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94th Congress }
2d Session }

COMMITTEE PRINT

A DISCURSIVE DICTIONARY
OF HEALTH CARE

PREPARED BY THE STAFF
FOR THE USE OF THE
SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT
OF THE
COMMITTEE ON INTERSTATE AND
FOREIGN COMMERCE
U.S. HOUSE OF REPRESENTATIVES



FEBRUARY 1976



ERRATA

A DISCURSIVE DICTIONARY
OF HEALTH CARE

The following corrigenda should be noted in the committee print, dated February 1976, prepared for the use of the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce, U.S. House of Representatives:

Page 88, abeling : should be labeling.

Page 122, placebo: Eli Lilly and Company, the manufacturers of propoxyphene, presented evidence shortly after publication of the Dictionary that it does provide pain relief superior to that of an inert placebo (although not to that of aspirin or codeine when they are used as placebos).

Page 159, Surgicenter ®: Surgicenter ® is a registered trademark, owned by Surgicenter, Inc. of Phoenix, Arizona, and should be defined as such. The definition given should be applied to a generic term such as ambulatory surgical center.





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A DISCURSIVE DICTIONARY OF HEALTH CARE

INTRODUCTION

The developing debate on national health insurance has already taught all of us who participate in it to use the bewildering array of new and unfamiliar terms which are part of the debate. These terms come from the disparate fields which are necessary parties to the effort to write a national health program, and include insurance terminology, concepts from health services and medical care, words used in government health and welfare programs, legal language, and administrative terminology. Therefore, in order to inform and clarify the debate, I have asked our professional staff to prepare the dictionary which follows in order to define and explain as many as possible of the more important and common terms which will be used in the debate. This has been necessary because, interestingly enough, a comparable dictionary to date has not been prepared by the academic community, the executive branch, or any of the interested professional associations. Some limited or specialized glossaries and dictionaries are available and they have been consulted and listed in the bibliography for the interest of the reader, but so far as I am aware this is the first reasonably complete dictionary of terms relevant to the consideration of national health insurance and health care that we have available.

The definitions which have been prepared are not in any sense official or final. They are not necessarily the definitions which the Committee will give to these terms when they are used in the actual writing of national health insurance law. Nor is any part of the dictionary completely exhaustive: available time and energy have necessarily limited the effort. I would be pleased to receive both suggested additions to the various parts of the dictionary, and criticisms and revisions of what has been done, since it is possible that we will subsequently prepare a second edition. Nevertheless, the staff has taken great care, and I believe has been generally successful, in assuring that the definitions are sufficiently complete and accurate throughout to explain the specialized uses given these concepts in our work.

Several comments on the use of the dictionary are in order. In any particular definition where a term is used which is defined elsewhere in the dictionary it has been printed in italics (except for very common terms like hospital) the first time it occurs to indicate that the reader will find a definition for it elsewhere. Many of the definitions include a list of closely related or otherwise relevant terms which should also be examined when trying to understand a given concept. Using the italics and lists of related terms, it is possible to read together definitions of families of related concepts such as those used in the Congressional process, the Federal budget, malpractice, insurance, epidemiology, drug regulation, health manpower, health planning,

Medicare, Medicaid, or hospital administration. As an appendix we have included an extensive list of abbreviations and acronyms which occur commonly in health care and in the national health insurance debate with their full meanings. These abbreviations and acronyms when they appear in the dictionary are listed under their full meanings. A person confronted with an acronym should start with the appendix and then proceed to the text of the dictionary. In addition to a simple definition, many of the definitions include one or more examples, an indication of important considerations relevant to the term in question, and references to, or quotations from, formal legal and official definitions of the term.

In any endeavor the quality of our work can only be as good as our understanding of the words we use. The following dictionary has been prepared in hopes of enhancing the quality of this Committee's work on national health insurance and I therefore take pleasure in recommending it to the attention of all parties to the debate.

PAUL G. ROGERS,
*Chairman, Subcommittee on Health and
the Environment.*

ACKNOWLEDGMENTS

The Committee often has reason to ask for assistance in its work and frequently cannot properly acknowledge the help it receives. It is therefore pleasing on this occasion to be able to do so, particularly since this effort has stimulated a really unusual amount of high quality help from those who were asked. People have given generously of their time for writing definitions, suggesting terms, locating existing glossaries and criticizing the various drafts of the dictionary. All of their efforts are much appreciated. The Committee particularly wishes to thank: the staff of the Congressional Research Service of the Library of Congress; Ira Raskin, John Gallicchio and other staff of the National Center for Health Services Research; Dan Pettingill of the Aetna Life & Casualty Company; Catherine Lyon, Joe Newhouse and other staff of the Rand Corporation; Irv Wolkstein and Steve Sieverts of the American Hospital Association; Joe Manes of the House Committee on the Budget; David Banta of the Office of Technology Assessment; Jane Murnaghan and Kerr White of the Department of Health Care Organization of the School of Hygiene and Public Health of the Johns Hopkins University; Steve Summers of the Association of American Medical Colleges; Edwin Tuller and other staff of the Blue Cross Association; Linda Horton and other staff of the Food and Drug Administration; Ruth Johnson and other staff of the Bureau of Health Manpower of the Health Resources Administration; the staff of Spectrum Research Inc.; the staff of the Health Policy Program of the University of California, San Francisco; Ruth Hanft and other staff of the Institute of Medicine of the National Academy of Sciences; the staff of the American Medical Association; and the staff of the Office of the Assistant Secretary for Planning of HEW. Special thanks also go to Anne Jordan, Susan Tomasky and Bill Burns of the Committee staff for doing much of the real work. Without the assistance of these and other people the job simply would never have been done. The responsibility for the results of course remains with the Committee professional staff, who would like to add to Samuel Johnson's explanation of errors in his dictionary, "Ignorance, sir, ignorance!", only "and laziness."

TERMS

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[Phone Number]
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a

abortion: termination of a pregnancy before the fetus has attained viability, i.e. become capable of independent extra-uterine life. Viability is usually defined in terms of the duration of pregnancy, weight of the fetus, and/or, occasionally, the length of the fetus. A recent inquiry by WHO revealed considerable variation in the definitions used in different countries. It has traditionally been assumed that viability is attained at 28 weeks of gestation, corresponding to a fetal weight of approximately 1000 g. This definition is based on the observation that infants below this weight have little chance of survival, while the mortality of infants above 1000 g. declines rapidly. A variety of different types of abortions is distinguished: early—less than twelve completed weeks of gestation; late—more than twelve weeks; induced—caused by deliberate action undertaken with the intention of terminating pregnancy; spontaneous—all abortions other than induced ones, even if externally caused, for instance by trauma or treatment of an independent condition; therapeutic—caused for the treatment of the pregnant woman. See also *stillbirth*.

abuse: improper or excessive use of program benefits, resources or services by either providers or consumers. Abuse can occur, intentionally or unintentionally, when services are used which are excessive or unnecessary; which are not the appropriate treatment for the patient's condition; when cheaper treatment would be as effective; or when billing or charging does not conform to requirements. It should be distinguished from *fraud*, in which deliberate deceit is used by providers or consumers to obtain payment for services which were not actually delivered or received, or to claim program eligibility. Abuse is not necessarily either intentional or illegal. See also *drug dependence*.

acceptability: an individual's (or group's) overall assessment of medical care available to him. The individual appraises such things as the cost, *quality*, results, and convenience of care, and provider attitudes in determining the acceptability of health services provided. See also *access* and *availability*.

access: an individual's (or group's) ability to obtain medical care. Access has geographic, financial, social, ethnic and psychic components and is thus very difficult to define and measure operationally. Many government health programs have as their goal improving access to care for specific groups or equity of access in the whole population. Access is also a function of the *availability* of health services, and their *acceptability*. In practice access, availability and acceptability, which collectively describe the things which determine the care people use, are very hard to differentiate.

accident: an unexpected, unplanned event which may involve *injury*.

accident and health insurance: *insurance* under which benefits are payable in case of *disease*, *accidental injury*, or, in some cases, *accidental death*.

accountable: responsible, liable, explainable. To account means to furnish a justification or detailed explanation of financial activities or responsibilities; to furnish substantial reasons or convincing explanations. Accountability entails an obligation to periodically disclose in adequate detail and consistent form to all directly and indirectly responsible or properly interested parties the purposes, principles, procedures, relationships, results, incomes, and expenditures involved in any activity, enterprise or assignment so that they can be evaluated by the interested parties. The concept is important in health *planning* and *regulation* programs (such as *health systems agencies*) which should be accountable to the public and those they affect for their actions. There is no specific or detailed agreement on what accountability is or how to assure it. P.L. 93-641, for example, contains a variety of provisions designed to make the planning conducted under it accountable: agency governing boards must have a *consumer* majority; the affected parties must be represented on agency governing boards; data, files, and meetings must all be open to the public; and decisions must be made according to established public procedures and criteria.

accreditation: the process by which an agency or organization evaluates and recognizes a program of study or an institution as meeting certain predetermined *standards*. The recognition is called accreditation. Similar assessment of individuals is called *certification*. Standards are usually defined in terms of: physical plant, governing body, administration, medical and other staff, and scope and organization of services. Accreditation is usually given by a private organization created for the purpose of assuring the public of the quality of the accredited (such as the *Joint Commission on Accreditation of Hospitals*). Accreditation standards and individual performance with respect to such standards are not always available to the public. In some situations public governments recognize accreditation in lieu of, accept it as the basis of, or require it as a condition of *licensure*. Public or private payment programs often require accreditation as a condition of payment for covered services. Accreditation may either be permanent once obtained or for a specified period of time. Unlike a license, accreditation is not a condition of lawful practice but is intended as an indication of high quality practice, although where payment is effectively conditioned on accreditation it may have the same effect.

acquisition cost: the immediate cost of selling, underwriting, and issuing a new *insurance policy*, including clerical costs, agents' commissions, advertising, and medical inspection fees. Also refers to the cost paid by a pharmacist or other retailer to a manufacturer or wholesaler for a supply of *drugs*.

actual charge: the amount a physician or other practitioner actually bills a patient for a particular medical service or procedure. The actual charge may differ from the *customary, prevailing, and/or reasonable charges* under *Medicare* and other insurance programs. See also *fractionation*.

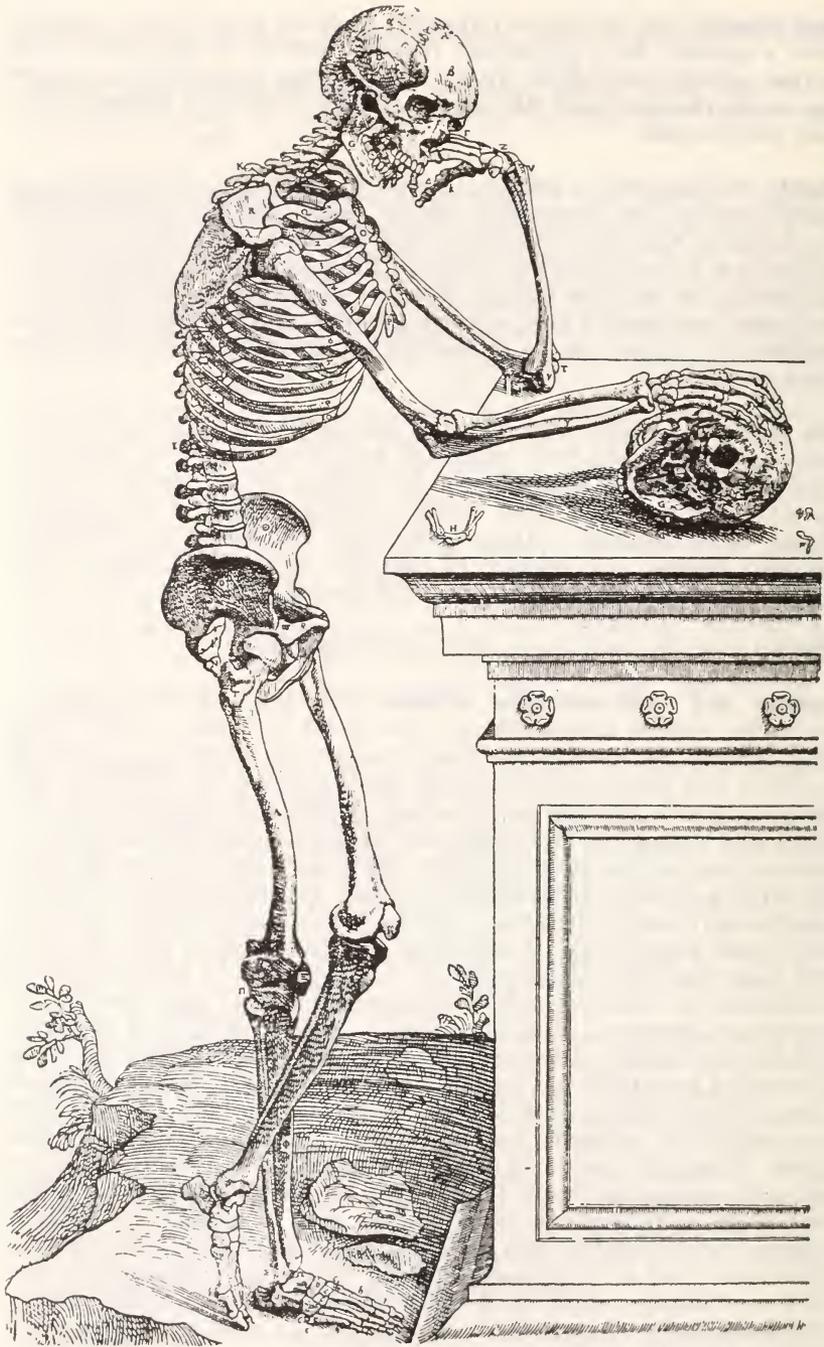
actuary: in *insurance*, a person trained in statistics, accounting, and mathematics who determines policy *rates, reserves,* and dividends by deciding what assumptions should be made with respect to each of the risk factors involved (such as the frequency of occurrence of the *peril*, the average benefit that will be payable, the rate of investment earnings, if any, *expenses,* and *persistence* rates), and who endeavors to secure as valid statistics as possible on which to base his assumptions.

acute disease: a *disease* which is characterized by a single episode of a fairly short duration from which the *patient* returns to his normal or previous state and level of activity. While acute diseases are frequently distinguished from *chronic diseases*, there is no standard definition or distinction. It is worth noting that an acute episode of a chronic disease (an episode of diabetic coma in a patient with diabetes) is often treated as an acute disease.

addiction: see *drug addiction, abuse, and dependence*.

adequate and well-controlled studies: the type of investigations, including clinical investigations, that must be conducted by a new drug sponsor to demonstrate that a *new drug* is *effective*. As amended in 1962, the Federal Food, Drug, and Cosmetic Act requires that drug sponsors provide substantial evidence of *effectiveness* and gives this term a special definition: "evidence consisting of adequate and well-controlled investigations, including clinical investigations, by experts qualified by scientific training and experience to evaluate the effectiveness of the drug involved, on the basis of which it could fairly and responsibly be concluded by such experts that the drug will have the effect it purports or is represented to have under the conditions of use *prescribed, recommended, or suggested* in the *labeling* or proposed labeling thereof" (section 505(d) of the Act). FDA *rules* further delineate the types of studies which must be conducted to satisfy this requirement, and permit waiver in certain cases. The study protocol must minimize bias and must assure comparability between test and control groups. Generally, four types of control are recognized: comparing *treated and untreated patients*, comparing results of new drug use with a *placebo*, comparing results of new drug use with results from a regimen of therapy known to be effective, and comparing results of new drug use with experience that is historically derived. The statute and regulations do not explicitly require that *safety* of a new drug be established by adequate and well-controlled studies; nor do they set forth explicit criteria for safety testing.

adjunct disability: in the Veterans Administration health care program, a *nonservice-connected disability* associated with or held to be aggravating a *service-connected disability*.



administration: the guidance of an undertaking toward the achievement of its purpose. Administration and management are so similar and irregularly distinguished that they may be considered synonymous, although they have been distinguished by applying administration to public activities and management to private, or by describing one as concerned with the making of broad *policy* and the other as concerned with the execution of that policy once formulated. See also *planning, goals* and *objectives*.

admission: the formal acceptance by a hospital or other *inpatient* health care facility of a *patient* who is to be provided with room, board, and continuous *nursing* service in an area of the hospital or facility where patients generally stay at least overnight.

admission certification: a form of medical care review in which an assessment is made of the medical *necessity* of a *patient's admission* to a hospital or other inpatient institution. Admission certification seeks to assure that patients requiring a hospital level of care, and only such patients, are admitted to the hospital without unnecessary delay and with proper planning of the hospital stay. *Lengths of stay* appropriate for the patient's admitting *diagnosis* are usually assigned and certified, and payment by any program requiring certification for the assigned stay is assured. Certification can be done before (*preadmission*) or shortly after (*concurrent*) admission.

admitted assets: assets of an *insurance* company recognized by a State regulatory body or other examining body in determining the company's financial condition.

admitting physician: the *physician* responsible for *admission* of a patient to a hospital or other *inpatient health facility*. The physician may remain responsible for the care of the patient once admitted (see *private patient*), or not (the *housestaff* usually becoming responsible). Some facilities have all admitting decisions made by a single physician (typically a rotating responsibility) called an admitting physician.

admitting privileges: see *staff privileges*.

advance appropriation: in the Federal budget, an *appropriation* provided by the Congress one or more years in advance of the fiscal year in which the *budget authority* becomes available for *obligation*. Advance appropriations allow State and local governments, and others sufficient time to develop plans with assurance of future Federal funding: e.g., the 1976 appropriation for the Washington Metropolitan Area Transit Authority contained in the Department of Transportation and Related Agencies Appropriation Act for 1975. An advance appropriation is sometimes mistakenly referred to as forward funding, which involves an agency in obligating funds in the current year for *outlay* to programs that are to operate in subsequent *fiscal years*.

adverse selection: disproportionate *insurance of risks* who are poorer or more prone to suffer *loss* or make claims than the average risk. It may result from the tendency for poorer risks or less desirable *insureds* (sick people) to seek or continue insurance to a greater extent than do better risks (healthy people), or from the tendency for the insured to take advantage of favorable options in insurance contracts. Favorable, as compared to adverse, selection, when intentional, is called *skimming*.

affiliated hospital: one which is *affiliated* in some degree with another health program, usually a medical school. Some definitions in fact limit the term to mean hospitals with close or extensive affiliations with medical schools.

affiliation: an agreement (usually formal) between two or more otherwise independent programs or individuals which defines how they will relate to each other. Affiliation agreements may specify: procedures for referring or transferring *patients* from one facility to another; joint faculty and/or medical staff appointments; teaching relationships; sharing of records or services; or provision of *consultation* between programs. See also *affiliated hospital*.

aggregate indemnity: the maximum dollar amount payable for any *disability*, period of disability, or covered service under an *insurance policy*.

alcoholism: a *chronic disease* manifested by repeated drinking of alcoholic beverages in excess of the dietary and social uses and norms of the community and to an extent that interferes with the drinker's *health*, or his social or economic functioning. The definition of alcoholism in both theory and practice is highly variable: sometimes requiring only excessive drinking or interference with the drinker's functioning rather than both; sometimes requiring, in addition to the above, physical signs of *drug dependence*, or being recognized as present without either. There are many, variable systems for separating different types of alcoholism and grading its severity. See also *drug abuse*.

allied health personnel: specially trained and *licensed* (when necessary) health workers other than *physicians, dentists, podiatrists* and *nurses*. The term has no constant or agreed upon detailed meaning: sometimes being used synonymously with *para-medical personnel*; sometimes meaning all health workers who perform tasks which must otherwise be performed by a physician; and sometimes referring to health workers who do not usually engage in independent practice.

allocated benefit provision: a provision in an *insurance policy* under which payment for certain *benefits* (such as miscellaneous hospital and medical services like X-rays, dressings and drugs) will be made at a rate for each specified (scheduled) in the provision. Usually there is also a maximum that will be paid for all such expenses. An allocated benefit is one which is subject to such a provision. In an

unallocated benefit provision no specification is given of how much will be paid for each type of service although the provision sets a maximum payable for all the listed services.

allopathic physician: usually used in contrast to *osteopathic* and *homeopathic*; a *physician* practicing a philosophy of medicine which views the role of the physician as an active interventionist who attempts to counteract the effect of a *disease* by using treatments, surgical or medical, which produce effects opposite to those of the disease. A homeopathic physician, on the other hand, generally uses a drug therapy which reinforces the body's natural self-healing process. Almost all physicians in the United States would be considered allopathic.

allowable charge: generic term referring to the maximum fee that a *third party* will use in reimbursing a *provider* for a given service. An allowable charge may not be the same as either a *reasonable*, *customary* or *prevailing charge* as the terms are used under the *Medicare* program.

allowable costs: items or elements of an institution's costs which are reimbursable under a payment formula. Both *Medicare* and *Medicaid* reimburse hospitals on the basis of certain costs, but do not allow reimbursement for all costs. Allowable costs may exclude, for example, uncovered services, luxury accommodations, costs which are not *reasonable*, expenditures which are unnecessary in the efficient delivery of health services to persons covered under the program in question (it would not be allowable to reimburse costs under Medicare involved in providing services to newborn infants), or depreciation on a capital expenditure which was disapproved by a health planning agency. See also *section 223* and *1122*.

alternatives to long-term institutional care: the whole range of health, nutritional, housing and social services designed to keep persons, particularly the aged, disabled and retarded, out of institutions like *skilled nursing facilities* which provide care on a long-term basis. The goal is to provide the range of services necessary to allow the person to continue to function in the home environment. Alternatives to long-term care include day-care centers, foster homes or *homemaker services*.

ambulatory care: all types of health services which are provided on an *outpatient* basis, in contrast to services provided in the home or to persons who are *inpatients*. While many inpatients may be ambulatory, the term ambulatory care usually implies that the patient has come to a location other than his home to receive services and has departed the same day.

amortization: the act or process of extinguishing a debt, usually by equal payments at regular intervals over a specific period of time.

ancillary expenses: *see miscellaneous expenses*.

ancillary services: hospital, or other inpatient health program, services other than room and board, and *professional services*. They may include X-ray, *drug*, laboratory or other services not separately itemized, but the specific content is quite variable. See also *miscellaneous expenses*.

