more would risk losing vital services like nursing-home care.''

The right way to control health care costs ''is to improve and strengthen these programs and make them more efficient,'' she said.

**** filed by:APE-() on 07/11/95 at 17:16EDT ****
**** printed by:WHPR(JSIL) on 07/12/95 at 16:17EDT ****

BC-clinton-medicare-correct
Clinton Administration Issues New Medicare Measures (Correct)
(Adds dropped word, ''million,'' in second paragraph)

Washington, July 11 (Bloomberg) -- Paperwork will be reduced and new measures of medical performance created under Medicare reforms announced by the Clinton administration.

The changes were presented today as part of the administration's initiative, led by Vice President Al Gore, to eliminate unnecessary rules and paperwork. They don't require Congressional approval and are separate from the efforts by the administration and the Republican-controlled Congress to sharply cut the growth of the federal health insurance program serving 37 million elderly and disabled Americans.

The changes range from something as simple as eliminating a hospital discharge form to creating a new set of criteria for evaluating the performance of hospitals and home health agencies.

The proposal also seeks to reduce the burden of laws that regulate medical testing laboratories. Doctors criticize the 1988 clinical lab testing laws as a bureaucratic nightmare that has forced many of them to cease office lab testing rather than submit themselves to federal review.

In another case, the administration plans to eliminate a protection against fraud that required doctors to sign a form attesting to the accuracy of the diagnoses and procedures for each Medicare patient discharged from the hospital.

Administration health officials found the procedure results in billing delays, hurts the cash flow of hospitals and interferes with service to the Medicare patient.

''With improved technology, hospitals are more equipped than ever to combat billing fraud and abuse,'' the administration said.

The administration estimated the rule change would eliminate use of 11 million of these forms, saving almost 200,000 hours of doctor time annually and reducing the labor costs of a hospital by about $22,500 a year.

The administration plans to change measures it uses to evaluate whether hospitals, end-stage kidney disease facilities and home health-care agencies meet the safety and health requirements to participate in Medicare.

In keeping with the national trend toward finding better ways to measure the quality of patient care, the administration plans to collect information necessary to look at the outcome of patient care at a facility.

Those measures would replace Medicare's focus on procedures and administration in evaluating the performance of hospitals and other facilities.

--Paul Heldman (202) 434-1842 ngm

(To graph projected federal budget deficits: type FDBEST
index> GP
go> and change ending range date to 12/3199. For more on federal government health-care policy: NI HCP; on health care: NI HEA; on Congress: NI CNG; on the Clinton administration: NI EXE)

16:20 -0- (BBN) Jul/11/95 16:21 EOS (BBN) Jul/11/95 16:21 86

**** filed by:CN-F(--) on 07/11/95 at 16:32EDT ****
**** printed by:WHPR(JSIL) on 07/12/95 at 16:22EDT ****

MEDICARE REGULATORY REFORM RADIO

Scheduled **32 interviews** for the following medical professionals following the event in room 450:

Irving K. Loh (Thousand Oaks)
Susan F. Reynolds (Malibu)
1. KNX, Los Angeles

Robert Grayson (Surfside)
1. Florida Radio Network

Mary J. Hayes
1. Illinois News Network
2. WGN, Chicago
3. WLS, Chicago
4. WBEZ, Chicago
5. WLS, Chicago

Steve Gleason (Des Moines)
1. Radio Iowa

Vin Sahney (Detroit)
1. WJR, Detroit
2. WWJ, Detroit
3. WXYT, Detroit

L. C. Dorsey (Mt. Bayou)
1. Mississippi Radio Network

Jerome Connally (Billings)
1. KBLG, Billings, MT
2. KEMC, Billings, MT

Karen Burke (Raleigh)
1. WPTF, Raleigh, NC
2. North Carolina Radio Network

Gordon K. MacLeod (Pittsburgh)
1. KDKA-AM, Pittsburgh
2. KQV, Pittsburgh
3. WTAE, Pittsburgh
4. Pennsylvania Radio Network

Kathy Wood-Dobbins (Nashville)
1. WLAC, Nashville, TN
2. Tennessee Radio Network

Patricia Starck (Houston)
1. KPRC, Houston
2. Texas Radio Network

Raymond D. Adelman (Norfolk)

1. Virginia Radio Network
2. WNIS-AM, Norfolk, VA

Kevin Fickenscher (Milwaukee)
1. WISN, Milwaukee WI
2. WTMJ, Milwaukee WI
3. Wisconsin Radio Network
4. Wisconsin Public Radio

Howard (Chip) Freed
1. WGY, Schnectady
2. WAMC, Albany

Iowa doctor hauls Medicare paperwork to White House

The physician displays a stack of forms, which the vice president announces will no longer be required.

By JANE NORMAN
OF THE REGISTER'S WASHINGTON BUREAU

Washington, D.C. — Grabbing center stage with the vice president and first lady at a White House event Tuesday were Dr. Steve Gleason of Des Moines — and a fat stack of paperwork.

The pile of forms represented the 11,127 physician attestation statements for Medicare processed in one year at Mercy Hospital Medical Center in Des Moines, said Gleason, a physician and head of the Mercy clinic system.