annual implementation plan (AIP): a plan, which the National Health Planning and Resources Development Act of 1974 (P.L. 93-641) requires *health systems agencies* to prepare or update annually, specifying, describing how to implement, and giving priority to, short-run *objectives* which will achieve the long range *goals* of the agency, detailed in its *health system plan*. Section 1513 of the PHS Act describes the place of AIP's in the larger context of agency functioning.

antibiotic: any *drug* containing any quantity of any chemical substance produced by a microorganism which has the capacity, in dilute solution, to inhibit the growth of, or to destroy, bacteria and other microorganisms (or a chemically synthesized equivalent of such a substance). Antibiotics are used in the *treatment* of infectious *diseases*.

antibiotic certification: an FDA program in which each batch of every *antibiotic drug* for human use is *certified* by FDA as possessing the necessary characteristics of identity, strength, *quality*, and purity to adequately insure *safety* and *effectiveness* in use. Before an antibiotic is eligible for certification, FDA must approve the drug as safe and effective under procedures that are substantially equivalent to those for approving *new drugs*. Similar procedures exist for batch certification of insulin. Both antibiotic and insulin certification services are supported by user fees.

anti-discrimination laws: in *insurance*, State laws which prohibit *insurers* from giving preferential terms or rates, not warranted by the rating of the *risks* involved.

anti-substitution laws: State laws that require the pharmacist to "dispense as written." The effect is to prohibit a pharmacist from substituting a different *brand name drug* for the one prescribed, or from substituting a *generic equivalent drug* in place of a *drug* prescribed by brand name, even if the drug that would be substituted is considered to be *therapeutically equivalent* to the drug prescribed and perhaps is less expensive. Drug reimbursement programs such as the *Maximum Allowable Cost Program*, which will limit reimbursement to the lowest cost at which a drug is generally available, will be more effective if they override anti-substitution laws.

appropriate: suitable for a particular person, condition, occasion, or place; proper; fitting. A term commonly used in making *policy*, usually without specific indication of which aspects of the person or thing to which the term is applied are to be judged appropriate, or how and by what standard those aspects are to be judged. A good example occurs in P.L. 93-641, in section 1523(a)(6) which requires *State health planning and development agencies* to periodically

review existing *institutional health services* and make public findings "respecting the appropriateness of such *services*." No indication is given in the law or *legislative history* of what the agencies are to find either appropriate or inappropriate (the *costs* or *charges*, *necessity*, *quality*, *staffing*, *administration*, or location of the services), or what methods and criteria are to be used.

appropriation: in the Federal budget, an act of Congress that permits Federal agencies to incur *obligations* and to make payments out of the Treasury for specified purposes. An appropriation usually follows enactment of *authorizing legislation*. An appropriation is the most common form of *budget authority*, but in some cases the authorizing legislation provides the budget authority. Appropriations are categorized by their period of availability (one-year, multiple-year, no-year), the timing of Congressional action (current, permanent), and how the amount of the appropriation is determined (definite, indefinite).

area health education center (AHEC): an organization or system of health, educational and service institutions whose *policy* and programs are frequently under the direction of a medical school or university health science center and whose prime *goals* are to improve the distribution, *supply*, *quality*, *utilization*, and *efficiency* of health personnel in relation to specific *medically underserved areas*. The primary *objectives* are to educate and train the health personnel specifically *needed* by that underserved community and to decentralize *health manpower* education, thereby increasing manpower supplies and providing a linkage between the health and educational institutions in scarcity areas. In practice, each AHEC has as its nucleus one or more public or nonprofit hospitals, some distance away from the medical school or university health science center, but whose educational efforts are under the effective guidance of such medical center. The development of AHECs is assisted by HEW under the *HMEIA* authority.

areawide comprehensive health planning agency (areawide CHP, or 314(b) agency): a sub-state (usually multi-county) agency assisted under section 314(b) of the *PHS Act*, created by the Comprehensive Health Planning and Public Health Service Amendments of 1966 (P.L. 89-749), and charged with the preparation of regional or local plans for the coordination and development of existing and new health services, facilities, and manpower. The agencies were authorized to review and comment upon proposals from hospitals and other institutions for development of programs and expansion of facilities, but had no significant powers of enforcement. Up to three quarters of the operating costs of the 314(b) agencies could be supported by Federal *project grants*. The balance of the costs were obtained from voluntary contributions from any source, including the health care providers affected by the agencies' plans. Under the provisions of the new health planning law, P.L. 93-641, existing 314(b) agencies will be replaced by *health systems agencies* which will have expanded duties and powers.

assessment: in *insurance*, a charge upon *carriers* to raise funds for a specific purpose (such as meeting the administrative costs of a government required program) made by government (usually State government) or a special organization authorized by government, and provided for in law or regulation. Applied to all carriers handling a specific line of coverage subject to regulation by the government in question and based upon a formula.

assigned risk: a *risk* which *underwriters* do not care to insure (such as a person with hypertension seeking health insurance) but which, because of State law or otherwise, must be insured. Insuring assigned risks is usually handled through a group of insurers (such as all companies licensed to issue health insurance in the State) and individual assigned risks are assigned to the companies in turn or in proportion to their share of the State's total health insurance business. Assignment of risks is common in casualty insurance and less common in health insurance. As an approach to providing insurance to such risks, it can be contrasted with pooling of such risks (see *insurance pool*) in which the *losses* rather than the risks are distributed among the group of insurers.

assignment: an agreement in which a *patient* assigns to another party, usually a *provider*, the right to receive payment from a *third-party* for the service the patient has received. Assignment is used instead of a patient paying directly for the service and then receiving reimbursement from public or private insurance programs. In *Medicare*, if a physician accepts assignment from the patient, he must agree to accept the program payment as payment in full (except for specific *coinsurance*, *copayment* and *deductible* amounts required of the patient). Assignment, then, protects the patient against liability for charges which the Medicare program will not recognize as *reasonable*. Under some *national health insurance* proposals physicians must agree to assignment for all of their patients or none of them; under Medicare, physicians may choose assignment for some of their patients but not others, and may do so on a claim by claim basis for some services but not others.

Assisted Health Insurance Plan (AHIP): one of three parts of the present administration's proposal for *national health insurance*, the *Comprehensive Health Insurance Plan*. AHIP is designed to provide health insurance coverage for low *income* and high medical risk people. It would be available to anyone electing coverage, at a premium no greater than 150 percent of the average group premium for private health insurance in the State. Premiums and *cost sharing* would be *indexed* to income. AHIP would replace *Medicaid* and would be State administered under contract with fiscal *intermediaries*. Benefits under AHIP would be identical to those under *EHIP* and *FHIP*. The plan would be financed by premiums, and subsidized by State and Federal revenues under a matching formula.

associate degree program: a program which educates *registered nurses* in a junior college, the associate degree being given upon junior college graduation. The student's classroom and laboratory teaching

is principally provided in the college and clinical teaching in an *affiliated hospital*. See also *diploma school* and *baccalaureate degree program*.

association: in *epidemiology*, the general name for a relationship between two variables. Two related variables, such as age and the incidence of diabetes, are said to be 'associated.' Several different types of association are recognized: such as artifactual, causal, and chance.

assurance: synonymous with *insurance*.

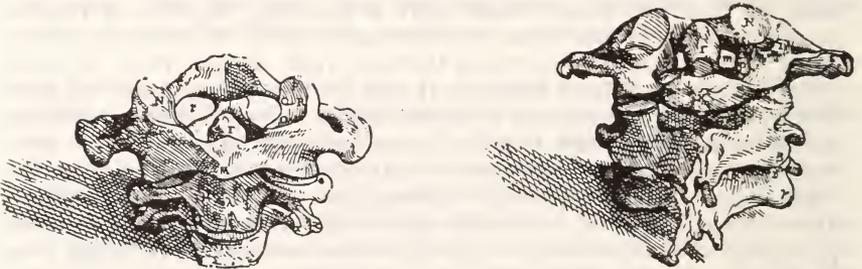
at risk: the state of being subject to some uncertain event occurring which comotes loss or difficulty. In the financial sense, this refers to an individual, organization (like an *HMO*) or insurance company assuming the chance of loss—through running the risk of having to provide or pay for more *services* than paid for through *premiums* or per capita payments. If payments are adjusted after the fact so that no loss can occur, then there is no risk. In fact, of course, losses incurred in one year may be made up by increases in premiums or per capita payments in the next year, so the "risk" is somewhat tempered. A firm which is at risk for losses also stands to gain from *profits* if costs are less than premiums collected. For a *consumer* being financially at risk usually means being without insurance or at risk for substantial *out-of-pocket* expenses. A second use of the term relates to the special vulnerability of certain populations to certain diseases or conditions; ghetto children are at risk for lead poisoning or rat bite; workers in coal mines are at risk for *black lung* disease.

attending physician: the physician legally responsible for the care given a *patient* in a hospital or other health program. Usually the *private physician* of a *private patient* who is also responsible for the patient's *outpatient* care. The attending physician for a *public patient* is typically chosen by the hospital upon the patient's *admission* from among members of its *medical staff*, or is one of its *teaching physicians*.

audiologist: an individual trained in *audiology* who evaluates hearing function and performs research related to hearing; and plans, directs, and conducts *habilitative* programs designed to improve the communication efficiency of individuals with impaired hearing. Approximately 26,500 persons were employed as *speech pathologists* and audiologists in 1973. *Licensure* generally requires a masters degree in audiology. The American Speech and Hearing Association awards a *certificate* of clinical competence which requires academic training at the master's degree level, one year of experience in the field, and the passing of a national examination. At the close of 1973, 1,313 persons held certificates of clinical competence in audiology. Nearly half of the ASHA members are employed in elementary or secondary schools and a large majority are engaged in clinical work—either diagnostic or therapeutic.

audiology: the study, examination, appreciation and treatment of hearing defects, including the use of auditory substitutional *devices* (hearing aids) and other *therapy*. See also *audiologist* and *pathologist*.

authorization or authorizing legislation: in the Federal budget, legislation enacted by Congress which sets up or continues the legal operation of a Federal program or agency indefinitely or for a specific period of time, often three years in the health area. Such legislation is a prerequisite for subsequent *appropriations*, or other kinds of *budget authority* to be contained in appropriation acts. It may limit the amount of budget authority to be provided subsequently or may authorize the appropriation of "such sums as may be necessary"; in a few instances budget authority may be provided in the authorization (see *backdoor authority*). The term is often used more narrowly to refer to annual dollar limits specified in authorizing legislation on amounts which may be appropriated for the authorized program.



B

autopsy: examination of the body after death (post mortem, therefore also called a 'post' or 'post mortem') to determine the cause of death. The autopsy rate (percentage of deaths receiving autopsies in a hospital) is sometimes considered a measure of the *quality* of a hospital. Consent for an autopsy, except where exception is made by law, is required from the dead person's survivors.

availability: a measure (in terms of type, volume and location) of the *supply* of health resources and services relative to the *needs* (or *demands*) of a given individual or community. Health care is available to an individual when he can obtain it at the time and place that he *needs* it, from *appropriate* personnel. Availability is a function of the distribution of appropriate resources and services, and the willingness of the *provider* to serve the particular *patient* in need. See also *access* and *acceptability*.

b

baccalaureate degree program: a program which educates *registered nurses* in a four-year college or university, the bachelor of arts or sciences degree being given upon graduation from the program.

Classroom and laboratory teaching is principally provided by the college (usually by its nursing school) and clinical teaching by the college's own or an *affiliated hospital*. See also *diploma school* and *associate degree program*.

backdoor authority: in the Federal budget, legislative authority for the *obligation* of funds outside the normal *appropriation* process. Sometimes called backdoor spending. The most common forms of backdoor authority are borrowing authority (authority to spend debt receipts) and contract authority. In other cases, (e.g., interest on the public debt) a permanent appropriation is provided that becomes available without any current action by the Congress. *Entitlement authority* is sometimes included as a form of backdoor authority, since the enactment of the basic benefit legislation may effectively mandate the subsequent enactment of the appropriations to pay the statutory benefits. Section 401 of the Congressional Budget and Impoundment Control Act of 1974 specifies certain limits on the use of backdoor authority. Examples of programs that have backdoor authority are the Environmental Protection Agency's construction grant program and the social security *trust funds*.

bad debts: the amount of *income* lost to a provider because of failure of patients to pay amounts owed. The impact of the loss of revenue from bad debts may be partially offset for *proprietary* institutions by the fact that income tax is not payable on income not received. They may also be recovered by increasing *charges* to paying patients by a proportional amount. Some *cost-based reimbursement* programs reimburse certain bad debts (see *reasonable cost*).

basic health services: the minimum *supply* of health *services* which should be generally and uniformly *available* in order to assure adequate *health status* and protection of the population from *disease*, or to meet some other *criteria* or *standards*. Given that all possible services cannot be supplied to the entire population, it is surprising how little definition or discussion there has been of what set of services constitutes an *appropriate* minimum and of how to assure its availability. A beginning has been made in Federal *policy* with the definition of *required services* for *Medicaid* and basic health services required of *HMO's* for Federal assistance or *qualification*. These include: *physician* services, *hospital* services, *medically necessary emergency care*, *preventive health* services, *home health* services, up to 20 *visits* of *outpatient mental health* services, *medical treatment* and *referral* services for *alcoholism* and *drug abuse*, and laboratory and radiologic services (section 1302(1) of the *PHS Act*). Where a minimum is defined, a higher level of service is usually also defined (*supplemental health* and *optional services* for *HMOs* and *Medicaid*, respectively). It is not clear in either case whether the higher level is thought of as all other, all other *needed*, or all other *affordable* services.

bed: literally a bed in a *hospital* or other inpatient health facility.

Many definitions require that the beds be maintained for continuous (24 hour) use by *inpatients*. Beds are often used as a measure of capacity (hospital sizes are compared by comparing their number of beds). *Licenses* and *certificates-of-need* may be granted for specific numbers or types of beds: e.g. surgical, pediatric, obstetric, or extended care. Facilities may have both licensed and unlicensed beds; and active and licensed but unused beds. Other qualifying adjectives are frequently used to categorize beds: e.g. available, occupied, *acute care* or observation beds.

beneficiary: a person who is eligible to receive, or is receiving, *benefits* from an *insurance policy* (usually) or *health maintenance organization* (occasionally, see *member*). Usually includes both people who have themselves contracted for benefits and their eligible *dependents*. See also *subscriber* and *insured*.

benefit: in *insurance*, a sum of money provided in an *insurance policy* payable for certain types of *loss*, or for covered services, under the terms of the policy. The benefits may be paid to the *insured* or on his behalf to others. In *prepayment* programs, like *HMOS*, benefits are the services the program will provide a *member* whenever, and to the extent *needed*.

benefit period: the period of time for which payments for *benefits* covered by an *insurance policy* are available. The availability of certain benefits may be limited over a specified time period, for example two well-baby visits during a one-year period. While the benefit period is usually defined by a set unit of time, such as a *year*, benefits may also be tied to a *spell of illness*.

bioavailability: the extent and rate of absorption of a dose of a given *drug*, measured by the time-concentration curve for appearance of the administered drug in the blood. The concept is important in attempting to determine whether different *brand name* drugs, a *generic name* as opposed to a brand name drug, or, in some cases, different batches of the same brand name drug, will produce the same *therapeutic effect*. The same drug made by two different manufacturers or different batches of the same drug made by the same manufacturer may demonstrate differing bioavailability. There is controversy as to whether such differences are therapeutically significant. See also *Maximum Allowable Cost Program*, *anti-substitution*, and *bioequivalence*.

bioequivalence: describes drug preparations which have the same *bioavailability*. Such *drugs* are *chemically equivalent* (indistinguishable by chemical means) although chemically equivalent preparations are not always bioequivalent. Bioequivalence is a function of bioavailability and the terms are often used synonymously. Chemically equivalent drugs which are bioequivalent are *therapeutically equivalent* (have the same treatment effect), although therapeutically equivalent preparations need not be either chemically or bioequivalent.

biologics: (biological products, biologicals) any virus, therapeutic serum, toxin, anti-toxin, or analogous product of plant or animal origin used in the *prevention, diagnosis, or treatment of disease*. Biologics, including vaccines and blood plasma products, are regulated by the Bureau of Biologics, a division of the Food and Drug Administration. They differ from *drugs* in that biologics are usually derived from living microorganisms and cannot be synthesized or readily standardized by chemical or physical means. They tend to be chemically less stable than drugs, their *safety* cannot be as easily assured and they are never as chemically pure as drugs.

biomedical research: *research* concerned with human and animal biology, and *disease* and its *prevention, diagnosis* and *treatment*. It contrasts with *health services research* which is concerned with the organization, effects and other aspects of health services.

birth control: see *family planning*.

birth rate: a fraction, whose numerator is the total number of births in a population during a given period and whose denominator is the total number of person-years lived by the population during that period. The latter is generally approximated by the size of the population at the mid-point of the period multiplied by the length of the period in years. The rate is usually stated per 1,000. Like other rates in which the population at the mid-point of the period is used as the denominator of the fraction, this is sometimes called the central birth rate. Where birth rate is used without qualification, the *live birth* rate is generally meant and only live births appear in the numerator. The total birth rate, based on live births and late fetal deaths, is sometimes calculated. Legitimate birth rates and illegitimate birth rates, with legitimate and illegitimate births respectively, are computed; and the illegitimacy ratio, the number of illegitimate births per 1,000 total births, is frequently used. To compare the fertility of different populations, standardized birth rates (the definition above being the crude birth rate) are often used to eliminate the effect on the birth rate of differences in structure of the population (most commonly the age and sex structure).

black lung: common name for pneumoconiosis, a *chronic* severely debilitating lung *disease* caused by inhaling coal dust and principally found among coal miners. Certain medical benefits for the victims of the disease are available under title IV of the Federal Coal Mine Health and Safety Act of 1969 (P.L. 91-173), as amended by P.L. 92-303.

blanket medical expense: a provision (usually included as an added feature of a policy primarily providing some other type of coverage, such as loss of income insurance) which entitles the *insured* to collect, up to a maximum established in the policy, for all hospital and medical expenses incurred, without limitations on individual types of medical expenses.

Blue Cross Association (BCA): the national non-profit organization to which the 70 *Blue Cross plans* in the United States voluntarily belong. BCA administers programs of *licensure* and approval for Blue Cross plans, provides specific services related to the writing and administering of health care benefits across the country, and represents the Blue Cross plans in national affairs. Under contract with the *Social Security Administration (SSA)*, BCA is *intermediary* in the *Medicare* program for 77 percent of the *participating providers* (90 percent of the participating *hospitals*, 50 percent of the participating *skilled nursing facilities*, and 76 percent of the participating *home health agencies*). See also *Health Services, Inc.* and *Blue Shield Plan*.

Blue Cross plan: a nonprofit, tax-exempt health service *prepayment* organization providing coverage for health care and related services. The individual plans should be distinguished from their national association, the *Blue Cross Association*. Historically, the plans were largely the creation of the hospital industry, and designed to provide hospitals with a stable source of revenues, although formal association between the Blue Cross and American Hospital Associations ended in 1972. A Blue Cross plan must be a nonprofit community service organization with a governing body with a membership including a majority of public representatives. Most plans are regulated by State *insurance commissioners* under special enabling legislation. Plans are exempt from Federal income taxes, and, in most States, from State taxes (both property and premium). Unlike most private insurance companies, the plans usually provide *service* rather than *indemnity benefits*, and often pay hospitals on the basis of *reasonable costs* rather than *charges*. There are 70 plans in the United States. See also *Health Services, Inc.* and *Blue Shield Plan*.

Blue Shield plan: a nonprofit, tax-exempt plan of a type originally established in 1939 which provides coverage of physician's services. The individual plans should be distinguished from the National Association of Blue Shield Plans. Blue Shield coverage is commonly sold in conjunction with *Blue Cross* coverage, although this is not always the case. The relationship between Blue Cross and Blue Shield plans has been a cooperative one; it is not uncommon for the two organizations to have a common board, one management, and to be located in the same building. Blue Shield plans cover some 65 million Americans through their group and individual business. In addition, plan activities affect some 20 million persons through participation in various government programs, including *Medicare* (32 plans act as *carriers* under part B), *Medicaid*, and *CHAMPUS*. Most States have enacted special enabling legislation for the Blue plans. See also *Medical Indemnity of America, Inc.*

board certified: describes a *physician* or other health *professional* who has passed an examination given by a medical *specialty board* and been *certified* by that board as a specialist in the subject in question. The examination cannot be taken until the professional meets requirements set by the specialty board for *board eligibility*. In 1972 there were 131,482 physicians who were board certified in at least one of 22 specialty areas.

board eligible: describes a *physician* or other health *professional* who is eligible for specialty board examination (including those who may have failed the examination if they remain eligible). Each of the *specialty boards* has requirements which must be met before the examination for specialty *board certification* can be taken. These include graduation from an approved school, training experience of specified type and length, and specified time in practice or on the job. The minimum time required after graduation from medical school to become board eligible is generally three to five years. Government and other types of health programs which define standards for specialists often accept board eligibility as equivalent to board certification, since the only difference is that the board certified professional has passed an examination.

boarding homes: organized or informal facilities which provide room and board (to those desiring it, often the aged), and, sometimes, *custodial care* for a fee. The provision of medical supervision, social activities or counseling is not normally included. They are not *licensed as health facilities* and usually are not subject to licensure at all.

borborygmus: a rumbling, gurgling noise in the intestines. See illustration H.

brand name: the registered trademark given to a specific *drug* product by its manufacturer. Also known as a *trade name*. As an example, there is a widely-prescribed broad-spectrum antibiotic with the *generic* or *established name* of tetracycline hydrochloride. Its *chemical name* is 4-dimethylamino-1,4,4a,5,5a,6,11,12a-octahydro-3,6,10,12, 12a-pentahydroxy-6-methyl-11-dioxo-2-naphthacene-carboxamide hydrochloride. Its chemical formula is $C_{22}H_{24}N_2O_8HCL$. This drug is marketed by Lederle Laboratories under the brand name "Achromycin", by Bristol-Myers under "Bristacycline", by Robins as "Robitet", by Squibb as "Sumycin", and so on. There are no official rules governing the selection of brand names. According to the Pharmaceutical Manufacturers Association, the objective is to coin a name which is "useful, dignified, easily remembered, and individual or proprietary." Drugs are primarily advertised to practitioners by brand name. When a physician prescribes by brand name, *anti-substitution laws* in most States forbid the pharmacist from substituting either a brand or generic name equivalent made by a different manufacturer, although either may be less expensive than the drug prescribed.

brown lung: new popular name for byssinosis; a chronic, *disabling* lung disease caused by chronic inhalation of cotton dust and *prevalent* among textile workers. Similar to, but not the same as, *black lung*. Federal benefits, like those available for miners disabled by black lung, are not available for people with brown lung.

budget: a detailed plan in financial terms for carrying out of a program of activities in a specified period, usually a *fiscal year*. The budget typically accounts for all the program's proposed income, by source, and expenses, by purposes such as salaries and *capital* costs,

for the year. Expenses are sometimes related to the program's *goals* and *objectives*. See also *policy planning*, *administration*, and *Congressional* and *Presidential budgets*.

budget authority (BA): in the Federal budget, authority provided by law to enter into *obligations* which will result in immediate or future *outlays* of government funds, except that it does not include the authority to insure or guarantee the repayment of indebtedness incurred by another person or government. The basic forms of budget authority are: *appropriations*, contract authority, and borrowing authority. Budget authority is classified by the timing of Congressional action (current or permanent); or by the manner of determining the amount available (definite or indefinite).

bureaucracy: a government or other organization characterized by specialization of functions, adherence to fixed rules, and a hierarchy of authority: a system of administration marked by officialism, red tape and proliferation. (From *Webster's New Collegiate Dictionary*.)

Bureau of Health Insurance (BHI): agency within the *Social Security Administration* which administers the *Medicare* program. Actual operation of the program is carried out through arrangements with *intermediaries* and *carriers*, who operate under contract with BHI/SSA and receive all policy guidance from the Bureau. BHI employs approximately 2,000 individuals.

Bureau of Quality Assurance (BQA): agency within the Health Resources Administration in HEW which administers the *Professional Standards Review Organization* program.

c

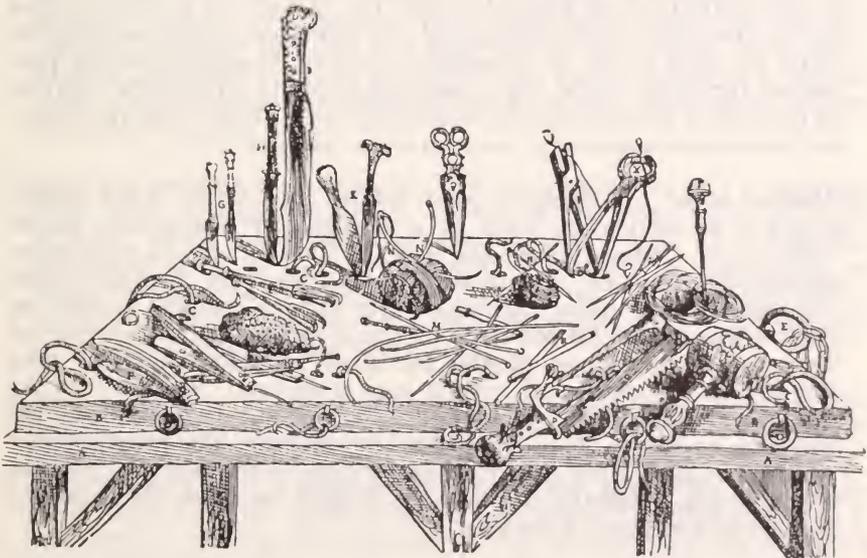
capital: fixed or durable non-labor inputs or factors used in the production of goods and services, the value of such factors, or money specifically available for their acquisition or development. This includes, for example, the buildings, *beds*, and equipment used in the provision of hospital services. Capital goods are usually thought of as permanent and durable (in cases of doubt, those lasting over a year) and should be distinguished from such things as *supplies*. Refers also to investment in self (human capital, for example where *preventive care* is purchased because of the positive effect such care may have on one's ability to sustain future earning capacity). See also *capital depreciation* and *working capital*.

capital depreciation: the decline in value of *capital* assets (assets of a permanent or fixed nature, goods and plant) over time with use. The rate and amount of depreciation is calculated by a variety of different methods (e.g., straight line, sum of the digits, declining balance) which often give quite different results. Reimbursement of health services usually includes an amount intended to be equivalent to the capital depreciation experienced by the provider of the services in conjunction with their provision. See also *debt service*, *section 1122* and *funded*.

capital expenditure review (CER): review of proposed *capital* expenditures of hospitals and/or other health facilities to determine the *need* for, and *appropriateness* of, the proposed expenditures. The review is done by a designated *regulatory* agency such as a *State health planning and development agency* and has a sanction attached which prevents (see *certificate-of-need*) or discourages (see *section 1122*) unneeded expenditures.

capitation: a method of payment for health services in which an individual or institutional provider is paid a fixed, per capita amount for each person served without regard to the actual number or nature of services provided to each person. Capitation is characteristic of *health maintenance organizations* but unusual for physicians (see *fee-for-service*). Also, a method of Federal support of health professional schools authorized by the Comprehensive Health Manpower Training Act of 1971, P.L. 92-157, and the Nurse Training Act of 1971, P.L. 92-158 (sections 770 and 810 of the PHS Act), in which each eligible school receives a fixed capitation payment from the Federal government for each student enrolled, called a capitation grant.

carrier: a commercial health *insurer*, a government agency, or a *Blue Cross* or *Blue Shield* plan which *underwrites* or administers programs that pay for health services. Under the *Medicare Part B (Supplemental Medical Insurance) Program* and the *Federal Employees Health Benefits Program*, carriers are agencies and organizations with which the program contracts for administration of various functions, including payment of *claims*. See also *intermediary* and *third party*.



case-control study: an inquiry in which groups of individuals are selected because they do (the cases) or do not (the controls) have the *disease* whose cause and other attributes are being studied; the groups are then compared with respect to their past, existing, or future characteristics judged likely to be relevant to the disease to see which of the characteristics differ, and how, in the cases as compared to the controls.

case-mix: the diagnosis-specific makeup of a health program's workload. Case-mix directly influences the *length of stays* in, and *intensity, cost* and *scope* of the *services* provided by a hospital or other health program.

cases treated: the number of *patients* cared for by a health program during a year. *Inpatient* discharges and *outpatient* visits can be combined into an aggregate weighted index of hospital output.

castastrophe policy: see *major medical policy*.

catastrophic health insurance: health insurance which provides protection against the high cost of treating severe or lengthy *illnesses* or *disabilities*. Generally such policies cover all or a specified percentage of medical expenses above an amount that is the responsibility of the insured himself (or the responsibility of another insurance policy up to a maximum limit of liability). Under pending *NHI* proposals of this type, protection would typically begin after an individual or family unit had incurred medical expenses equal to a specified dollar amount (e.g., \$2,000 within a 12-month period) or a specified percentage of *income* (e.g., fifteen percent); or had been in a medical institution for a specified period (e.g., 60 days). Individuals would be liable for all costs up to the specified limits. However, in the absence of any effective prohibition against doing so, they could be expected to obtain health insurance protection for costs below the catastrophic limits. Generally there is no maximum amount of coverage under these plans; however, many include some *coinsurance*. See also *major medical*.

catchment area: a geographic area defined and served by a health program or institution such as a hospital or *community mental health center*. Delineated on the basis of such factors as population distribution, natural geographic boundaries, and transportation accessibility. Should be contrasted with service, medical market, or *medical trade area*. All residents of the area needing the services of the program are usually eligible for them, although eligibility may also depend on additional criteria (age or *income*). Residents of the area may or may not be limited to obtaining services from the program, be known to, or *enrolled* in the program. The program may or may not be limited to providing services to residents of the area or under any obligation to know of, *register*, or have the capacity to serve all residents of the area.

categorically needy: persons who are both members of certain categories of groups eligible to receive public assistance, and economically needy. As used in *Medicaid*, this means a person who is aged,

blind, disabled, or a member of a family with children under 18 (or 21, if in school) where one parent is absent, incapacitated or unemployed and, in addition, meets specified *income* and *resources* requirements which vary by State. In general, categorically needy individuals are persons receiving cash assistance under the AFDC or SSI programs. A State must cover all recipients of AFDC payments under Medicaid; however, it is provided certain options (based, in large measure, on its coverage levels under the old Federal/State welfare programs) in determining the extent of coverage for persons receiving Federal SSI and/or State *supplementary SSI payments*. In addition, a State may cover additional specified groups, such as foster children, as categorically needy. A State may restrict its Medicaid coverage to this group or may cover additional persons who meet the categorical requirements as *medically needy*.

categorically related: in the *Medicaid* program, the requirements (other than *income* and *resources*) which an individual must meet in order to be eligible for Medicaid benefits; also individuals who meet these requirements. Specifically, any individual eligible for Medicaid must fall into one of the four main categories of people who are eligible for welfare cash payments. He must be "aged", "blind", or "disabled" (as defined under the *Supplemental Security Income Program*, title XVI of the Social Security Act) or a member of a family with dependent children where one parent is absent, incapacitated, or unemployed (as defined under the Aid to Families with Dependent Children Program, title IV of the Social Security Act). After the determination is made that an individual is categorically related, then income and resources tests are applied to determine if the individual is poor enough to be eligible for assistance (*categorically needy*). As a result of this requirement, single persons and childless couples who are not aged, blind, or disabled and male-headed families in States which do not cover such groups under their AFDC programs cannot receive Medicaid coverage no matter how poor they are.

categorical program: originally, a health program which concerned itself with research, education, control and/or *treatment* of only one or a few specific *diseases*. Now more generally used for a program concerned with only a part, instead of all, of the population or health system. Even more generally used by the present administration to refer to any existing program which it feels the Federal government should cease to support.

cause: something that, if prevented, removed or eliminated, will prevent the occurrence of the event in question, and/or, if permitted, introduced or maintained, will be followed by the event in question. A necessary cause is a cause that must exist if a given event is to occur, but may not itself result in the event. A sufficient cause is one which is inevitably followed by a given event or the existence of a given thing.

Center for Disease Control (CDC): organization within HEW serving as a focal point for *disease* control and *public health* activities. The Center provides facilities and services for the investigation, prevention and control of diseases; supports *quarantine* and other activities to prevent introduction of communicable diseases from foreign countries; conducts research into the *epidemiology*, laboratory *diagnosis*, *prevention* and *treatment* of infectious and other controllable diseases at the community level; provides grants for work on venereal disease, immunization against infectious diseases, and disease control programs; and sets standards for laboratories. Activities focus on the improvement of the health care system through emphasis on prevention and investigations, surveillance and control operations, including training of State and local health workers in specific control techniques or methodologies, rather than through direct treatment.

certificate of insurance: in *group insurance*, a statement issued to a *member* of a *group* certifying that an insurance contract covering the member has been written and containing a summary of the terms applicable to that member.

certificate-of-need or necessity: a certificate issued by a governmental body to an individual or organization proposing to construct or modify a *health facility*, or offer a new or different *health service*, which recognizes that such facility or service when available will be *needed* by those for whom it is intended. Where a certificate is required (for instance for all proposals which will involve more than a minimum *capital* investment or change *bed* capacity), it is a condition of *licensure* of the facility or service, and is intended to control expansion of facilities and services in the public interest by preventing excessive or duplicative development of facilities and services. An example of *capital expenditure review*, certificate of need for construction of new *hospitals* is a requirement of law in 23 States and the District of Columbia. Under the National Health Planning and Resources Development Act of 1974, P.L. 93-641, all States are required to have the *State health planning and development agency* (designated pursuant to the law) administer a State certificate of need program, which must apply to all new *institutional health services* proposed to be offered or developed in the State. The *health systems agencies* (local planning bodies under P.L. 93-641) are required to make recommendations to the State agencies regarding proposed new institutional health services within their areas.

certification: the process by which a governmental or nongovernmental agency or association evaluates and recognizes an individual, institution or educational program as meeting predetermined *standards*. One so recognized is said to be certified. Essentially synonymous with *accreditation*, except that certification is usually applied to individuals and accreditation to institutions. Certification programs are generally nongovernmental and do not exclude the uncertified from *practice* as do *licensure* programs. In the *PSRO* and

other *regulatory* programs, certification of services means that their provision has been approved and payment for them is assured (see *admission certification*). See also *certificate-of-need*.

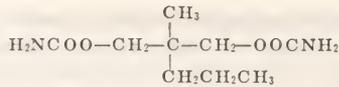
chairside: the dental equivalent of bedside.

charges: prices assigned to units of medical service, such as a visit to a physician or a day in a hospital. Charges for services may not be related to the actual *costs* of providing the services. Further, the methods by which charges are related to costs vary substantially from service to service and institution to institution. Different *third party* payers may require use of different methods of determining either charges or costs. Charges for one service provided by an institution are often used to subsidize the costs of other services. Charges to one type or group of patients may also be used to subsidize the costs of providing services to other groups. See also *actual, allowable, customary, prevailing, reasonable* and *usual charge*.

charitable immunity: in *malpractice*, a doctrine in use in a decreasing number of States that nonprofit, or charitable, hospitals and other health facilities are not subject to suit for malpractice. The doctrine of charitable immunity relies on and involves: waiver of the patient's right to sue for negligence by accepting the charity; the basic unfairness, either assumed or stated, of applying a doctrine such as *respondet superior*, which applies to commercial pursuits, to a nonprofit enterprise; and the increased financial demands upon the assets of the charity which might result from adverse judgments. There are exceptions to the rule of charitable immunity: a charity may be held liable for the negligence of an agent of the institution; a charity may be held liable to a stranger, i.e., one who is not a *beneficiary*; and, sometimes, a charity may be held liable only to the extent of its nontrust assets. The trend today is toward abolition of charitable immunity. This is based on the contention that there were illogical and conflicting bases upon which the doctrine was founded, the alleged unfairness of forcing the injured party to contribute indirectly to the charity by refusing him the opportunity to recover, and the availability of liability insurance. See also *governmental immunity*.

chemical equivalents: *drug* products from different sources which contain essentially identical amounts of the identical active ingredients in identical dosage forms, meet existing physiochemical *standards* in official *compendia*, and are therefore chemically indistinguishable. See also *bioequivalence*.

chemical name: the exact description of the chemical structure of a *drug*, based on the rules of standard chemical nomenclature, such as the tranquilizer with the chemical name 2-methyl-2-propyl, 3-propenediol dicarbamate. While long and cumbersome, this name is also precise, serving as a complete identification of the compound to any trained chemist. It is related to the chemical formula of the particular drug—



This drug is known *generically* as meprobamate. It is sold under various *brand names* by different firms, such as Miltown, Equanil, Pathibamate, and SK-Bamate.

chiropodist: see *podiatrist*.

chiropractor: a practitioner of chiropractic, a system of mechanical therapeutics based on the principles that the nervous system largely determines the state of *health*, and that *disease* results from abnormal nerve function and conformity. Treatment consists primarily of the adjustment or manipulation of parts of the body, especially the spinal column. Some chiropractors also use physiotherapy, nutritional supplementation and other therapeutic modalities; radiography is used for *diagnosis* only. *Operations, drugs* and immunizations are usually rejected as violations of the human body. Chiropractic was founded in 1895 by D. D. Palmer and had grown by 1971 to 19,151 *practitioners* with 36 active chiropractic colleges (requiring four years of post high school education). Chiropractors are licensed by all States. Their services are covered in 27 State *Medicaid* programs. Manual manipulation of the spine is covered under *Medicare* when *subluxation of the spine* is demonstrated on X-ray.

Christian Science: a religion, and system of healing through prayer and the control of mind over matter. The services of Christian Science sanatoria are covered under some health insurance programs including *Medicare* and, in some States, *Medicaid*, often with an exemption from *standards* applied by such programs to traditional medical providers.

chronic disease: *diseases* which have one or more of the following characteristics: are permanent; leave residual *disability*; are caused by nonreversible pathological alteration; require special training of the patient for *rehabilitation*; or may be expected to require a long period of supervision, observation or care. See also *acute disease*.

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS): a program, administered by the Department of Defense, without *premium* but with *cost-sharing* provisions, which pays for care delivered by civilian health providers to retired members, and *dependents* of active and retired members, of the seven uniformed services of the United States (Army, Navy, Air Force, Marine Corps, Commissioned Corps of the Public Health Service, Coast Guard, and the National Oceanic and Atmospheric Administration).

Civilian Health and Medical Program of the Veterans Administration (CHAMPVA): a program, administered by the Department of Defense for the Veterans Administration, without *premium* but with

cost-sharing provisions, which pays for health care provided by civilian providers to dependents of totally *disabled* veterans who are eligible for retirement pay from a uniformed service.

claim: a request to an *insurer* by an *insured* person (or, on his behalf, by the provider of a service or good) for payment of benefits under an *insurance policy*.

claims incurred policy: the conventional form of *malpractice insurance*, under which the *insured* is covered for any claims arising from an incident which occurred or is alleged to have occurred during the policy period, regardless of when the claim is made. The only limiting factors are the *statutes of limitations*, which vary from State to State. An alternative type of policy is the *claims made policy*.

claims made policy: a form of *malpractice insurance* gaining increasing popularity among *insurers* because it increases the accuracy of rate-making. In this type of policy the *insured* is covered for any claim made, rather than any *injury* occurring, while the policy is in force. Claims made after the insurance lapses are not covered as they are by a *claims incurred policy*. This type of policy was initially resisted by *providers* because of the nature of medical malpractice claims, which may arise several years after an injury occurs (see *discovery rule*). A retired physician, for example, could be sued and not covered, unless special provisions are made to continue his coverage beyond his years of *practice*. There are also retrospective problems for providers who switch from a conventional policy to a claims made policy, since the latter policy would not cover claims arising from events occurring during the years when the conventional policy was in effect. Insurers marketing such policies are now offering providers the opportunity to purchase insurance for both contingencies.

claims review: review of *claims* by governments, *medical foundations*, *PSROs*, *insurers* or others responsible for payment to determine liability and amount of payment. This review may include determination of the eligibility of the claimant or *beneficiary*; of the eligibility of the *provider* of the *benefit*; that the benefit for which payment is claimed is covered; that the benefit is not payable under another policy (see *coordination of benefits*); and that the benefit was *necessary* and of *reasonable cost* and *quality*.

clinic: a *facility*, or part of one, for *diagnosis* and *treatment* of *out-patients*. Clinic is irregularly defined, sometimes either including or excluding physicians' offices, sometimes being limited to facilities which serve *poor* or *public patients*, and sometimes being limited to facilities in which *graduate* or *undergraduate medical education* is done.

clinical equivalents: see *therapeutic equivalents* and *bioequivalence*.

clinical privileges: see *staff privileges*.

clinical psychologist: a health *professional* specializing in the evaluation and treatment of mental and behavioral disorders, without having a degree in medicine, as does a psychiatrist. A clinical psychologist generally has a doctoral degree in psychology, plus clinical training in treating psychological disorders. Clinical psychologists are *licensed* by most States for independent professional practice and their services are reimbursed by many health insurance programs. They do not treat physical causes of *mental illness* with *drugs*, or other medical or surgical measures since they are not licensed to practice *medicine*.

cohort study: an inquiry in which a group (the cohort) is chosen for the presence of a specific characteristic at or during a specified time (the independent variable, hypertension, for example) and followed over time for the appearance of particular (presumably) related characteristics (the dependent variables, heart failure and strokes, for example).

coinsurance: a *cost-sharing* requirement under a health insurance policy which provides that the *insured* will assume a portion or percentage of the costs of covered services. The health insurance policy provides that the *insurer* will reimburse a specified percentage (usually 80 percent) of all, or certain specified covered medical expenses in excess of any *deductible* amounts payable by the insured. The insured is then liable for the remaining percentage of the costs, until the maximum amount payable under the insurance policy, if any, is reached.

Commission on Professional and Hospital Activities (CPHA): a non-profit, nongovernmental organization in Ann Arbor, Michigan, established in 1955, which collects, processes, and distributes data on *hospital* use for *management*, evaluation and research purposes. The two main programs of CPHA are the *Professional Activity Study* (PAS) and the *Medical Audit Program* (MAP) which represent a continuing study of hospital practice. More than 1,800 hospitals throughout the United States, Canada, Venezuela, Saudi Arabia, and Australia participate in PAS and MAP. PAS hospitals account for almost 40 percent of all *patients* discharged from short-term general hospitals in the United States and Canada. The system abstracts and classifies information from medical records in a standard format. The computer-accessible data library at CPHA now contains information on more than 86,000,000 hospitalizations—the world's largest collection of such data—and is growing at the rate of approximately 14,000,000 abstracts annually. CPHA is sponsored by the American College of Physicians, American College of Surgeons, American Hospital Association, and Southwestern Michigan Hospital Council. See also *discharge abstract*.

committee report: in Congress, a formal report by a Congressional committee to the House, Senate or both (see *conference*) on a proposed law or other matter. The report is part of the *legislative history* and includes: a summary of the proposed law, recommendations as to its passage and amendments, relevant background information,

a discussion and defense of its provisions, a detailed section-by-section analysis of them, a demonstration of the changes it makes in existing law, reports on the law from the administration, cost estimates, and dissenting views from members of the committee.