But in an announcement that appeared designed to emphasize that Republicans in Congress are not the only ones interested in regulatory reform, Vice President Al Gore said that from now on, the forms are history.

"We are officially canceling the regulation that requires these forms," said Gore. "It's gone."

Nine members of Mercy's medical records staff spent 6,100 hours in one year to process the forms, Gleason said. The paperwork ate up 927 hours of physician office time, cost $158,000 and produced a 30-day delay in hospital payments.

Designed to legally bind physicians as to the accuracy of their hospital discharge statements, and summarize diagnoses already summarized elsewhere, the forms became just another burden for overworked health-care providers, the vice president said.

Gleason *Details costs*

"If the doctor were a crook, do we really think that he would ... suddenly have a change of heart and say, 'Aha! I'm going to come clean now. It's all over'?" said Gore. "Is it really the official opinion of the U.S. government the vast majority of doctors and hospitals in this country are crooks?"

The form also is a hassle, he said. Some hospitals had to send out messengers around town to round up physicians' signatures on the forms, Gore said. Others would try to entice physicians with offers of free brownies.

Gleason said that when Mercy's numbers are extrapolated to the nation, it meant the Medicare form created $136.8 million in unnecessary expense and 6.1 million hours of paperwork.

"Eliminating this form is a very important step on our road to recovery from bureaucracy," he told an audience made up in part of other physicians and health-care providers. Gleason has worked closely with the administration on health-care reform and is chairman of the National Health Policy Council, a nonprofit group that studies national health issues.

Gore announced a series of other health-care reforms within the Health Care Financing Administration, which is in charge of Medicare, the government health insurance program for the elderly and disabled, and Medicaid, which serves low-income Americans.

The focus of all regulations will be changed so that the outcome of care is measured, rather than the process, which will give providers more time to spend on patients, officials said. And the government will move toward use of a standard claim form for all federal health-care programs, including federal employees' benefit program.

The congressional budget agreement calls for $270 billion in reduction of growth of Medicare, but Hillary Clinton said there is "a right way and a wrong way" to slow that growth.

"The proposals that are currently being discussed by the majority in Congress to take deep Medicare cuts to pay for tax breaks for the wealthiest Americans are the wrong way," she said. "The right way is to improve and strengthen these programs and make them more efficient."

THE WHITE HOUSE
OFFICE OF THE PRESS SECRETARY

FOR IMMEDIATE RELEASE
Tuesday, July 11, 1995

Contact: 202-632-0150

VICE PRESIDENT, FIRST LADY ANNOUNCE REFORM OF HEALTH CARE RULES

Less Paperwork, More Time For Patient Care Will Result From Reinvented Regulations

Vice President Al Gore and First Lady Hillary Rodham Clinton today unveiled a series of health care regulatory reforms within the Health Care Financing Administration (HCFA), an agency of the U.S. Department of Health and Human Services. The changes, part of the Clinton-Gore administration's continuing regulatory reform efforts, include cutting burdensome paperwork requirements--giving health care providers more time to care for patients--and the removal of roadblocks to innovation and cost-cutting.

Highlights of the HCFA reforms include:

- Eliminates the Physician Attestation Form, a cumbersome Medicare paperwork requirement which must be completed by a physician each time a patient is released from treatment. Result is elimination of 11 million forms and savings of 200,000 hours of physician time. Will cut labor costs $22, 500 per hospital per year.

- Reward good performance by laboratories by reducing regulatory oversight burdens. Incentives are created for manufacturers to develop more reliable equipment.

- Give Medicare providers more time for patient care by eliminating unnecessary government micromanagement and focusing instead on results. This will produce savings because providers will be free to achieve high quality outcomes in most cost-effective manner.

- Begin moving toward use of a standard claim form for all federal health care programs including the Federal Employees Health Benefit Program.

Vice President Gore said: "We need to focus on first class health care rather than forcing our doctors and caregivers to worry more and more about staying within the lines of undue regulations. Our medical personnel should be allowed to use the best of innovation and inspiration to provide quality health care."

"As part of our health care reform efforts last year, we looked for ways to streamline regulations and simplify the health care system," Mrs. Clinton said. "At the same time, Vice President Gore's Reinventing Government Initiative began eliminating unnecessary regulatory burdens in all areas of government. Today's meeting represents the perfect marriage of the two efforts. We can simplify the health care system and regulate the right way, without compromising quality."

"We're putting patients first, " said HHS Secretary Donna E. Shalala. "Health professionals will now be able to focus more on patient care and less on paperwork."

"As a result of HCFA's recent regulatory review, we are proposing significant changes," said Bruce C. Vladeck, HCFA Administrator. "We are taking actions that will cut red tape for doctors and other providers, and allow us to be more responsive to the needs of our customer--the Medicare beneficiary."

The Health Care Financing Administration operates the Medicare program, oversees state-federal Medicaid plans, and is responsible for the quality of health care provided by 60, 000 hospitals, nursing homes, home health agencies and other facilities. HCFA also oversees the quality of 152,000 testing laboratories in the U.S. and the federal licensing of health maintenance organizations (HMOs).