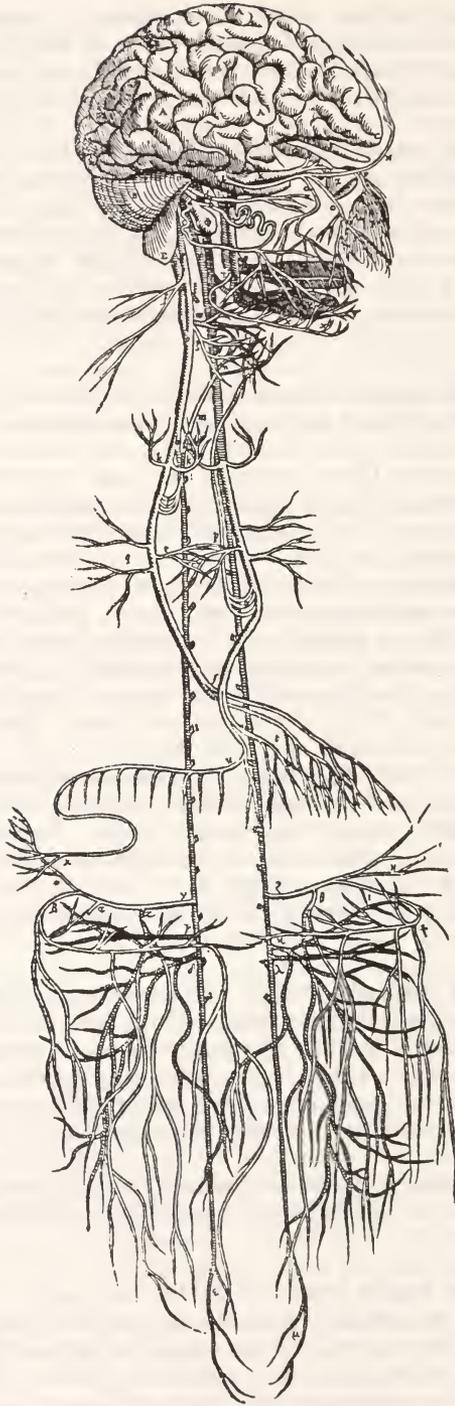
community health care: activities and programs intended to improve the healthfulness of, and general *health status* in, a specified community. The term is widely used with many different definitions, and thus must be used with caution. It is variously defined, as above, in a manner similar to *public health*, synonymously with environmental health, as all health services of any kind available to a given community, or even synonymously with a community's *ambulatory care*.

community health center: an *ambulatory* health care program usually serving a *catchment area* with scarce or non-existent health services or a population with special health needs. Often known as neighborhood health centers. Grant support for such centers was originally provided on a research and demonstration basis from the Community Action Program of the Office of Economic Opportunity. Subsequently, the funding authority for these projects shifted to section 314(e) of the *Public Health Service Act*. Community health centers attempt to coordinate Federal, State, and local resources in a single organization capable of delivering both health care and related social services to a defined population. Other ambulatory centers providing health services in areas of *medical underservice* and supported with 314(e) funds include family health centers and *community health networks*. P.L. 94-63, the Health Revenue Sharing and Health Services Act of 1975, incorporates "neighborhood health centers," "family health centers" and "community health networks" under the single term, "community health centers," defined in section 330 of the PHS Act. While such centers may not directly provide all types of health care, they usually take responsibility for arranging for all medical services needed by their patients.

community health network (CHN): a community (State, county or city) health system for delivering medical care to the *poor*. Started by OEO in the early 1970's, the program was transferred to HEW and has now become part of the *community health center* program. A *CHN* usually consisted of several, centrally managed *community* or *neighborhood health centers* with necessary back-up hospital care.

community medicine: variously defined synonymously with *community health care*, *public health*, *preventive medicine*, or *primary care*.

community mental health center (CMHC): an entity which provides comprehensive, principally *ambulatory*, *mental health* services, primarily to individuals residing or employed in a defined *catchment area*. The term is defined in the Community Mental Health Centers Act (section 201) which specifies the services to be provided and requirements for the governance, organization and operation of the centers. The CMHC Act provides for Federal financial assistance



for the construction, development and initial operation of CMHCs, and, on an ongoing basis, for the costs of their *consultation and education services*.

community rating: a method of establishing *premiums* for health *insurance* in which the premium is based on the average cost of actual or anticipated health care used by all *subscribers* in a specific geographic area or industry and does not vary for different groups or subgroups of subscribers or with such variables as the group's *claims* experience, age, sex, or *health status*. The *HMO Act* (section 1302(8) of the PHS Act) defines community rating as a system of fixing rates of payments for health services which may be determined on a per person or per family basis "and may vary with the number of persons in a family, but must be equivalent for all individuals and for all families with similar composition." The intent of community rating is to spread the cost of illness evenly over all *subscribers* (the whole community) rather than charging the sick more than the healthy for health insurance. Community rating is the exceptional means of establishing health insurance premiums in the United States today. The *Federal Employee's Health Benefits Program* for example is *experience rated*, not community rated.

comparability provision: a provision in *Medicare* specifying that the *reasonable charge* for a service may not be higher than *charges* payable for comparable services insured under comparable circumstances by a *carrier* for its non-Medicare *beneficiaries* (see section 1842(b)(3)(B) of the Social Security Act).

compendium: a collection of information about *drugs*. Under the Federal Food, Drug, and Cosmetic Act, *standards* for strength, *quality*, and purity of drugs are those which are set forth in one of the three official compendia: the United States Pharmacopeia, the Homeopathic Pharmacopeia of the United States, the National Formulary, or any supplement to any of them. Since the mid-1960's, publication by the FDA of a compendium has been proposed which would compile the *labeling* of all marketed drugs, to improve the amount and quality of information on drugs that is available to physicians or pharmacists as an aid in prescribing or dispensing. The compendium would consist of one or more volumes and would probably resemble an expanded version of the popular *Physicians' Desk Reference*, a private compendium in which drug manufacturers must purchase space and which does not provide information on all drugs. See also *formulary*.

Comprehensive Health Insurance Plan (CHIP): the present administration's *national health insurance* proposal submitted in 1974 to Congress and introduced as H.R. 12684. The proposal was not resubmitted in 1975 because of the President's moratorium on new spending programs. The plan would provide all citizens with identical *benefits* but does so through three separate plans with varying administration, financing and *cost sharing*: the *Employee, Assisted and Federal Health Insurance Plans*.

comprehensive health planning (CHP): health planning which encompasses all factors and programs which impact on people's *health*. Federally assisted CHP was done on a geographic basis by *areawide* and *State CHIP agencies* which had authority to concern themselves with environmental and *occupational health*, health education, and personal health behavior as well as medical resources and services. CHP was initiated by the Comprehensive Health Planning and Public Health Services Amendments of 1966, P.L. 89-749, and replaced by the National Health Planning and Resources Development Act of 1974, P.L. 93-641. CHP was also noteworthy for the fact that the planning was guided by a council—a majority of whose members were health services *consumers*.

compulsory: used in connection with coverage under proposed *national health insurance* or other health insurance plans which require coverage to be offered or taken. A plan may be compulsory only for an employer (coverage must be offered to employees and a specified portion of the *premium* paid, if they opt to take it) or for individuals as well. Any universal public plan is necessarily compulsory in that the payment of taxes to support the plan is not optional with the individual.

concurrent resolution on the budget: in the Federal budget, a resolution passed by both Houses of Congress, but not requiring the signature of the President, setting forth, reaffirming, or revising the *Congressional budget* for the United States government for a *fiscal year*. There are two such resolutions that must be completed each year: the first concurrent resolution by May 15, and the second concurrent resolution by September 15.

concurrent review: review of the medical *necessity* of *hospital* or other health facility *admissions* upon or within a short period following an admission and the periodic review of services provided during the course of *treatment*. The initial review usually assigns an appropriate *length of stay* to the admission (using *diagnosis specific criteria*) which may also be reassessed periodically. Where concurrent review is required, payment for unneeded hospitalizations or services is usually denied. HEW recently issued *utilization review rules* which would have required concurrent review (defined as review within one working day of admission) of all *Medicare* and *Medicaid* cases after July 1, 1975. Admissions which were found unnecessary would not have been reimbursed under either Medicare or Medicaid beyond three days after this finding. As a result of suit by the AMA against implementation of certain portions of these regulations, particularly the concurrent review requirement, implementation of the requirements was enjoined by temporary injunction. HEW is rewriting the regulations. Under the enjoined regulations, review was to be conducted by a physician member or by a qualified nonphysician member of the committee or group assigned the utilization review responsibility in each hospital. Such individual was to be appropriately trained and qualified to perform the assigned review functions, and the review was to use criteria selected or developed by the hospital *utilization review committee* or group. Concurrent review should be contrasted

with a retrospective *medical audit*, which is done for *quality* purposes and does not relate to payment, and *claims review*, which occurs after the hospitalization is over.

conditions of participation: the various conditions which a *provider* (e.g. *hospital, skilled nursing facility*) or *supplier* of services desiring to participate in the *Medicare* program is required to meet before participation is permitted. These conditions are specified in the statute and *regulations* and include compliance with title VI of the Civil Rights Act, signing an agreement to participate acceptable to the Secretary of HEW, meeting the definition of the particular institution or facility contained in the law (e.g., in order to participate as a hospital an institution must be a hospital within the meaning of section 1861(e) of the Social Security Act and must further meet standards for health and safety specified in regulations), conformity with State and local laws, having an acceptable *utilization review* plan, and meeting appropriate *PSRO* requirements. Investigations to determine whether or not health care facilities meet or continue to meet conditions of participation are made by the appropriate State health agency, which is responsible for *certifying* that the conditions have been met and that the provider or supplier is eligible to participate.

conference: in Congress, a formal meeting of representatives of the House and Senate at which the differences between House and Senate versions of a single piece of legislation or *policy* are resolved. The members of the House and Senate chosen to conduct the conference are called managers and together form the conference committee. They jointly recommend a compromise version of the legislation, the text of which is the conference report. With the report comes an explanation of how the differences were resolved (the equivalent of a *committee report*, called the joint statement of managers) which becomes part of the *legislative history*. Since the compromise version is different from those originally passed, the conference report must be enacted by both the House and Senate before being sent for Presidential signature.

confidential: private or secret information, practices, or procedures. Confidentiality, as of a *medical record*, refers to the degree and circumstances in which information in such a record is private or secret. Information which is held confidential may include medical, financial or other information about *patients* obtained in the course of medical practice, and information about the cost, *quality* and nature of the practice of individual and institutional *providers* obtained through payment and *regulation* programs. Confidentiality is in practice very hard to protect and various detailed efforts to do so in the health field have already been written into law, see section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 and title XI, part B of the Social Security Act. The circumstances under which information should be confidential are often controversial since confidentiality may well keep secret inappropriate acts by patients or providers, but its absence may well limit the freedom and confidence with which *medicine* is practiced or expose providers

and patients to unnecessary embarrassment. See also *Hippocrates of Cos*.

Congressional budget: in the Federal budget, the *budget* as set forth by Congress in a *concurrent resolution* on the budget. These resolutions shall include: the appropriate level of total budget *outlays* and of total new *budget authority*, an estimate of budget outlays and new budget authority for each major functional category, for contingencies, and for undistributed intra-governmental transactions (based on allocations of the appropriate level of total budget outlays and of total new budget authority); the amount, if any, of the surplus or deficit in the budget; the recommended level of Federal revenues; and the appropriate level of the public debt.

consultation: in *medical or dental practice*, the act of requesting advice from another *provider*, usually a *specialist*, regarding the *diagnosis* and/or *treatment* of a *patient*. The consultant usually reviews the history, examines the patient, and then provides his written or oral opinion to the requesting practitioner. *Referral* for consultation should be distinguished from referral for services, because responsibility for patient care is not usually delegated to the consultant. This definition distinguishes a consultation between providers from an *encounter* or *visit* between a provider and *consumer*.

consultation and education services: services required of each *community mental health center* (CMHC) by section 201 of the CMHC Act which consist of consultation with, and education for, the staffs of programs and institutions in the CMHC's community which are likely to be responsible for or come in contact with people with *mental illness* (such as schools, prisons, bars and courts). Such services are specially subsidized by section 204 of the CMHC Act because they are high priority *preventive care*, not usually reimbursed by the recipient institutions, and not covered under health insurance (which rarely covers services not directly delivered to *insured* individuals).

consumer: one who may receive or is receiving health services. While all people at times consume health services, a consumer as the term is used in health legislation and programs is usually someone who is never a *provider*, i.e., is not associated in any direct or indirect way with the provision of health services. The distinction has become important in programs where a consumer majority on the governing body is required, as is the case with *community health centers* and *health systems agencies* assisted under the *PHS Act*. See also *patient*.

Consumer Price Index (CPI): an economic index prepared by the Bureau of Labor Statistics of the U.S. Department of Labor. It measures the change in average prices of the goods and services purchased by urban wage earners and clerical workers and their families. It is widely used as an indicator of changes in the cost of living, as a measure of inflation (and deflation, if any) in the economy, and as a means for studying trends in prices of various

goods and services. The CPI is made up of several components which measure prices in different sectors of the economy. One of these, the medical care component, gives trends in medical care *charges* based on specific indicators of hospital, medical, dental and drug prices. The medical care component of the CPI characteristically rises faster than the CPI itself as do some other service components of the index. However, since the CPI measures charges, which are not always related to *costs*, the CPI may fail to accurately reflect changes in medical care costs.

contingency fees: fees based or conditioned on future occurrences or conclusions, or on the results of services to be performed. Contingency fees are used by lawyers representing patients as plaintiffs in *malpractice* cases and are usually a set fraction (commonly a third) of any settlement awarded the patient. If no settlement is awarded, the lawyer is not paid. Such fees are said to give the lawyer incentives to try the case with full vigor, choose only cases which are likely to succeed, choose only cases which will have large settlements, and increase the amount of settlements sought. See also *New Jersey rule*.

contingency reserves: *reserves* set aside by an *insurance* company for unforeseen or unplannable circumstances and expenses other than the normal *losses* incurred by the *risks* insured.

continued stay review: review during a *patient's* hospitalization to determine the medical *necessity* and *appropriateness* of continuation of the patient's stay at a hospital level of care. It may also include assessment of the *quality* of care being provided. Occasionally used for similar review of patients in other health facilities, see *medical review*. Used in the *PSRO* and *Medicare* programs where it is sometimes called extended duration review. See also *concurrent review*.

continuing education: formal education obtained by a health *professional* after completing his degree and post-graduate training. Such education is usually intended to improve or maintain the professional's competence. For physicians, some, but not all, States require a specified number of hours of recognized continuing education per year as a condition of continued *licensure*. The AMA conducts a voluntary program of recognition for physicians completing required amounts of recognized continuing education.

continuing resolution: in the Federal *budget*, legislation enacted by the Congress to provide *budget authority* for specific ongoing activities in a *fiscal year* in cases where the regular *appropriation* for such activities has not been enacted by the beginning of the fiscal year. The continuing resolution usually specifies a maximum rate at which the agency may *obligate* funds, based on the rate of the prior year, the *President's budget* request, or an appropriation bill previously passed by either House of the Congress.

contributory insurance: *group insurance* in which all or part of the *premium* is paid by the employee, the remainder, if any, being paid by the employer or union. In this context, noncontributory insurance is insurance in which the employer pays all the premium. So called because the *risk*, or employee, contributes to the cost of the insurance as well as the *insured*. See also *enrollment period*.

contributory tax: see *payroll tax*.

controllability: in the Federal *budget*, the ability of the Congress or the President under existing law to control *outlays* during a given *fiscal year*. Uncontrollable and relatively uncontrollable describe outlays, and the programs (such as *Medicare*) in which they occur, that cannot be increased or decreased without changes in existing substantive law. Such spending is usually the result of open-ended programs and fixed costs, like social security and veterans benefits, and payments due under *obligations* incurred or commitments made during prior years.

conversion privilege: in *group health insurance*, the right given the *insured* to change his *group insurance* to some form of individual insurance, without medical examination, upon termination of his group insurance (usually upon termination of employment or other source of membership in the group). Group insurance does not always offer a conversion privilege and, when it does, the available individual insurance is generally not of comparable scope of benefits or cost (usually being more expensive).

Cooperative Health Statistics System (CHSS): a program of the National Center for Health Statistics in which Federal, State, and local governments cooperate in collecting health statistics, so that any particular item of data is collected by that level which is best equipped to collect and distribute it to all levels. When in full operation, CHSS will collect data in the following seven subject areas: *health manpower* (inventories and surveys), *health facilities* (inventories and surveys), hospital care, household interviews, *ambulatory care*, *long-term care*, and *vital statistics*. Legislative authority for the CHSS is found in section 306(e) of the *PHS Act*.

Coordinated Transfer Application System (COTRANS): a system begun in 1970 by the American Association of Medical Colleges in which the AAMC evaluates U.S. citizens receiving *undergraduate medical education* outside the United States and sponsors those it deems qualified for part one of the *national board examinations*. Students who take and pass the boards with this sponsorship may then apply to a U.S. medical school for completion of their training with advanced standing. Some students obtain sponsorship for the boards from an individual school without using COTRANS.

Coordinating Council on Medical Education (CCME): a supervisory body established in 1972 to coordinate *policy matters* and *accreditation* at all levels of medical education. Among its organizational members are the AMA, the American Board of Medical Specialties, the AAMC, the AHA, and the Council of Medical Specialty Societies.

It also has public and Federal members. See also *Liaison Committees on Medical Education* and *Graduate Medical Education*.

coordination of benefits (COB): provisions and procedures used by *insurers* to avoid duplicate payment for *losses* insured under more than one *insurance policy*. For example, some people have a *duplication of benefits*, for their medical costs arising from an automobile accident, in their automobile and health insurance policies. A coordination of benefits or antiduplication clause in one or the other policy will prevent double payment for the expenses by making one of the insurers the *primary payer*, and assuring that no more than 100 percent of the costs are covered. There are standard rules for determining which of two or more plans, each having COB provisions, pays its benefits in full and which pays a sufficiently reduced benefit to prevent the claimant from making a *profit*.

copayment: a type of *cost sharing* whereby *insured* or covered persons pay a specified flat amount per unit of service or unit of time (e.g., \$2 per visit, \$10 per inpatient hospital day), their *insurer* paying the rest of the cost. The copayment is incurred at the time the service is used. The amount paid does not vary with the cost of the service (unlike *coinsurance*, which is payment of some percentage of the cost).

cosmetic surgery: any *operation* directed at improving appearance, except when required for the prompt repair of accidental *injury* or for the improvement of the functioning of a malformed body member. The term would not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, or to surgery for therapeutic purposes which coincidentally serves some cosmetic purpose, but would include reshaping an ugly nose. Most health insurance plans and programs do not cover cosmetic surgery.

cost center: accounting device whereby all related *costs* attributable to some "center" within an institution, such as an activity, department, or program (e.g., a hospital burn center), are segregated for accounting or reimbursement purposes. Contrasts with segregating costs of different types, such as *nursing*, *drugs* or laundry, regardless of which "center" incurred them.

cost of insurance: the amount which a policyholder pays to the *insurer* minus what he gets back from it. This should be distinguished from the *rate* for a given unit of insurance (\$10 for a \$1000 life insurance policy). Such costs, which may be difficult to obtain and are rarely compared, are roughly approximated by the *loading* or the ratio of amounts paid in benefits to income produced from premiums. See also *expenses*.

cost-related or cost-based reimbursement: one method of payment of medical care programs by *third parties*, typically *Blue Cross* plans or government agencies, for services delivered to patients. In cost-related systems, the amount of the payment is based on the *costs* to the provider of delivering the service. The actual payment

may be based on any one of several different formulae, such as full cost, full cost plus an additional percentage, *allowable costs*, or a fraction of costs. Other reimbursement schemes are based on the *charges* for the services delivered, or on budgeted or anticipated costs for a future time period (*prospective reimbursement*). *Medicare*, *Medicaid*, and some *Blue Cross* plans reimburse hospitals on the basis of costs; most private insurance plans pay charges.

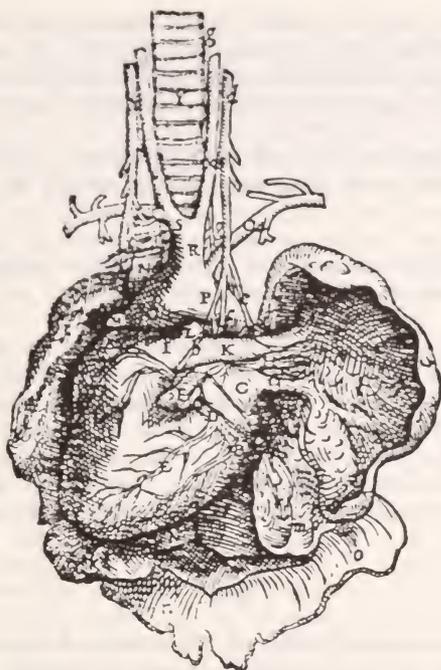
costs: expenses incurred in the provision of services or goods. Many different kinds of costs are defined and used (see *actual*, *allowable*, *direct*, *indirect*, *life*, *marginal* and *opportunity costs*). *Charges*, the price of a service or amount billed an individual or third party, may or may not be the same as, or based on, costs. Hospitals often charge more for a given service than it actually costs in order to recoup losses from providing other services where costs exceed feasible charges. Despite the terminology, cost control programs are often directed to controlling increases in charges rather than in real costs.

cost sharing: provisions of a health *insurance policy* which require the *insured* or otherwise covered individual to pay some portion of his covered medical expenses. Several forms of cost-sharing are employed, particularly *deductibles*, *coinsurance* and *copayments*. A deductible is a set amount which a person must pay before any payment of *benefits* occurs. A copayment is usually a fixed amount to be paid with each service. Coinsurance is payment of a set portion of the cost of each service. Cost-sharing does not refer to or include the amounts paid in *premiums* for the *coverage*. The amount of the premium is directly related to the benefits provided and hence reflects the amount of cost-sharing required. For a given set of benefits, premiums increase as cost-sharing requirements decrease. In addition to being used to reduce premiums, cost sharing is used to control *utilization* of covered services, for example, by requiring a large copayment for a service which is likely to be overused.

coverage: the guarantee against specific *losses* provided under the terms of an *insurance policy*. Frequently used interchangeably with *benefits* or protection. The extent of the insurance afforded by a policy. Often used to mean insurance or an insurance contract.

creaming: see *skimming*.

credentialing: the recognition of *professional* or technical competence. The credentialing process may include *registration*, *certification*, *licensure*, professional association membership, or the award of a degree in the field. Certification and licensure affect the supply of *health manpower* by controlling entrance into *practice*, and influence the stability of the labor force by affecting geographic distribution, mobility, and retention of workers. Credentialing also determines the *quality* of personnel by providing *standards* for evaluating competence, and defining the scope of functions and how personnel may be used.



E

criteria: pre-determined elements of health care against which the *necessity*, *appropriateness* or *quality* of health services may be compared. For example, criteria for appropriate diagnosis of a urinary tract infection may be performance of a urine culture and urinalysis. Often used synonymously with guidelines.

crook: deprecating *housestaff* term for a *patient* whose *illness* the housestaff (but not the patient) feels is unreal, nonphysical or insignificant. Use of the term should be discouraged since it often blinds the user to real patient *needs*, whether or not correctly perceived by the patient.

Current Procedural Terminology (CPT): a system of terminology and coding developed by the American Medical Association that is used for describing, coding and reporting medical *services* and procedures.

current services budget: in the Federal *budget* a budget that projects estimated *budget authority* and *outlays* for the upcoming *fiscal year* based on the continuance of existing programs without *policy* changes at the same levels of service as the fiscal year in progress. The Congressional Budget and Impoundment Control Act of 1974 requires that the President submit a current services budget

to the Congress by November 10 of each year. To the extent mandated by existing law, estimates take into account anticipated changes in economic conditions (such as unemployment or inflation), different caseloads, pay increases, and benefit changes.

custodial care: board, room, and other personal assistance services generally provided on a long-term basis, which do not include a medical component. Such services are generally not paid for under private or public health *insurance* or medical care programs, except as incidental to medical care which a *hospital* or *nursing home inpatient* receives. See also *boarding homes*.

customary charge: generally, the amount which a physician normally or usually *charges* the majority of his patients. Under *Medicare*, it is the median charge used by a particular physician for a specified type of service during the calendar year preceding the *fiscal year* in which a *claim* is processed. There is therefore, an average delay of a year and a half in recognizing any increase in actual charges. Customary charges in addition to *actual* and *prevailing charges* are taken into account in determining *reasonable charges* under Medicare.

d

data set: a minimum aggregation of uniformly defined and classified statistics that describe an element, episode or aspect of health care, e.g. a hospital *admission* (see *discharge abstract*), ambulatory *encounter*, or a *physician* or *hospital*. Such data sets are used for evaluation, research and similar purposes.

death: a permanent cessation of all vital functions; the end of life (often called *mortality*). A simple concept whose actual occurrence *medicine* has made very difficult to define and measure. A consensus appears to be forming that death occurs when all measurable or identifiable brain functioning (electrical or any other kind) is absent for over 24 hours. See also *hospice* and *euthanasia*.

debt service: the payment of matured interest on and principal of debts; the amount needed, supplied, or accrued for meeting such payments during any given accounting period; a budget or operating statement heading for such items.

deductible: the amount of loss or expense that must be incurred by an *insured* or otherwise covered individual before an *insurer* will assume any liability for all or part of the remaining cost of covered services. Deductibles may be either fixed dollar amounts or the value of specified services (such as two days of hospital care or one physician visit). Deductibles are usually tied to some reference period over which they must be incurred, e.g. \$100 per calendar year, *benefit period*, or *spell of illness*. Deductibles in existing policies are generally of two types: (1) static deductibles which are fixed dollar amounts, and (2) dynamic deductibles which are adjusted from time to time to reflect increasing medical prices. A third type of deductible is proposed in some *national health insurance* plans: a *sliding scale deductible*, in which the deductible is related to *income* and increases as income increases.

defensive medicine: alteration of modes of medical *practice*, induced by the threat of liability, for the principal purposes of forestalling the possibility of *malpractice* suits by patients and providing a good legal defense in the event of such lawsuits. While surveys have shown that 50 to 70 percent of physicians say they practice defensive medicine, it is difficult to define and measure specifically and, except for increasing the costs of care, unclear what effects it has.

deferral of budget authority: in the Federal *budget*, any action or inaction of the executive branch, including the establishment of reserves under the Antideficiency Act, which temporarily withholds, delays, or effectively precludes the *obligation* or expenditure of *budget authority*. Under section 1013 of the Congressional Budget and Impoundment Control Act of 1974, the President is required to report each proposed deferral to the Congress in a special message. Deferrals may not extend beyond the end of a *fiscal year* and may be overturned by the passage of an *impoundment* resolution by either House of Congress. See also *rescission*.

deficiency disease: any specific *disease* or pathological state, with characteristic clinical signs, that is due to an insufficient intake of energy or essential nutrients; it is usually of dietary origin and can often be prevented or cured by bringing the intake up to an adequate level or otherwise changing the diet.

delegation: in the *PSRO* program, the formal process by which a PSRO, based upon an assessment of the willingness and capability of a hospital or other health program to effectively perform PSRO review functions, assigns the performance of some (partial delegation) or all (full delegation) PSRO review functions to the program. Delegation must be agreed upon in a written memorandum of understanding signed by both the PSRO and the program. The PSRO monitors the program's performance of the delegated functions without itself conducting them, and retains responsibility for the effectiveness of the review.

demand or demand schedule: in health economics, the varying amount of a good or service sought at varying prices, given constant income and other factors. Demand must be distinguished from *utilization* (the amount of services actually used), and *need* (for various reasons services are often sought which either the *consumer* or *provider* feel are unneeded). It is not always translated into use, particularly when queues develop. See also *supply*, and *elasticity of demand*.

dental assistant: an individual who assists a *dentist* at the *chairside* in a dental operatory, performs reception and clerical functions, and carries out dental radiography and selected dental laboratory work. The actual number of active dental assistants is not known since most dentists train and employ dental assistants who are neither *certified* nor *registered* as members of an official organization. However, it is estimated that 116,000 persons were employed as dental assistants in 1972. Dental assistants who have completed *accredited*

educational programs are eligible for national certification examinations conducted by the Certifying Board of the American Dental Assistants Association. In 1972, there were 12,000 dental assistants maintaining current certifications. An accredited dental assistant program is usually conducted in a community college or vocational-technical school and must provide at least one year of academic training.

dental health: a state of complete normality and functional efficiency of the teeth and supporting structures, the surrounding parts of the oral cavity, and the various structures related to mastication and the maxillo-facial complex.

dental health services: all services designed or intended to promote, maintain or restore *dental health* including educational, *preventive*, and therapeutic services.

dental hygienist: a specially trained individual who works under the supervision of a dentist in providing services to dental patients: such as performing complete oral prophylaxis, applying medication, performing dental radiography, and providing dental education services both for *chairside* patients and in community health projects. Dental hygienists are required to obtain a *license* in all States. An estimated 21,000 were in *practice* in 1972. Dental hygiene programs are either 2- or 4-year programs at the college level.

dental laboratory technician: see *dental technician*.

dental technician: an individual who makes complete and partial dentures, orthodontic appliances, bridgework, crowns, and other dental restorations and appliances, as *prescribed* by *dentists*. There were an estimated 32,000 dental technicians in 1972. Most dental technicians work in commercial dental laboratories. However, increasing numbers are employed by private dental practitioners and by Federal, State, and private institutions. Traditionally, dental technicians have been trained on the job, but the predominant method of training now is through formal programs offered by two-year post-secondary educational institutions. Upon completion of an aggregate of five years in dental technology training and experience, technicians are eligible to apply for examination and *certification* by the National Board for Certification in Dental Laboratory Technology. See also *denturist*.

dentist: a *professional* person qualified by education and authorized by law (usually by having obtained a *license*) to *practice* dentistry; the promotion, maintenance and restoration of individual *dental health*, and *treatment* of *diseases* of the teeth and oral cavity.

denturist: a *dental technician* who provides dentures for patients without benefit of a dentist's professional services. Denturists are rarely found in the United States and their practice is illegal in many States. They are increasingly common in Canada, particularly in Ontario where the provincial government has proposed legalizing their practice.

department: a *functional* or *administrative* division of a *hospital*, health program or government agency. Sometimes also known as a *service*. A department within a hospital or medical school is typically headed by a responsible individual, either a chairman or director, has its own *budget* and *admits* its own *patients*, but is not a separate legal entity. They are frequently organized by medical *specialty*, i.e., a pediatric, radiology, or surgery department. There is no standard departmental organization for health programs.

dependence: see *drug, dependence*.

dependent: an individual who relies upon another individual for a significant portion of his support. In addition to the requirement for financial support there is often a requirement for a blood relationship. The Internal Revenue Code defines as dependents for the purposes of *tax deductions* any of the following over half of whose support for the calendar year was received from the taxpayer: children (biologic or adopted), grandchildren, etc.; stepchildren; brothers and sisters; stepbrothers and stepsisters; half brothers and half sisters; parents, grandparents, greatgrandparents, etc.; stepparents; nephews and nieces; uncles and aunts; inlaws (father, mother, son, daughter, brother or sister); nonrelatives living as members of the taxpayer's household; and a descendant of a brother or sister of the father or mother of the taxpayer who is receiving institutional care and who, before receiving such care, was a member of the taxpayer's household. The IRS Code provides that if the support of a dependent was furnished by several persons, one may claim the dependency deduction, if the others agree. The gross income of a taxpayer's dependent must be less than \$750, unless he is the taxpayer's child under 19 years of age, or taxpayer's child who is a student, and the taxpayer still furnishes the child's chief support. In *insurance* and other programs the specific definition is quite variable, often being limited to the individual's spouse and children. Other dependents of the kinds recognized by the IRS are sometimes known as sponsored dependents.

depreciation: see *capital depreciation*.

detail person: a sales representative of a pharmaceutical manufacturer who promotes *prescription drugs* for use by physicians, dentists, and *pharmacists*. Such detailing includes personal presentations, advertising, and provision of drug samples and educational materials prepared by the manufacturers to *professionals* in their offices. Many detail persons are now pharmacists.

developmental disability (DD): a *disability* which: originates before age 18; can be expected to continue indefinitely; constitutes a substantial handicap to the disabled's ability to function normally in society; and is attributable to *mental retardation*, cerebral palsy, epilepsy, autism, any other condition closely related to mental retardation because it results in similar impairment of general intellectual functioning or adaptive behavior or requires similar treatment and services, or dyslexia resulting from one of the conditions just listed. The term is defined in the Developmental

Disabilities Services and Facilities Construction Act (section 102(7)) which authorizes Federal assistance for services and facilities for the developmentally disabled. See also *rehabilitation*.

device: an item or piece of equipment used in the healing arts that is not a *drug*. Device is defined in the Federal Food, Drug, and Cosmetic Act as including instruments, apparatus and contrivances, including their components, parts and accessories, intended: for use in the diagnosis, cure, mitigation, treatment, or prevention of *disease* in man or other animals; or to affect the structure or any function of the body of man or other animals. Among the products that are *regulated* as devices are crutches, bandages, wheelchairs, artificial heart valves, cardiac pacemakers, intrauterine devices, eye glasses, hearing aids, and prostheses. The term device will be broadened and clarified in legislation that is now pending in Congress. The proposed definition of device will still make it clear that what distinguishes a device from a drug is that a device does not achieve any of its principal intended purposes through chemical action within or on the body and is not dependent on being metabolized for the achievement of any of its principal intended purposes. The proposed legislation will also provide new detailed authority for *regulation* of the marketing of devices which, properly used, will assure that devices are *safe* and *effective*. See also *pre-market approval*.

diagnosis: the art and science of determining the nature and *cause* of a *disease*, and of differentiating among *diseases*.

dictionary: a malevolent literary device for cramping the growth of language. This dictionary, however, is a most useful work. (From *The Devil's Dictionary*.)

diploma school: a program which educates *registered nurses* in a *hospital*, the diploma being given upon completion of the program and *licensure* as a registered nurse. Classroom and laboratory teaching may be given under an arrangement with a college, but are the responsibility of the hospital and no college level degree is given (see *associate degree* and *baccalaureate programs*).

diplomat: somebody who has a diploma; sometimes used to describe a *board certified* physician, because a diploma is given with *certification*, and in other similar situations.

direct cost: a *cost* which is identifiable directly with a particular activity, service or product of the program experiencing the cost. See also *indirect cost*.

disability: any limitation of physical, mental, or social activity of an individual as compared with other individuals of similar age, sex, and occupation. Frequently refers to limitation of the usual or major activities, most commonly vocational. There are varying types (functional, vocational, learning), degrees (partial, total), and durations (temporary, permanent) of disability. *Benefits* for disability

are often only available for specific disabilities, such as total and permanent (the requirement for social security and *Medicare*). See also *rehabilitation*.

disability income insurance: a form of health insurance that provides periodic payments to replace *income* when the *insured* is unable to work as a result of *injury* or *disease*. See also *workmen's compensation*.

discharge abstract: a summary description of an *admission* prepared upon a patient's discharge from a hospital or other health facility. The abstract records selected data about the patient's stay in the hospital, including *diagnoses*, services received, *length of stay*, source of payment and demographic information. The information is usually obtained from the patient's *medical record* and abstracted in standard, coded form. See also *Uniform Hospital Discharge Data Set*.

discovery rule: in *malpractice*, a rule in use in some jurisdictions under which the statute of limitations does not commence to run until the wrongful act is discovered or, with reasonable diligence, should have been discovered. The statute of limitations is the period of time, ordinarily beginning with the wrongful act, during which an *injured* party may sue for recovery of damages arising from the act. In some jurisdictions application of the discovery rule is limited to cases involving a foreign object left in the body of a patient. Some States have adopted statutory rules in malpractice cases which impose double time limits within which an action for malpractice may be brought. Typically these statutes provide that the action must be brought within a limited time after its discovery as well as within a limited time from the date the negligent act occurred.

disease: literally "without ease", may be defined as a failure of the adaptive mechanisms of an organism to counteract adequately, normally or appropriately the stimuli and stresses to which it is subject, resulting in a disturbance in the function or structure of some part of the organism. This definition emphasizes that disease is multi-factorial and may be prevented or treated by changing any of the factors. Disease is a very elusive and difficult concept to define, being largely socially defined. Thus, criminality and *drug dependence* presently tend to be seen as diseases, when they were previously considered to be moral or legal problems. See also *health*, *injury*, *acute*, *chronic* and *illness*.

dispensing fee: a fee charged by a pharmacist for filling a *prescription*. One of two ways that *pharmacists* charge for the service of filling a prescription, the other being a standard percentage markup on the *acquisition cost* of the *drug* involved. A dispensing fee is the same for all prescriptions, thus representing a larger mark-up on the cost of an inexpensive drug or a small prescription than on an expensive drug or large prescription. However, it reflects the fact that a pharmacist's service is the same whatever the cost of the drug. Some pharmacists combine the two approaches, using a percentage mark-up with a minimum fee.

doctor: usually used synonymously with *physician*, but actually means any person with a doctoral degree.

double blind technique: a method of studying a *drug*, or other medical procedure in which both subjects and investigators are kept unaware of (blind to) who is actually getting which specific *treatment*. The method is one of the few ways of eliminating bias, conscious or unconscious, in both subjects and investigators. Classically, in drug studies the method involves the use of a look-alike *placebo*. In "triple blind" studies the people analyzing the data are also unaware of the treatment used.

dread disease insurance: see *specific disease insurance*.

drug: any substance intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease, or intended to affect the structure or function of the body (not including food), or components of these substances. Substances recognized in the official U.S. Pharmacopeia, the official Homeopathic Pharmacopeia of the U.S., or the official National Formulary are drugs. See also *device* and *biologic*, *safe* and *effective*, *compendium* and *formulary*, *new* and *not new* (and "me too"), *over-the-counter* and *prescription*, *labeling* and *package insert*, *established* and *brand*, *NDA* and *MAC*, *DESI* and *IND*, and *drug monograph* and *drug dependence*.

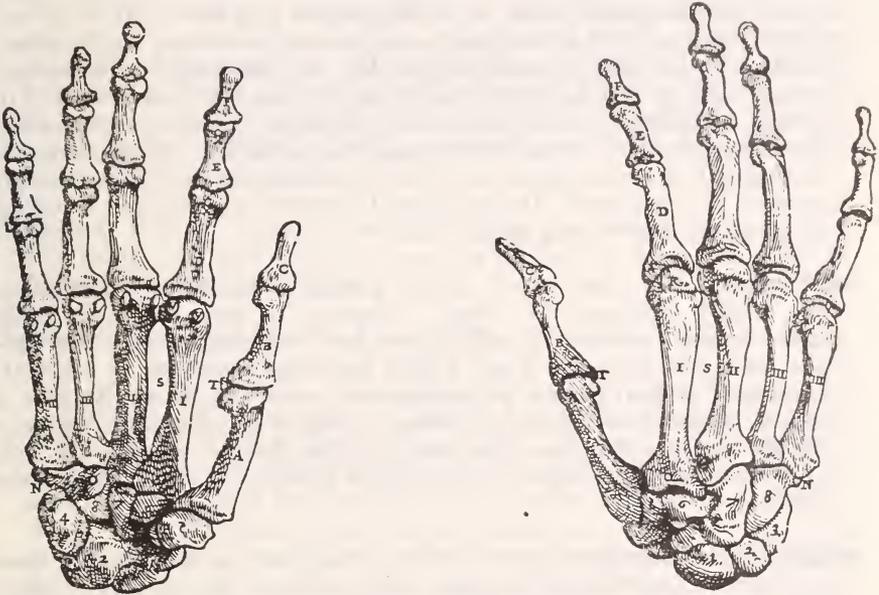
drug abuse: persistent or sporadic *drug* use inconsistent with or unrelated to acceptable medical or cultural practice. The definition of drug abuse is highly variable, sometimes also requiring excessive use of a drug, unnecessary use (thus incorporating recreational use), *drug dependence*, or that the use be illegal. See also *alcoholism*.

drug addiction: generally used synonymously with *drug dependence*, sometimes used to mean physical drug dependence, often wrongly assumed to be synonymous with *drug abuse*, and very irregular in meaning.

drug compendium: see *compendium*.

drug dependence: a state, psychic and sometimes also physical, resulting from the interaction between a person and a *drug*, characterized by behavioral and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort and other physical effects of its withdrawal or absence. Tolerance for the drug may or may not be present. A person may be dependent on more than one drug. Its characteristics will vary with the agent involved, and this must be made clear by designating the particular type of drug dependence in each specific case—for example, drug dependence of *narcotic* type, of *cannabis* type, of *barbiturate* type, of *amphetamine* type, etc. As defined here drug dependence may or may not be dangerous to the dependent individual or the public, severe, or illegal. Psychic and physical dependence are sometimes separated, although this is difficult

definitionally and in practice. Psychic dependence is sometimes called habituation and physical dependence called addiction, but both terms are irregularly used, as are all terms in this area. See also *drug abuse* and *alcoholism*.



F

Drug Efficacy Study Implementation (DESI): the plan of the Food and Drug Administration for implementing the evaluations and recommendations of the Drug Efficacy Study Group of the National Academy of Science—National Research Council respecting the *effectiveness* of *drugs* marketed prior to 1962 under approved *new drug applications*. The Drug Efficacy Study was undertaken in 1966 to evaluate all of the drugs the FDA had approved as *safe* prior to 1962, when Congress first required that drugs also be proved effective before marketing. The Drug Efficacy Study Group evaluated nearly 4,000 individual drug products, finding many of them ineffective or of only possible or probable effectiveness. The FDA is still in the process of implementing those judgments by removing some of the drugs from the market.

druggist: somebody who operates a *drug store*. Sometimes considered synonymous with *pharmacist*, but is not always limited to people with a pharmacy degree (or even to operators of drug stores in which *prescription drugs* are dispensed) and is usually applied only to pharmacists who operate, or at least work in, drug stores.

drug habituation: generally used synonymously with *drug dependence*, sometimes used to mean psychic drug dependence, often wrongly assumed to be synonymous with *drug abuse*, and very irregular in meaning.

drug monograph: a *rule* which prescribes, for a *drug* or class of related drugs, the kinds and amounts of ingredients which it may contain, the conditions for which it may be offered, and directions for use, warnings and other information which its *labeling* must bear. Drug monographs established by FDA state conditions under which drugs may be marketed as *safe* and *effective* and not adulterated or misbranded, and thus without an approved *new drug application*. FDA is establishing monographs for non-prescription (*over-the-counter*) drugs and in the future plans to develop monographs for certain established *prescription drugs*. Special statutory provisions already authorize use of monographs for antibiotic drugs. Once a monograph is promulgated, anyone who meets its requirements can market the product (absent patent protection) without seeking approval of a new drug application.

dual choice: the practice of giving people a choice of more than one health insurance or health program to pay for or provide their health services. Usually done by employers who offer employees more than one *group health insurance program*, or a health insurance program and a *prepaid group practice* to choose from as a benefit of their employment. Characteristic of the *Federal Employees Health Benefits Program*. Required by the *HMO Act*, P.L. 93-222, of employers with respect to *qualified HMOs* (section 1310 of the *PHS Act*).

duplication of benefits: occurs when a person covered under more than one health or accident *insurance policy* collects, or may collect, payments for the same hospital or medical expenses from more than one *insurer*. Individual health insurance policies, under State laws, sometimes include antiduplication clauses against overinsurance due to two similar policies issued by the same insurer; loss-of-time coverage in excess of the insured's monthly earnings; and duplicate coverage with other insurers, if the insurer has not been given written notice of such duplicate coverage prior to the date of *loss*. Because of this notice limitation, many individual insurance policies do not include antiduplication clauses. Since the limitation does not apply to *group insurance*, it usually does contain such clauses, especially in *major medical* policies. However, most States will not allow group policies to apply such clauses to individual insurance. Where duplication exists with a group antiduplication clause, the group insurer responsible for paying its benefits first is the *primary payer*. See also *coordination of benefits*.

e

Early and Periodic Screening Diagnosis and Treatment Program (EPSDT): a program mandated by law as part of the *Medicaid* program. The law (section 1905(a)(4)(B) of the Social Security Act) requires that by July 1, 1969, all States have in effect a program for eligible children under age 21 "to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in *regulations* of the Secretary."

Issuance of regulations implementing the program was delayed until November, 1971, and States were allowed to phase in their programs by age groups until July 1, 1973. By law (section 403(g) of the Social Security Act), States which do not have a program in effect in any fiscal quarter after June 30, 1974, for all children in families receiving AFDC payments are subject to a financial penalty. The State programs are not just to pay for services but also to have an active outreach component to inform eligible persons of the benefits available to them, actively to bring them into care so that they can be screened, and, if necessary, to assist them in obtaining appropriate treatment. EPSDT should properly refer only to programs which have all of these elements.

ecological fallacy: the common erroneous assumption that because two things are *associated* one must be *caused* by the other. See also *Hawthorne* and *Halo effects*.

Economic Stabilization Program (ESP): a Federal program established to control wages and prices. On August 15, 1971, all wages and prices were frozen for a period of ninety days. During that period a system of wage and price controls administered through a Cost of Living Council was implemented. Controls continued, with periodic changes in the flexibility and the intensity with which they were enforced until their legislative authority ultimately expired in April, 1974. Wages and prices in the health care industry were controlled through a specialized series of regulations. The 32½ months the controls were in effect is the only period in which medical care price increases have slowed markedly since the enactment of *Medicare* and *Medicaid*; during that period increases in medical care prices were limited to 4.3 percent.

economies of scale: cost savings resulting from aggregation of resources and/or mass production. In particular, it refers to decreases in average cost when all factors of production are expanded proportionately. For example, hospital costs for a unit of service are generally less in 300 than 30 bed hospitals. (There is some evidence that they may be greater in 1,000 bed than 300 bed hospitals, a diseconomy of scale.) Frequently used, less accurately, to refer to savings achieved when underused resources are used more efficiently. For example when many individuals use the same product, or when health care facilities share in the costs and use of expensive equipment (e.g., automated laboratory equipment) or otherwise underused and highly trained personnel (e.g., open-heart surgery teams).

Educational Commission for Foreign Medical Graduates (ECFMG): an organization sponsored by the AMA, AHA, AAMC, Association for Hospital Medical Education, and Federation of State Medical Boards of the U.S. which operates a program of educating, testing and evaluating *foreign medical graduates* who seek *internships* and *residencies* in the U.S. The ECFMG was formed in 1974 by merger of the Educational Council for Foreign Medical Graduates, incorporated in 1956, and the Commission for Foreign Medical Graduates. *Certification* of FMGs is granted by the ECFMG after

receiving documentation of their education, and passage of an examination of their medical competence and comprehension of spoken English. Such certification is necessary for full *licensure* of FMGs in 47 States and territories. See also *Federation Licensing Examination*.

effectiveness: the degree to which diagnostic, preventive, therapeutic or other action or actions achieves the intended result. Effectiveness requires a consideration of *outcomes* to measure. It does not require consideration of the cost of the action, although one way of comparing the effectiveness of actions with the same or similar intended results is to compare the ratios of their effectiveness to their costs. The Federal Food, Drug, and Cosmetic Act requires prior demonstration of effectiveness for most *drugs* marketed for human use. No similar requirement exists for most other medical action paid for or *regulated* under Federal or State law. Usually synonymous with *efficacy* in common use. See also *safety, quality, efficiency* and *DESI*.

efficacy: commonly used synonymously with *effectiveness*, but may usefully be distinguished from it by using efficacy for the results of actions undertaken under ideal circumstances and effectiveness for their results under usual or normal circumstances. Actions can thus be efficacious and effective, or efficacious and ineffective, but not the reverse.

efficiency: the relationship between the quantity of inputs or resources used in the production of medical services and the quantity of outputs produced. Efficiency has three components: input productivity (technical efficiency), input mix (economic efficiency), and the scale of operation. Efficiency is usually measured by indicators such as output per man hour or cost per unit of output. However, such indicators fail to account for the numerous relevant dimensions (such as *quality*) of both inputs and outputs and are, therefore, only partial measures. Colloquially, efficiency measures the "bang for the buck" but, as the above suggests, it is a difficult concept to define and quantify. Ultimately, efficiency should probably be measured in terms of the costs of achieving various health outcomes: defining it in terms of productivity assumes that what is produced is *efficacious* and used in an effective manner.

elasticity of demand: in health economics, a measure of the sensitivity of demand for a product or *service* to changes in its price (price elasticity) or the income of the people demanding the product or service (income elasticity). Price elasticity is the ratio of the resulting percentage change in demand to a given percentage change in price. Price elasticity of demand for health services allows one to predict the effect on demand of different *cost sharing* provisions in proposed *NHI* programs and thus aids in predicting the differing stress their enactment would place on the health system.

elective surgery: *surgery which need not be performed on an emergency basis, because reasonable delays will not affect the outcome of surgery unfavorably. It should be understood that such surgery is usually necessary and may be major.*

elephant policy: *see trolley car policy.*

emergency care: *care for patients with severe, life-threatening, or potentially disabling conditions that require intervention within minutes or hours. Most hospitals and programs providing emergency care are also asked to provide care for many conditions which providers would not consider as emergencies, suggesting that consumers define the term more nearly synonymously with primary care and use such programs as screening clinics. See also emergency medical service system.*

emergency medical service system (EMSS): *an integrated system of appropriate health manpower, facilities and equipment which provides all necessary emergency care in a defined geographic area. The development of such systems is Federally assisted under the Emergency Medical Services Systems Act of 1973, P.L. 93-154, in which the term is defined and the necessary components of the system listed (sections 1201 and 1206 of the PHS Act). Prototype systems are found in the State of Illinois and Jacksonville, Florida. One characteristic of such a system would be a central communications facility using the universal emergency telephone number, 911, and having direct communications with all parts of the system with planned dispatching of cases to properly categorized facilities.*

Employee Health Insurance Plan (EHIP): *one of the three parts of the present administration's national health insurance proposal, the Comprehensive Health Insurance Plan, providing health insurance for full time employees and their dependents. The plan would operate by requiring employers to offer comprehensive health insurance with cost sharing and pay 75 percent of the premium cost (65 percent for the first three years). The benefits would be underwritten by private insurers and financed entirely by premiums. Premiums could be experience rated for large employers (over 50 employees), but would have to be community rated for small employers.*

encounter: *a contact between a patient and health professional in which care is given. Some definitions exclude either telephone contacts or home visits. An encounter form records selected demographic, diagnostic and related information describing an encounter.*

endorsement: *recognition by a State of a license given by another State, when the qualifications and standards required by the original licensing State are equivalent to or higher than those of the endorsing State. The licensee is relieved by endorsement of the full burden of obtaining a license in the endorsing State. There is not necessarily any reciprocity between the two States.*

enroll: to agree to participate in a contract for *benefits* from an *insurance* company or *health maintenance organization*. A person who enrolls is an enrollee or *subscriber* (see also *member* and *beneficiary*). The number of people (and their *dependents*) enrolled with an insurance company or HMO is its enrollment. See also *open enrollment*.

enrollment period: period during which individuals may *enroll* for *insurance* or *health maintenance organization* benefits. There are two kinds of enrollment periods, for example, for *supplementary medical insurance of Medicare*: the initial enrollment period (the seven months beginning three months before and ending three months after the month a person first becomes eligible, usually by turning 65); and the general enrollment period (the first three months of each year). Most *contributory group insurance* has an annual enrollment period when members of the group may elect to begin contributing and become covered. See also *open enrollment*.

entitlement authority: in the Federal *budget*, legislation that requires the payment of benefits or entitlements to any person or government meeting the requirements established by such law. Mandatory entitlements include social security benefits and veterans' pensions. Section 401 of the Congressional Budget and Impoundment Control Act of 1974 places restrictions on the enactment of new entitlement authority.

epidemiology: the study of the nature, *cause*, control, and determinants of the frequency and distribution of *diseases* and *disability* in human populations. This involves characterizing the distribution of *health status*, diseases or other health problems in terms of age, sex, race, geography, etc.; explaining the distribution of a disease or health problem in terms of its causal factors; and assessing and explaining the impact of control measures, clinical intervention and health services on diseases and other problems. The epidemiology of a disease is the description of its presence in a population and the factors controlling its presence or absence. See also *incidence*, *prevalence*, *morbidity* and *mortality*.

equivalency testing: testing intended to equate an individual's knowledge, experience and skill, however acquired, with the knowledge, experience and skill acquired by formal education or training. Successful completion of equivalency tests may be used to obtain course credits toward an academic degree without taking the courses, or a *license* which requires academic training without having the training. See also *proficiency testing*.

established name: name given to a *drug* or pharmaceutical product by the United States Adopted Names Council (USAN). This name is usually shorter and simpler than the *chemical name*, and is the one most commonly used in the scientific literature. It is the name by which most physicians and pharmacists learn about a particular drug product in their professional training. An example would be penicillin, a well-known antibiotic. Also known as the *generic name* or official name. An established name for drugs is required by section 502(e) of the Federal Food, Drug, and Cosmetic Act.

ethical drug: a *drug* which is advertised only to physicians and other *prescribing health professionals*. Drug manufacturers which make only or primarily such drugs are referred to as the ethical drug industry. Synonymous with *prescription drug*.

etiology: see *cause*.

euthanasia: the act or practice of killing individuals (active) or allowing them to die without giving all possible *treatment* for their *disease* (passive), because they are hopelessly *sick* or *injured*, for reasons of mercy. See also *hospice* and *death*.

evidence of insurability: any statement or proof of a person's physical condition or occupation affecting his acceptability for *insurance*.

excise tax: a single-stage commodity tax (i.e. a tax levied on a commodity only once as it passes through the production process to the final consumer). An excise tax is narrowly based; enabling legislation specifies precisely which products are taxed, as well as the tax rate. Sales taxes are more broadly based; their tax base comprises many commodities and legislation designates those commodities not subject to tax. Excise taxes are commonly assessed on automobiles, cigarettes, liquor or gasoline. They are sometimes levied in hopes of discouraging the use of the product taxed. Revenues from such taxes may also be set aside from general revenues and used for some purpose related to the taxed product. For example, an excise tax on cigarettes might discourage smoking by raising its cost and revenues from it might be used to fund cancer screening programs.

exclusions: specific *hazards*, *perils* or conditions listed in an *insurance* or medical care coverage policy for which the policy will not provide benefit payments. Common exclusions may include *preexisting conditions*, such as heart disease, diabetes, hypertension or a pregnancy which began before the policy was in effect. Because of such exclusions, persons who have a serious condition or disease are often unable to secure insurance coverage, either for the particular disease or in general. Sometimes excluded conditions are excluded only for a defined period after coverage begins, such as nine months for pregnancy or one year for all exclusions. Exclusions are often permanent in *individual health insurance*, temporary (e.g., one year) for small groups in *group insurance*, and uncommon for large groups capable of absorbing the extra risk involved.

executive session: a *mark-up* which is closed to the general public, being open only to the committee members, their staff and others specifically invited. Sometimes used synonymously with *mark-up*, especially in the House of Representatives where *mark-ups* are now rarely held in private.

expenses: in *insurance*, the cost to the *insurer* of conducting its business other than paying *losses*, including *acquisition* and administrative costs. Expenses are included in the *loading*.

experience rating: a method of establishing *premiums* for health insurance in which the premium is based on the average cost of actual or anticipated health care used by various groups and subgroups of *subscribers* and thus varies with the health experience of groups and subgroups or with such variables as age, sex, or health status. It is the most common method of establishing premiums for health insurance in private programs. See also *community rating*.

experimental health service delivery system (EHSDS): a system developed under a program supported by the Health Services and Mental Health Administration under general health services research authorities to develop, test and evaluate the organization and operation of coordinated, community-wide health service *management* systems (EHSDS) in various kinds and sizes of communities. EHSDS sought to improve *access* to services, moderate their *costs* and improve their *quality*. The EHSDS program is now being gradually terminated under the requirements of P.L. 93-694.

experimental medical care review organization (EMCRO): an organization assisted by a program initiated in 1970 by the National Center for Health Services Research and Development (now the NCHSR). The program, a forerunner of the *PSRO* program, was set up to help medical societies in creating formal organizations and procedures for reviewing the *quality* and use of medical care in hospitals, nursing homes, and offices throughout a defined community. The use of explicit *criteria* and standard definitions were required of all EMCROs but the particular approach to organizing the review was determined by the individual organization. Ten such organizations were initially supported (only some of which actually reviewed services) and the program was phased out after enactment of the PSRO program.

extended care facility (ECF): previously used in *Medicare* to mean a *skilled nursing facility* which qualified for participation in Medicare. In 1972, the law was amended to use the more generic term skilled nursing facility for both Medicare and *Medicaid*. Medicare coverage is limited to 100 days of post hospital *extended care services* during any *spell of illness*; thus Medicare coverage in a skilled nursing facility is limited in duration, must follow a hospital stay, and must be for services related to the cause of the hospital stay. These conditions do not apply to skilled nursing facility benefits under Medicaid. Thus, the continued use of the term "extended care facility benefits" is a kind of shorthand to refer to the benefit limitations on skilled nursing facility care under Medicare.

extended care services: as used in *Medicare*, services in a *skilled nursing facility* provided for a limited duration (up to 100 days during a *spell of illness*) after a hospital stay, and for the same condition as the hospital stay was for. As defined under Medicare, the following items and services furnished to an *inpatient* of a skilled nursing facility are included: *nursing care* provided or supervised by a *registered professional nurse*; bed and board associated with the nursing care; *physical, occupational, or speech therapy*

furnished by the skilled nursing facility or by others under arrangements with the facility; medical social services; such *drugs, biologicals, supplies*, appliances and *equipment* as are ordinarily used in care and treatment in the skilled nursing facility; medical services provided by an *intern* or *resident* of a hospital with which the facility has a transfer agreement; and other services as are necessary to the *health* of the patients.

extended duration review: see *continued stay review*.

externality: in health economics, something that results from an *encounter* between a *consumer* and *provider*, which confers benefits or imposes *costs* on others, and is not considered in making the transaction (its value, the external cost, not being reflected in any *charge* for the transaction). Pollution is the classic example. In health, an externality of immunizations is the protection that they give the unimmunized, since that protection is not considered when an individual immunization is obtained or priced.

extra cash policy: an *insurance* policy which pays cash *benefits* to hospitalized individuals in fixed amounts unrelated to the individual's medical expenses or *income*. Such policies are usually sold to individuals separately from whatever other health insurance they have, and typically have high *loadings*.

f

facilities: buildings, including physical plant, equipment, and supplies, used in providing health services. They are one major type of health resource and include *hospitals, nursing homes, and ambulatory care centers*. Usually it is not intended to include the offices of individual practitioners.

factoring: the practice of one individual or organization selling its accounts receivable (unpaid bills) to a second at a discount. The latter organization, called the 'factor,' usually, but not always, assumes full risk of loss if the accounts prove uncollectible. In health services delivery, the expression generally refers to a hospital's or physician's sale of unpaid bills to a collection agent. Factoring has sometimes been used in *Medicaid* because of the delays that hospitals and physicians experience collecting from the State Medicaid agency. In these cases, the improved cash flow is worth the discount in the amount received by the *provider*. Because factoring is subject to *fraud* and *abuse*, Congress has sought to prohibit some of its uses.

false negative: a person wrongly diagnosed as not having a *disease* or condition which in fact he does have. See also *false positive*.

false positive: a person wrongly diagnosed as having a *disease* or condition when in fact he does not. When assessing a medical *screening* or other *diagnostic* procedure it is important to know both how many false positives and *false negatives* the procedure gives in normal use. See also *sensitivity* and *specificity*.

family: for U.S. census purposes, a group of two or more persons related by blood, marriage, or adoption who are living together in the same household. *Group insurance* and some *national health insurance* proposals offer coverage for eligible individuals and their families. In this context family usually refers to an individual and his *dependents*, which, since dependents do not necessarily have to be related to or living with the individual, is quite a different definition. In fact the specific or detailed meaning is quite variable.

family ganging: the practice of requiring or encouraging a *patient* to return for care to a health program with his whole *family*, even if the rest of the family does not *need* care, so that the program can charge the patient's *third-party* for care given to each member of the family. The practice and term originated and is most common in *Medicaid mills*, which frequently have the mother of a sick child bring in all her other children for care whether or not they need it.

family physician: a *physician* who assumes continuing responsibility for supervising the health and coordinating the care of all *family* members, regardless of age. Often viewed as low-level generalists, such physicians are now trained as *specialists* whose work demands specific skills. These skills include functioning as medical managers, advocates, educators and counselors for their patients. See also *personal physician*, *primary care*, and *general practitioner*.

family planning: the use of a range of methods of fertility regulation to help individuals or couples to avoid unwanted births; bring about wanted births; produce a change in the number of children born; regulate the intervals between pregnancies; and control the time at which births occur in relation to the age of parents. It may include an array of activities ranging from birth planning, the use of contraception and the management of infertility to sex education, marital counselling and even genetic counselling. Family planning has succeeded the older term, birth control, which is now felt to be too negative and restrictive in meaning. Birth control can be separately defined as the prevention of pregnancy by contraception, *abortion*, sterilization or abstinence from coitus.

favorable selection: see *skimming*.

Federal Employees Health Benefits Program (FEHBP): the *group health insurance* program for Federal employees; the largest employer-sponsored *contributory* health insurance program in the world. It is voluntary for the employees; about 80 percent of those eligible being covered. At present it covers 8.8 million persons—2.8 million Federal employees and annuitants and their 6 million *dependents*. It was established under the Federal Employees Health Benefits Act of 1959 (P.L. 86-382, codified in chapter 89, title V, U.S. Code), began operation in July, 1960, and is administered by the United States Civil Service Commission. Every employee may choose between two government-wide plans: a *service benefit* plan administered by *Blue Cross* and *Blue Shield*, and an *indemnity*

benefit plan offered by the insurance industry through the Aetna Life Insurance Company. In addition to the two government-wide plans, there are fifteen employee organizations offering indemnity type plans to their members. An additional choice is available to employees residing in certain geographic areas where *prepaid group practice* plans are in operation. There are now seven *individual practice plans* and nineteen group practice plans participating in the program. One of the various different types of plans operating as a part of the FEHB Program is referred to as a FEHB Plan.

Federal Health Insurance Plan (FHIP): one of three health insurance plans making up the present administration's 1974 proposal for *national health insurance*, the *Comprehensive Health Insurance Plan*. This plan would replace *Medicare* and provide health insurance coverage for persons 65 and older. Although many of the features of FHIP are the same as Medicare, there were changes made in the *benefits* structure and *cost sharing* provisions. Among the more significant changes are combining the hospital and medical portions of the benefits package, and adding *drugs* as covered service.

Federal Register: an official, daily publication of the Federal government providing a uniform system for making available to the public proposed and final *rules*, legal notices, and similar proclamations, orders and documents having general applicability and legal effect. The Register publishes material from all Federal agencies.

Federation Licensing Examination (FLEX): a standardized *licensure* test for *physicians* developed by the Federation of State Medical Boards of the U.S. for potential use on a nationwide basis. In fact, some 48 States now use the FLEX as their test for licensure, although they vary in the score required for licensure. The FLEX exam is based on test material developed by the *National Board of Medical Examiners*. See also *national board examinations*.

fee for service: method of *charging* whereby a physician or other practitioner bills for each *encounter* or service rendered. This is the usual method of billing by the majority of the country's physicians. Under a fee for service payment system, expenditures increase not only if the fees themselves increase but also if more units of service are charged for, or more expensive services are substituted for less expensive ones. This system contrasts with salary, per capita or *prepayment* systems, where the payment is not changed with the number of services actually used or if none are used. While the fee-for-service system is now generally limited to physicians, dentists, podiatrists and optometrists, a number of other practitioners, such as *physician assistants*, have sought reimbursement on a fee for service basis. See also *fee schedule*, *fractionation* and *capitation*.

fee schedule: a listing of accepted *charges* or established allowances for specified medical or dental procedures. It usually represents either a physician's or *third party's* standard or maximum charges for the listed procedures. See also *relative value scale*.

fetal death: see *stillbirth*.

fiduciary: relating to or founded upon a trust or confidence. A fiduciary relation exists where an individual or organization has an explicit or implicit obligation to act in behalf of another person's or organization's interests in matters which affect the other person or organization. A *physician* has such a relation with his *patient* and a hospital trustee with a hospital. Because a fiduciary relationship with a *provider* obligates one to act in the interests of the provider, people with such relationships are defined as providers by P.L. 93-641, rather than as *consumers*, for such purposes as determining whether a *health systems agency* governing board has a consumer majority.

fifth pathway: one of the several ways that an individual who obtains all or part of his *undergraduate medical education* abroad can enter *graduate medical education* in the United States. The fifth pathway provides a period of supervised clinical training to students who obtained their premedical education in the United States, received undergraduate medical education abroad, and pass a screening examination approved by the *CCME*. When these students successfully complete a year of clinical training sponsored by a U.S. medical school they then become eligible for an AMA approved *internship* or *residency*.

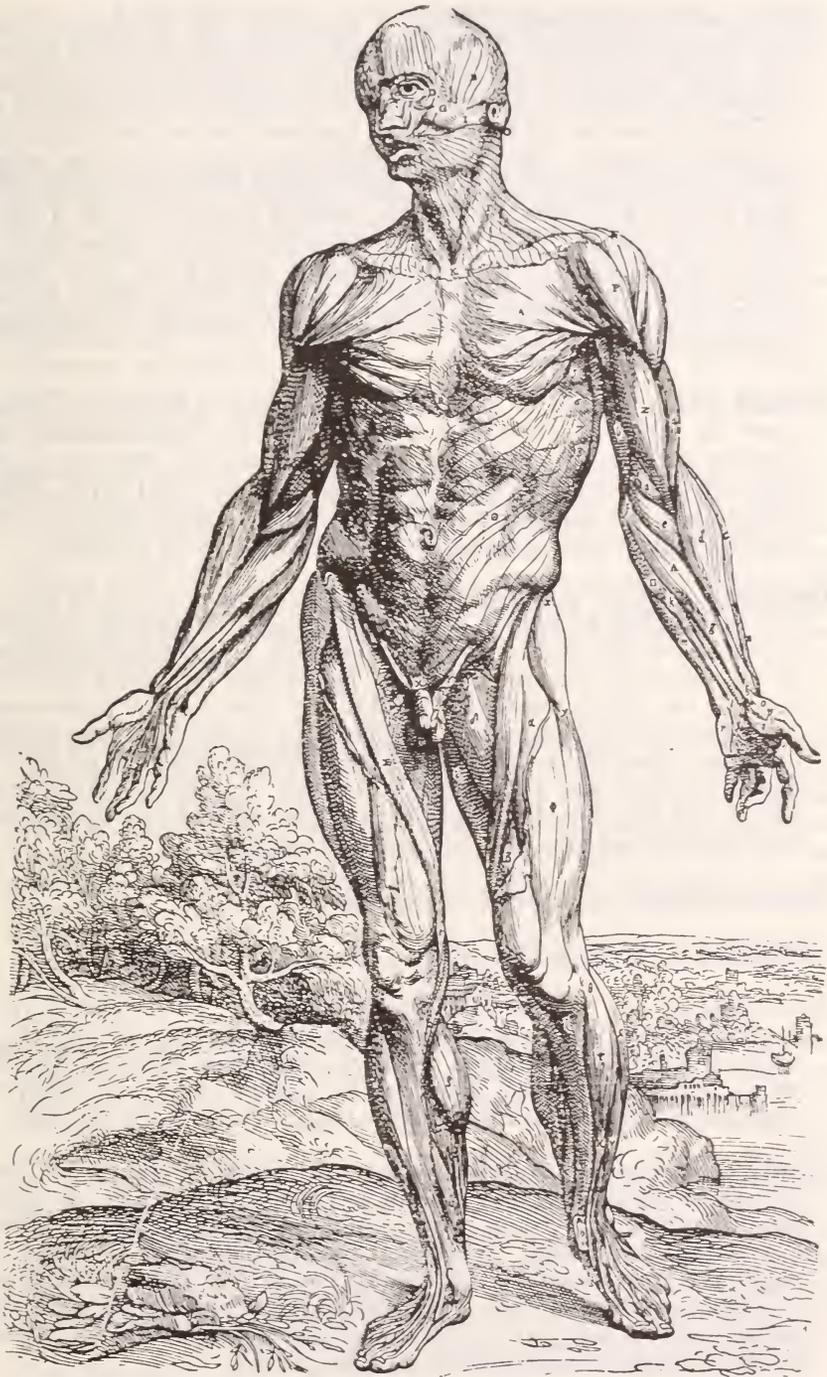
first-dollar coverage: coverage under an *insurance* policy which begins with the first dollar of expense incurred by the *insured* for the covered benefits. Such coverage, therefore, has no *deductibles* although it may have *copayments* or *coinsurance*. See also *last dollar coverage*.

fiscal agent or intermediary: a contractor that processes and pays *provider claims* on behalf of a State *Medicaid* agency. Fiscal agents are rarely *at risk*, but rather serve as an *administrative* unit for the State, handling the payment of bills. Fiscal agents may be insurance companies, management firms, or other private contractors. Medicaid fiscal agents are sometimes also *Medicare carriers* or *intermediaries*.

fiscal year: any twelve month period for which annual accounts are kept. Sometimes, but by no means necessarily, the same as a calendar year. The Federal government's fiscal year has been from July 1 to the following June 30 for years, but will change in 1976 to be from October 1 to the following September 30.

flat maternity: a single inclusive *maternity benefit* for all *charges* incurred as a result of pregnancy, childbirth, and complications arising therefrom. A limit (such as \$1,000) may be applied per pregnancy or per year. See also *switch* and *swap maternity*.

fluoridation: the addition of controlled, small amounts of fluoride to public water supplies for the purpose of reducing the *incidence* of dental cavities in the public using the water.



G

foreign medical graduate (FMG): a *physician* who graduated from a medical school outside of the United States and, usually, Canada. U.S. citizens who go to medical school outside this country are classified as foreign medical graduates (sometimes distinguished as USFMGs), just as are foreign-born persons who are not trained in a medical school in this country, although native Americans represent only a small portion of the group. As of 1972 there were more than 63,000 graduates of foreign medical schools in the United States, constituting more than 20 percent of active physicians in this country. The term is occasionally defined as, and nearly synonymous with, any graduate of a school not *accredited* by the LCME. See also *COTRANS*, *ECFMG*, *fifth pathway*, *J visa*, *labor certification*, and *schedule A*.

formula grant: a grant of Federal funds, usually to States but sometimes to other governmental units or private organizations, authorized by law for specified purposes in which the amount of the grant is based on a formula which divides the total funds available among the eligible recipients according to such factors as the number and average income of the population to be served.

formulary: a listing of *drugs*, usually by their *generic names*. A formulary is intended to include a sufficient range of medicines to enable physicians or dentists to *prescribe* medically *appropriate* treatment for all reasonably common *illnesses*. A hospital formulary normally lists all the drugs routinely stocked by the hospital pharmacy. *Substitution* of a *chemically equivalent* drug in filling a prescription by *brand name* for a drug in the formulary is often permitted. A formulary may also be used to list drugs for which a *third party* will or will not pay, or drugs which are considered appropriate for treating specified illnesses. See also *compendium*.

forward funding: see *advance appropriation*.

foundation for medical care (FMC): see *medical foundation*.

fractionation: the practice of *charging* separately for several services or components of a service which were previously subject to a single charge or not charged for at all. The usual effect is that the total charge is increased. The practice is most commonly seen as a response to limiting increases in the charge which is fractionated.

fraud: intentional misrepresentation by either *providers* or *consumers* to obtain services, obtain payment for services, or claim program eligibility. Fraud may include the receipt of services which are obtained through deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain reimbursement or certification; or claiming payment for services which were never delivered or received. Fraud is illegal and carries a penalty when proven. See also *abuse*.

free clinics: neighborhood clinics or health programs which provide medical services in relatively informal settings and styles to, generally, students, transient youth, and minority groups. Care is given

at no or nominal *charge* by predominantly volunteer staffs. The first such clinic is considered to be the Haight-Ashbury Free Clinic, organized in San Francisco in the summer of 1967 by David Smith. There are now estimated to be 175–200 such clinics around the country.

function or functional classification: in the Federal *budget*, a means of presenting *budget authority*, *outlay*, and *tax expenditure* data in terms of the principal purposes which Federal programs are intended to serve. Each specific account is generally placed in the single function (e.g., national defense, health) that best represents its major purpose, regardless of the agency administering the program. The Congressional Budget and Impoundment Control Act of 1974 requires the Congress to estimate outlays, budget authority, and tax expenditures for each function. Functions are subdivided into narrower categories called subfunctions.

funded: in *insurance*, having sufficient funds to meet future *liabilities*. Can also be used in speaking of *trust funds* for *social insurance* programs. *Capital depreciation* is said to be funded if the amounts included in an institution's reimbursements for capital depreciation are set aside in a fund used for capital purposes rather than being spent on current operating costs. Few *third party payers* which reimburse capital depreciation require that it be funded as a condition of reimbursing it.

g

Galen [Plaudius Galenus] (130–200 A.D.): a celebrated Greek *physician* and medical writer, born at Pergamum (Asia Minor); latterly he practiced in Rome, where he became physician to the Emperor, Marcus Aurelius. Although he did not dissect the human cadaver, he made many valuable anatomical and physiological observations on animals, and his writings on these and other subjects are extensive. His influence on medicine was profound for many centuries—his teleology (“nature does nothing in vain”) being particularly attractive to the medieval mind, although it was stultifying to advances in medical thought and practice.

generally recognized as effective (GRAE): one of the conditions which a *drug* must fulfill if it is not to be considered a *new drug*, and thus not subject to the pre-market approval requirements of the Federal Food, Drug, and Cosmetic Act. To be generally recognized as effective, the drug must be so considered by “experts qualified by scientific training and experience to evaluate the *safety* and *effectiveness* of drugs” and have been “used to a material extent or for a material time.” FDA determines that a drug is GRAE, subject to judicial reversal if its determination is arbitrary or capricious. The Supreme Court has held that for a drug to be generally recognized as effective, its sponsor must supply the FDA with the same kind of evidence consisting of *adequate and well-controlled investigations* by qualified experts that the law requires in order to secure approval of a *new drug application*. See also *generally recognized as safe*.

generally recognized as safe (GRAS); one of the conditions which a *drug* must fulfill if it is not to be considered as a *new drug*: or a food must fulfill if it is not to be considered as a food additive. A drug which is GRAS and *GRAE* need not go through the pre-market approval procedures prescribed in the Federal Food, Drug, and Cosmetic Act for new drugs. General recognition of safety of a drug must be "among experts qualified by scientific training and experience to evaluate the *safety* and *effectiveness* of drugs", and to acquire general recognition of safety and effectiveness a drug must be "used to a material extent or for a material time."

general practitioner (GP): a *practicing physician* who does not specialize in any particular field of *medicine* (e.g. is not a *specialist*). Should be contrasted with a *family physician* who has specialized (not all do), and is subject to *specialty board* examination, in the care of families, and a *primary care physician* who may be a *specialist* in any of several specialties.

general revenue: government revenues raised without regard to the specific purpose for which they might be used. Federal general revenues come principally from personal and corporate *income* taxes and some *excise* taxes. State general revenues come primarily from personal income and sales taxes. Most proposed *national health insurance* programs would be financed in part from general revenues in addition to whatever financing might be obtained from *premiums*, *cost-sharing*, and *payroll taxes* whose revenues are used only for the program. The expenditure of general revenues is determined by legislative *authorizations* and *appropriations*.

generic equivalents: drug products with the same active chemical ingredients sold under the same *generic name* but often with different *brand names*. Generic equivalents are often assumed to be, but are not necessarily, *therapeutic equivalents*. The term has such inconsistent meaning that it must be used with care or avoided.

generic name: the *established*, official, or non-proprietary, name by which a drug is known as an isolated substance, irrespective of its manufacturer. Each drug is *licensed* under a generic name, and also may be given a *brand name* by its manufacturer. The generic name is assigned by the United States Adopted Names Council (USAN), a private group of representatives of the American Medical Association, American Pharmaceutical Association, United States Pharmacopeia and Food and Drug Administration, plus one public member. There have been recent attempts to encourage *physicians* to *prescribe* drugs by generic names whenever possible instead of by brand names. This is said to allow considerable cost savings. Considerable controversy has arisen over whether drugs sold by generic name are in fact *therapeutically equivalent* to their brand-name counterparts. In some cases two versions of the same drug, manufactured by the same or different manufacturers, may not, usually for reasons of *bioavailability*, be therapeutically equivalent. Advocates of generic prescribing question whether such differences are universal or always significant. See also *Maximum Allowable Cost Program* and *antisubstitution*.

goal: in health *planning*, a quantified statement of a desired future state or condition, such as an infant mortality of less than 20 per thousand live births, a physician to population ratio greater than four per thousand, or an average access time for emergency medical services less than 20 minutes. Health planning formulates goals and seeks to achieve them. A goal differs from an *objective* by lacking a deadline, and usually by being long range (five to ten years) rather than short (one to two years).

gork: originally an acronym for "God only really knows," and then used by *housestaff* for *patients* whose problems were so mysterious as to defy diagnosis. It has now lost all connection with its original meaning and is used offensively to describe patients who are, and are likely to remain, comatose.

governmental immunity: in *malpractice*, a doctrine providing that, despite the general proposition that a negligent act gives rise to tort liability for that act, the government, subject to certain qualifications, cannot be sued for the negligent acts of its officers, agents, or employees unless it consents to such a suit. This concept of governmental immunity had its origin in ancient common law doctrine and the principle has been firmly established that a State cannot be sued without its consent. As with *charitable immunity*, the trend is towards an increasing willingness of the courts to impose liability as the States and the Federal government enact statutes to waive their immunity in tort suits.

grace period: a specified period, after a *premium* payment is due on an insurance policy, in which the policyholder may make such payment, and during which the protection of the policy continues.

graduate medical education: medical education given after receipt of the M.D. or equivalent degree, including the education received as an *intern*, *resident* or *fellow*, and *continuing education*. This use contrasts with that in general education where graduate education refers to graduate school education leading to a masters, doctoral or equivalent degree (called *undergraduate medical education* in medicine). It is sometimes limited to education required for specialty *board certification*. Education at this level usually includes supervised practice, research and even teaching, as well as didactic learning.

grandfather clause or provision: a clause or provision of law that permits continued eligibility or coverage for individuals or organizations receiving program benefits under the law despite a change in the law which would otherwise make them ineligible; or in some other manner exempts a person, organization or thing from a change in law which would otherwise effect it. For example, the Federal Food, Drug, and Cosmetic Act exempts certain *drugs* from the Act's pre-market approval requirements on the basis of their longstanding use.

group: in *group insurance*, a body of *subscribers* eligible for group insurance by virtue of some common identifying attribute, such as common employment by an employer, or membership in a union, association or other organization. Groups considered for insurance are usually larger than nine persons.

group insurance: any *insurance* plan by which a number of employees of an employer (and their *dependents*), or members of a similar homogeneous *group*, are *insured* under a single policy, issued to their employer or the *group* with individual *certificates of insurance* given to each insured individually or *family*. Individual employees may be insured automatically by virtue of employment, only on meeting certain conditions (employment for over a month), or only when they elect to be insured (and usually to make a contribution to the cost of the insurance). Group health insurance is usually *experience rated* (except for small groups, all of which insured by an individual company in the same area are given the same rate by that company) and less expensive for the insured than comparable individual insurance (partly because an employed population is generally healthier than the general population, and partly because of lower administrative costs, especially in marketing and billing). Note that the policyholder or *insured* is the employer not the employees. See also *contributory insurance*.

group practice: a formal association of three or more physicians or other health *professionals* providing services with income from medical *practice* pooled and redistributed to the members of the group according to some prearranged plan (often, but not necessarily, through partnership). By 1969, 12.8 percent of all physicians in the U.S. were practicing in groups, mostly in groups of one medical specialty, and this number is apparently growing rapidly. Multi-specialty groups offer advantages to the *patient* by their ability to provide several kinds of services on an integrated basis. Groups vary a great deal in size, composition and financial arrangements. See also *solo*, *private* and *prepaid group practice*.

guidelines: see *criteria* and *policy*.

h

habilitation: see *rehabilitation*.

habituation: see *drug habituation*, *abuse* and *dependence*.

halo effect: the effect (usually beneficial) which the manner, attention and caring of a *provider* have on a *patient* during a medical *encounter* regardless of what medical procedures or services the encounter actually involves. See also *Hawthorne effect* and *placebo*.

Harvey, William (1578–1657): a celebrated English physician whose brilliant inductive reasoning and experiments, described in his *De motu cordis* (1628), establish him as the true discoverer of the circulation of the blood. He was also one of the first to doubt the doctrine of preformation of the fetus.

Hawthorne effect: the effect (often beneficial, almost always present) which an *encounter* with a *provider*, health program or other part of the health system has on a *patient* which is independent of the medical content of the encounter. The Hawthorne effect is similar to the *placebo* effect, but is not obtained intentionally and is the effect of the encounter with a provider or program on the patient rather than of what they do for him. The effect may be changed (intentionally or not) by changing the provider or program (for instance by painting a *clinic* or changing its appointments system). Since *health services research* usually changes the services being studied simply by being done or in unintentional ways, the resulting change in the Hawthorne effect may well confound the results of the research. The name comes from classic industrial management experiments at the Hawthorne plant of the Western Electric Company.

hazard: a situation or event which introduces, or increases the probability of, occurrence of a *loss* arising from a *peril*, or that increases the extent of a loss; such as slippery floors, unsanitary conditions, or congested traffic.

health: defined by the World Health Organization as "a state of complete physical, mental, and social well-being and not merely the absence of *disease* or infirmity." Experts recognize, however, that health has many dimensions (anatomical, physiological, and *mental*) and is largely culturally defined. The relative importance of various *disabilities* will differ depending upon the cultural milieu and the role of the affected individual in that culture. Most attempts at measurement have taken a negative approach in that the degree of ill health has been assessed in terms of *morbidity* and *mortality*. In general, the detection of changes in *health status* is easier than the definition and measurement of the absolute level of health.

health card: an identification card, similar to a credit card, proposed in several *national health insurance* bills, which would be issued to each covered individual or *family* unit. This card would be presented at the time services were rendered in lieu of any cash payment. The individual would subsequently receive a bill for any *cost-sharing* not covered under the insurance plan. Health cards, it is said, would simplify eligibility determination, billing and accounting, and the study of use of services. The idea presents interesting *confidentiality* problems, particularly under the Federal Credit Disclosure Act.

health care corporation (HCC): an organization proposed by the American Hospital Association in its *NHI* proposal which would assume overall *management* responsibility for providing all *needed* personal health services in a defined *catchment area*.

health facilities: collectively, all buildings and *facilities* used in the provision of health *services*. Usually limited to facilities which were built for the purpose of providing health care, such as *hospitals* and *nursing homes*, and, thus, does not include an office building which includes a physician's office. Health facilities, with *health manpower* are the principal health resources used in producing health

services. See also *beds, boarding homes, capital, capital depreciation, certificate-of-need, clinic, Hill-Burton, institutional health services, institutional licensure, JCAH, inpatient, length of stay, Life Safety Code, modernization, outpatient, per diem cost, proprietary hospital.*

health insurance: *insurance* against loss by *disease* or accidental bodily *injury*. Such insurance usually covers some of the medical costs of treating the disease or injury, may cover other losses (such as loss of present or future earnings) associated with them and may be either *individual* or *group* insurance.

Health Insurance Benefits Advisory Council (HIBAC): an advisory council to HEW whose primary role, pursuant to section 1867 of the Social Security Act and as detailed in its charter, is to provide advice and recommendations on matters of general *policy* in the administration of *Medicare* and *Medicaid*. This role was reaffirmed after Departmental review, and the Council was rechartered on December 13, 1974, to continue the provision of such advice to the Secretary for two additional years. The Council consists of nineteen non-governmental experts in health related fields who are selected by the Secretary and hold office for terms of four years. In recognition of the broad impact of Medicare and Medicaid on health care delivery throughout the country, the management and staff support for the Council has been transferred to the Office of the Assistant Secretary for Health. Organizationally, this is said to enable information on policy issues to be more directly channeled to the Council and provides the Assistant Secretary for Health ready access to, and analysis of, HIBAC issues.

Health Insurance for the Aged and Disabled: the *social insurance* program authorized by title XVIII of the Social Security Act and known as *Medicare*.

health maintenance organization (HMO): an entity with four essential attributes:

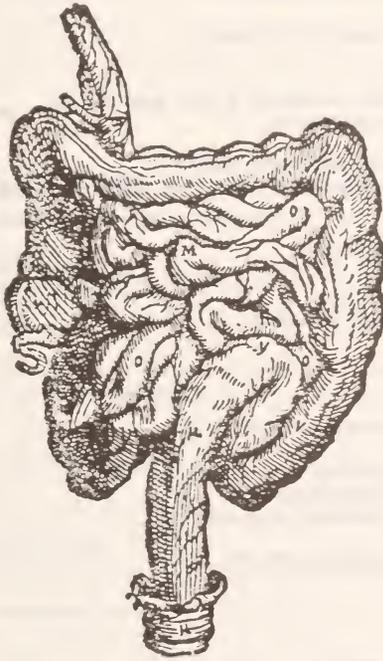
(1) an organized system for providing health care in a geographic area, which entity accepts the responsibility to provide or otherwise assure the delivery of

(2) an agreed upon set of *basic* and *supplemental health* maintenance and treatment *services* to

(3) a voluntarily enrolled group of persons, and

(4) for which services the HMO is reimbursed through a predetermined, fixed, periodic *prepayment* made by or on behalf of each person or family unit *enrolled* in the HMO without regard to the amounts of actual services provided. (From the report of the Committee on Interstate and Foreign Commerce on the HMO Act of 1973, P.L. 93-222, in which the term is legally defined, section 1301 of the *PHIS Act*.) The HMO is responsible for providing most health and medical care services required by enrolled individuals or *families*. These services are specified in the contract between the HMO and the enrollees. The HMO must employ or contract with health care providers who undertake a continuing responsibility to

provide services to its enrollees. The prototype HMO is the Kaiser-Permanente system, a *prepaid group practice* located on the West Coast. However, *medical foundations* sponsored by groups of physicians are included under the definition. HMOs are of public policy interest because the prototypes appear to have demonstrated the potential for providing high *quality* medical services for less money than the rest of the medical system. Specifically, rates of hospitalization and surgery are considerably less in HMOs than occurs in the system outside such prepaid groups, although some feel that earlier care, *skimping* or *skimming* may be better explanations. See also *prepaid health plans* (PHPs), *individual practice associations*, *qualified* and *group practice*.



H

health manpower: collectively, all men and women working in the provision of health services whether as individual practitioners or employees of health institutions and programs; whether or not professionally trained; and whether or not subject to public *regulation*. *Facilities* and manpower are the principal health resources used in producing health services. In 1973 there were over four million people working in over 200 health occupations. Some of these are shown in the following table. It is often difficult to agree on which occupations are health occupations, but the table does suggest the variety of possibilities. See also *capitation*, *CCME*, *FMG*, *graduate* and *undergraduate medical education*, *professional*, *practice*, *credentialing*, *internship* and *residency*, and *proficiency* and *equivalency testing*.

Estimated persons employed in selected occupations within each health field: 1973

<i>Health field and occupation</i>	<i>Active workers</i>
Total ¹	4, 403, 450-4, 448, 250
Administration of health services	48, 200
Health department and public health administrator	5, 200
Hospital administrator and assistant	17, 000
Nursing home administrator and assistant	² 16, 000
Voluntary health agency administrator and program representative	² 10, 000
Anthropology and sociology	² 1, 600
Anthropologist—cultural and physical	700
Sociologist—medical	900
Automatic data processing in the health field	4, 000
Systems analyst and programmer	4, 000
Basic sciences in the health field ³	60, 000
Research scientist (other than physician, dentist, veterinarian)	60, 000
Biomedical engineering	11, 500
Biomedical engineer	4, 000
Biomedical engineering technician	7, 500
Chiropractic	15, 500
Chiropractor	15, 500
Clinical laboratory services	162, 800
Clinical laboratory scientist	5, 500
Clinical laboratory technologist	90, 300
Clinical laboratory technician and assistant	67, 000
Dentistry and allied services	274, 400
Dentist	105, 400
Dental hygienist	21, 000
Dental assistant	116, 000
Dental laboratory technician	32, 000
Dietetic and nutritional services	68, 000
Dietitian and nutritionist	45, 000
Dietetic technician and food service supervisor	23, 000
Economic research in the health field	² 400
Economist—health	400
Environmental sanitation	17, 000-20, 000
Sanitarian	² 12, 000-15, 000
Technician and aide	5, 000

See footnotes at end of table.

Estimated persons employed in selected occupations within each health field:
1973—Continued

<i>Health field and occupation</i>	<i>Active workers</i>
Food and drug protective services	44, 400
Inspector (health, food and drug, other)	15, 000
Food and drug chemist, microbiologist	1, 000
Food technologist	25, 000
Food technician	3, 400
Funeral directors and embalmers	50, 000
Funeral director and embalmer	50, 000
Health and vital statistics	⁴ 1, 350
Health statistician	1, 100
Vital record registrar	150
Demographer	100
Health education	22, 500-23, 000
Public health educator	2, 500-3, 000
School health educator, coordinator	² 20, 000
Health information and communication	6, 700-9, 300
Biomedical photographer	² 2, 000
Health information specialist and science writer	2, 000-4, 000
Medical writer	1, 200
Technical writer and editor	1, 000-1, 500
Medical illustrator	² 500-600
Library services in the health field	² 7, 900
Medical librarian	3, 800
Medical library technician and clerk	4, 100
Medical records	54, 000
Registered record administrator	9, 000
Accredited record technician	45, 000
Medicine and osteopathy	345, 300
Physician (M.D.)	333, 300
Physician (D.O.)	² 12, 000
Midwifery	4, 200
Lay midwife	2, 900
Nurse midwife	1, 300
Nursing and related services	2, 207, 000-2, 212, 000
Registered nurse	815, 000
Practical nurse	459, 000
Nursing aide, orderly, attendant	910, 000
Home health aide	23, 000-28, 000

See footnotes at end of table.

Estimated persons employed in selected occupations within each health field:
1973—Continued

<i>Health field and occupation</i>	<i>Active workers</i>
Occupational therapy	13, 200-14, 200
Occupational therapist	7, 700
Occupational therapy technician, assistant	² 5, 500-6, 500
Opticianry	11, 000
Dispensing optician	11, 000
Optometry	25, 100-25, 300
Optometrist	19, 300
Optometric assistant	² 5, 000
Optometric technician	² 800-1, 000
Orthotic and prosthetic technology	2, 500-3, 500
Orthotist and prosthetist	2, 500-3, 500
Pharmacy	132, 900
Pharmacist	132, 900
Physical therapy	24, 600
Physical therapist	16, 500
Physical therapy technician, assistant	8, 100
Podiatric medicine	² 7, 100
Podiatrist	7, 100
Psychology	27, 000
Psychologist	27, 000
Radiologic technology	100, 000
Radiologic (X-ray) technologist, technician, assistant	100, 000
Respiratory therapy	11, 000-12, 000
Respiratory therapist	11, 000-12, 000
Secretarial and office services in the health field	² 275, 000-300, 000
Receptionist, secretary, assistant, aide	275, 000-300, 000
Social work	33, 800
Social worker—medical and psychiatric	29, 500
Social work assistant and aide	⁴ 4, 300
Specialized rehabilitation services	² 11, 050
Corrective therapist	1, 100
Educational therapist	350
Manual arts therapist	900
Music therapist	2, 200
Therapeutic recreational specialist	6, 000
Home economist in rehabilitation	500
Speech pathology and audiology	26, 500
Speech pathologist and audiologist	26, 500

See footnotes at end of table.

Estimated persons employed in selected occupations within each health field;
1973—Continued

Health field and occupation	Active workers
Veterinary medicine.....	26,900
Veterinarian.....	26,900
Vocational rehabilitation counseling.....	17,000
Vocational rehabilitation counselor.....	17,000
Miscellaneous health services.....	252,950-258,450
Ambulance attendant.....	207,000
Animal technician.....	5,000
Electrocardiograph technician.....	² 9,500
Electroencephalograph technician.....	3,500-4,000
Operating room technician.....	11,400
Ophthalmic assistant.....	¹ 15,000-20,000
Orthoptist.....	² 450
Physician's assistant.....	900
Surgeon's assistant.....	200

¹ Each occupation is counted only once. For example, all physicians are in medicine and osteopathy.

² Previous estimate repeated in absence of sufficient information on which to base revision.

³ Statistics are not available on what percentage of the estimated 250,000 physical scientists are employed in the health field.

⁴ 1968 estimate repeated in absence of sufficient information on which to base revision.

Source: National Center for Health Statistics.—*Health Resources Statistics: Health Manpower and Health Facilities, 1974*. 1974. Health Resources Administration. U.S.P.H.S., H.E.W., pp. 9-12.

health manpower education initiative award (HMEIA): a grant or contract under section 774 of the *PHS Act* (added by the Comprehensive Health Manpower Training Act of 1971, P.L. 92-157) which authorizes awards to health or educational entities for *health manpower* programs which will improve the distribution, *supply, quality, utilization, and efficiency* of health personnel and the health services delivery system. Support has been provided for the development of *area health education centers* (AHECs), the training of *physician assistants*, and the identification and encouragement of disadvantaged students with a potential for training in the health professions, among other activities. In fiscal 1975, funding was at the level of \$12 million for AHECs, \$8 million for physician assistant training, \$6.7 million for career opportunity grants (disadvantaged students), and \$19.5 million for other manpower initiatives.

health planning: *planning* concerned with improving health, whether undertaken comprehensively for a whole community (see *CHP*) or for a particular population, type of health service, or health program. Some definitions clearly include all activities undertaken for the purpose of improving health (such as education, traffic and environmental control and nutrition) within the scope of responsibility of the planning process; others are limited to including conventional health services and programs, *public health*, or *personal health services*. See also *goals and objectives, State health planning and development agency and health systems agency, and policy, management and budget*.

health professional: see *professional*.

health resources: resources (human, monetary or material) used in producing health care and services. They include money, *health manpower*, *health facilities*, equipment and *supplies*. Resources, available or used, can be measured and described for an area (see *medically underserved* and *catchment area*), population (see *medically underserved population*), or an individual program (an *HMO*) or service.

health service area: a geographic area appropriate for the effective *planning* and development of health services. Section 1511 of the *PHIS Act* requires that health service areas be delineated throughout the United States. The governors of the various States designate the areas using requirements specified in the law respecting geography, political boundaries, population, *health resources* and coordination with areas defined for other purposes. See also *catchment area* and *locality*.

Health Service, Inc. (HSI): a *stock insurance company* organized in Illinois by *Blue Cross plans* to serve as a national enrollment agency, to assist individual plans in negotiating contracts, and to serve large national accounts in which two or more plans are involved. While HSI and *Medical Indemnity of America* are separate companies with separate boards of directors, they have an integrated administration and a common president.

health services research: research concerned with the organization, financing, administration, effects, or other aspects of health services; rather than with human biology, and disease and its prevention, diagnosis and treatment. In a sense, health services research concerns itself with the form, and *biomedical research* with the content of *medicine*.

health status: the state of *health* of a specified individual, group or population (such as Ohioans, an HMO membership, or an employer's employees). It is as difficult to describe or measure as the health of an individual and may be measured with people's subjective assessment of their health, or with one or more indicators of *mortality* and *morbidity* in the population, such as longevity, maternal and *infant mortality*, and the *incidence* or *prevalence* of major *diseases* (communicable, coronary, malignant, nutritional, etc.). These are, of course, measures of *disease* status, but have to be used as proxies in the absence of measures of either objective or subjective health. Health status conceptually is the proper *outcome measure* for the *effectiveness* of the specific population's medical care system, although attempts to relate variations in health status and the effects of available medical care have proved difficult and generally unsuccessful. It cannot be measured with measures of *available* health resources or services (such as physician to population ratios) which, in this context, would be *process measures*. See also *vital statistics* and *National Health Survey*.

health survey: a program for studying a group or population, in order to assess its *health status*, the conditions influencing or influenced by its *health*, and the health services and medical care *available* to and used by it. See also *National Health Survey*.

health systems agency (HSA): a *health planning* and resources development agency designated under the terms of the National Health Planning and Resources Development Act of 1974, P.L. 93-641. P.L. 93-641 requires the designation of an HSA in each of the *health service areas* in the United States. HSAs are to be non-profit private corporations, public regional planning bodies, or single units of local government, and are charged with performing the health planning and resources development functions listed in section 1513 of the PHS Act. The legal structure, size, composition and operation of HSAs are specified in section 1512 of the Act. HSA functions include preparation of a *health system plan* (HSP) and an *annual implementation plan* (AIP), the issuance of grants and contracts, the review and approval or disapproval of proposed uses of a wide range of Federal funds in the agency's health service area, and review of proposed new and existing *institutional health services* and making of recommendations respecting them to *State health planning and development agencies*. HSAs will replace existing *areawide CHIP agencies* but with expanded duties and powers.

health system plan (HSP): a long range health plan prepared by a *health systems agency* for its *health service area* specifying the health *goals* considered appropriate by the agency for the area. The HSPs are to be prepared after consideration of national guidelines issued by HEW and study of the characteristics, resources and special needs of the health service area. Section 1513 of the PHS Act requires and specifies the nature of an HSP. See also *annual implementation plan*.

high option: in a *Federal Employees Health Benefits Plan*, and some other insurance policies, denotes one of two or more levels of insurance which may be chosen by the *subscriber*. Under such options the *benefits* covered are usually essentially the same except that the high option provides lower *deductibles* and other *cost-sharing* requirements and more generous time or quantity limits than the low option. The *premium* for the high option is higher than the low option to reflect the more generous coverage.

Hill-Burton: legislation, and the programs operated under that legislation, for Federal support of construction and *modernization* of hospitals and other *health facilities*, beginning with P.L. 79-725, the Hospital Survey and Construction Act of 1946. The original law, which has been amended frequently, provided for surveying *State needs*, developing plans for construction of hospitals and public health centers, and assisting in constructing and equipping them. Until the late 1960s, most of the amendments expanded the program in dollar amounts and scope. More recently, the administration has attempted to terminate the program while the Congress

has sought to restructure it toward support of *outpatient* facilities, facilities to serve areas deficient in health services, and training facilities for health and allied health professions. Under P.L. 93-641, the National Health Planning and Resources Development Act of 1974, the Hill-Burton program will be administered by the *State health planning and development agency*. The purpose of the existing Hill-Burton programs was modified by P.L. 93-641 to allow assistance in the form of grants, loans or loan guarantees for the following purposes only: modernization of health facilities; construction of outpatient health facilities; construction of inpatient facilities in areas which have experienced recent rapid population growth; and conversion of existing medical facilities for the provision of new health services.

Hippocrates of Cos (late 5th century B.C.): a famous Greek physician who is generally regarded as the father of medicine. Many of the writings of Hippocrates and his school have survived, the so-called *Corpus Hippocraticum*, but it is not certain which were written by Hippocrates himself. These writings are usually characterized by the stress laid on treatment and prognosis. An oath which appears in the body of work attributed to Hippocrates and his school, and known as the Hippocratic oath, has been the ethical guide of the medical profession since those days. It is as follows:

I swear by Apollo the physician, by Æsculapius, Hygeia and Panacea, and I take to witness all the gods, and all the goddesses, to keep according to my ability and my judgment the following Oath:

To consider dear to me as my parents him who taught me this art; to live in common with him and if necessary to share my goods with him; to look upon his children as my own brothers, to teach them this art if they so desire without fee or written promise; to impart to my sons and the sons of the master who taught me and the disciples who have enrolled themselves and have agreed to the rules of the profession, but to these alone, the precepts and the instruction. I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone. To please no one will I prescribe a deadly drug, nor give advice which may cause his death. Nor will I give a woman a pessary to procure abortion. But I will preserve the purity of my life and my art. I will not cut for stone, even for patients in whom the disease is manifest; I will leave this operation to be performed by practitioners (specialists in this art). In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction, and especially from the pleasures of love with women or with men, be they free or slaves. All that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal. If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lot.

Hippocratic Oath: see *Hippocrates of Cos*.

hold harmless provision: a provision of law that prevents a governmental entity, institution or other party from suffering additional expenses or loss of benefits as a result of a change in a statute or *regulations*. Without such a provision such an entity or institution would be responsible for expenses not previously anticipated due to an expanded caseload, more generous coverage provisions, or both. On the other hand, the use of hold harmless provisions often creates substantial confusion, heterogeneity and inequity in eligibility,

coverage and responsibilities under a statute. In *insurance*, a provision offering the *insured* protection in disputes between the *insurer* and the *provider* of a covered service.

home health agency: an agency which provides *home health care*. To be certified under *Medicare* an agency must provide skilled nursing services and at least one additional therapeutic service (*physical, speech* or *occupational therapy*, medical social services, or home health aide services) in the home.

home health care: health services rendered to an individual as *needed* in the home. Such services are provided to aged, disabled, or sick or convalescent individuals who do not need institutional care. The services may be provided by a *visiting nurse association* (VNA), *home health agency*, hospital or other organized community group. They may be quite specialized or comprehensive (nursing services, speech, physical, occupational and rehabilitation therapy, homemaker services, and social services). Under *Medicare*, such services must be provided by a home health agency. Under *Medicaid*, States may, but do not have to, restrict coverage of home health care to services provided by *home health agencies*.

homemaker services: non-medical support services (e.g., food preparation, bathing) given a homebound individual who is unable to perform these tasks himself. Such services are not covered under the *Medicare* and *Medicaid* programs, or most other health insurance programs, but may be included in the social service programs developed by the States under title XX of the Social Security Act. Homemaker services are intended to preserve independent living and normal family life for the aged, disabled, sick or convalescent. See also *alternatives to long term institutional care*.

Homeopathic Pharmacopeia of the U.S.: one of the three official *compendia* in the United States recognized in the Federal Food, Drug and Cosmetic Act.

homeopathy: a system of *medicine* expounded by Samuel Hahnemann based on the simile phenomenon (*similia similibus curantur*). Cure of *disease* was said to be effected by minute doses of *drugs* which produce the same signs and symptoms in a healthy person as are present in the disease for which they are administered. This was said to stimulate bodily defenses against the signs and symptoms. This system of medicine is no longer practiced in the United States. The Hahnemann Medical College now trains *allopathic* physicians. See also *osteopathy*.

hometown medical and dental care: in the Veterans Administration health care program, outpatient medical or dental treatment paid for by the program and provided eligible veterans in their own communities by VA approved doctors or dentists of their own choice. Such treatment is furnished when the care cannot be given by VA clinic facilities, or when the health of the patient or distance to be traveled gives sufficient justification.

home visit: see *housecall* and *visit*.

hospice: a program which provides palliative and supportive care for terminally ill *patients* and their *families*, either directly or on a *consulting* basis with the patient's *physician* or another community agency such as a *visiting nurse association*. Originally a medieval name for a way station for crusaders where they could be replenished, refreshed and cared for; used here for an organized program of care for people going through life's last station. The whole family is considered the unit of care and care extends through the mourning process. Emphasis is placed on symptom control and preparation for and support before and after *death*. Hospices originated in England (where there are about 25) and are now appearing in the U.S. As one example of their human and cost-saving effects, 61 percent of one hospice's patients died at home (compared with the 2 percent of all American deaths which occur at home). Some would consider the hospice as an alternative to *euthanasia*.

hospital: an institution whose primary function is to provide *inpatient* services, *diagnostic* and *therapeutic*, for a variety of medical conditions, both surgical and nonsurgical. In addition, most hospitals provide some *outpatient* services, particularly *emergency care*. Hospitals are classified by *length of stay* (short-term or long-term); as teaching or nonteaching; by major type of service (psychiatric, tuberculosis, general and other specialties, such as maternity, childrens' or ear, nose and throat); and by control (government, Federal, State or local, for-profit (or *proprietary*), and non-profit). The hospital system is dominated by the short-term, general, non-profit community hospital, often called a *voluntary hospital*.

hospital-based physician: a *physician* who spends the predominant part of his *practice* time within one or more hospitals instead of in an office setting, or providing services to one or more hospitals or their *patients*. Such physicians sometimes have a special financial arrangement with the hospital (salary or percentage of fees collected), and include directors of medical education, pathologists, anesthesiologists and radiologists, as well as physicians who staff emergency rooms and *outpatient departments*.

Hospital Insurance Program (Part A, HI): the *compulsory* portion of *Medicare* which automatically enrolls all persons aged 65 and over, entitled to benefits under *OASDHI* or railroad retirement, persons under 65 who have been eligible for *disability* for over two years, and insured workers (and their *dependents*) requiring renal dialysis or kidney transplantation. The program pays, after various *cost-sharing* requirements are met, for *inpatient* hospital care and care in *skilled nursing facilities* and *home health agencies* following a period of hospitalization. The program is financed from a separate *trust fund* funded with a contributory tax (*payroll tax*) levied on employers, employees and the self-employed. In 1976 the tax is 0.9 percent of the first \$15,300 of covered yearly earnings. Under the program each hospital nominates an *intermediary* which reviews and pays *claims* from that hospital for the program.



I

Hospital International Classification of Diseases Adapted for use in the United States (H-ICDA): see *International Classification of Diseases, Adapted for use in the United States.*

hospital privileges: see *staff privileges.*

housecall: a *visit* by a physician or other *provider* to a *patient's* home. Now considered by some to be an obsolete practice with respect to physicians.

house officers: see *housestaff.*

housestaff: generally, the *physician* staff in training at a hospital, principally comprised of the hospital's *interns, residents* and fellows. Members of the housestaff are called houseofficers. Occasionally also applies to physicians salaried by a hospital who are not receiving any *graduate medical education.*

humanistic medicine: medical *practice* and culture which respects and incorporates the concepts that: the *patient* is more than his *disease*, the *professional* more than a scientifically trained mind using technical skills, both are whole human beings interacting in the healing effort; a person is more than his body, he is a unique, interdependent

relationship of body, mind, emotions, culture and spirit; each person has the capacity to define and be increasingly responsible for himself, the professional seeks to assist the patient in taking and fulfilling his responsibility for himself; health and disease are not matters of the moment but have an intricate past, present and future; physical disease, pain, suffering, aging and even death can frequently be valuable, meaningful events in an individual's life; and effective practice requires not just conventional skills but also effective development and use of human qualities such as intuition, inventiveness and empathy.

i

iatrogenic: resulting from the activity of a *physician*. Originally applied to disorders induced in the patient by autosuggestion based on the physician's examination, manner or discussion (see *halo effect*). It is now applied to any condition in a patient occurring as a result of *treatment* by a physician or surgeon, such as a drug reaction.

illness: usually used synonymously with *disease*. Can be differentially defined by saying illness is present when an individual perceives himself as diseased and disease is present when identifiable by objective, external *criteria*.

impoundment: in the Federal *budget*, any executive branch action or inaction that precludes the *obligation* or expenditure of *budget authority* provided by the Congress. An impoundment resolution is a resolution of the House of Representatives or the Senate which expresses its disapproval of a proposed *deferral* of budget authority set forth in a special message ordinarily transmitted by the President. Passage of an impoundment resolution by either House of Congress has the effect of overturning the proposed deferral and requires that such budget authority be made available for obligation. See also *rescission*.

incidence: in *epidemiology*, the number of cases of *disease*, infection, or some other event having their onset during a prescribed period of time in relation to the unit of population in which they occur. It measures *morbidity* or other events as they happen over a period of time: the number of accidents occurring in a manufacturing plant during a year in relation to the number of employees in the plant; or the number of cases of mumps occurring in a school during a month in relation to the pupils enrolled in the school. Usually refers only to the number of new cases, particularly of *chronic diseases*. The incidence of common colds is high relative to their *prevalence*. In health economics, the distribution of a tax among groups, usually *income* groups, in the population. Nominal incidence is the distribution mandated by law, such as a specified division of a *payroll tax* between employers and employees. Ultimate incidence is the distribution after the income effects of the tax are allowed for. For example, most economists feel that the employer's share of a payroll tax is ultimately borne by the employees in lower wages or consumers in higher prices.

income: the return, usually measured in money, from one's business, labor, or *capital* invested. As one example of the complexity of defining income in operational terms the I.R.S. 1040 should be considered as a specific definition of income. Welfare programs attempt to distinguish earned income (wages or net earnings from employment) and unearned income (support or maintenance furnished in kind or cash; annuities, pensions, retirements or disability benefits; prizes, gifts, and awards; proceeds from *insurance policies*, support and alimony payments; inheritances; and rents, dividends, interest and royalties). Note that fringe benefits of employment (such as the employer's contribution to the cost of health insurance) are often not considered as income for tax purposes thus enhancing their real value (and creating, for example, an indirect Federal subsidy of group health insurance). See also *resources*.

incur: in *insurance*, to become *liable* for a *loss*, claim or expense. Cases or losses incurred are those occurring within a fixed period for which an insurance plan becomes liable whether or not reported, adjusted and paid.

indemnity, indemnity benefits: under health *insurance policies*, *benefits* in the form of cash payments rather than services. The indemnity insurance contract usually defines the maximum amounts which will be paid for the covered services. In most cases, after the provider of service has billed the patient in the usual way, the insured person submits to the insurance company proof that he has paid the bills and is then reimbursed by the company in the amount of the covered costs, making up the difference himself. In some instances, the provider of service may complete the necessary forms and submit them to the insurance company directly for reimbursement, billing the patient for costs which are not covered. Indemnity benefits are contrasted with *service benefits*.

independent professional review (IPR): another name for *medical review* required by *Medicaid* for *inpatients* in *long-term care facilities*.

indexed: describes an amount which is regularly adjusted in proportion to changes in some index, e.g. social security payments are now indexed to (or adjusted to reflect changes in) the *Consumer Price Index*. Some proposed *NIH* plans index *premiums*, *cost-sharing*, catastrophic thresholds, income levels, or reimbursement rates to the CPI.

Indian Health Service: the bureau in HEW which is responsible for delivering *public health* and medical services to Indians throughout the country. The Federal government has variable but direct and permanent legal obligations to provide health services to most Indian peoples undertaken in treaties written with the Indian Nations in the last two centuries. The Indian Health Service is responsible for trying to fulfill these obligations within its very severe budgetary restrictions.

indirect cost: a *cost* which cannot be identified directly with a particular activity service or product of the program experiencing the cost. Indirect costs are usually apportioned among the program's services in proportion to each service's share of *direct costs*.

individual health insurance: health *insurance* covering an individual (and usually his *dependents*) rather than a group. Individual insurance usually offers *indemnity benefits* and has higher *loadings* than *group insurance*.

individual insurance: insurance policies which provide protection to the policyholder and/or his *family* (as distinct from *group insurance*). Sometimes called personal insurance.

individual practice: see *solo practice*.

individual practice association (IPA): a partnership, corporation, association, or other legal entity which has entered into an arrangement for provision of their services with persons who are *licensed* to *practice medicine, osteopathy, dentistry*, or with other *health manpower* (a majority of whom are licensed to practice medicine or osteopathy), which arrangement provides: that such persons provide their professional services in accordance with a compensation arrangement established by the entity; and to the extent feasible (i) that such persons use such additional professional personnel, allied health professions personnel, and other health personnel as are available and appropriate for the *effective* and *efficient* delivery of the services, (ii) for the sharing by such persons of *medical* and other *records, equipment, and professional, technical and administrative staff*, and (iii) for the arrangement and encouragement of the *continuing education* of such persons in the field of clinical medicine and related areas. The term originated and is defined in the Health Maintenance Organization Act of 1973, P.L. 93-222, section 1302(5) of the *PHS Act*. IPAs are one source of professional services for *HMOs* and are modeled after *medical foundations*. See also *individual practice plan*.

individual practice plan: usually synonymous with a *medical foundation*. Sometimes used to refer specifically to a *health maintenance organization* which obtains its professional services from an *individual practice association*.

industrial health services: health services provided by physicians, dentists, nurses, or other health personnel in an industrial setting for the appraisal, protection, and promotion of the health of employees while on the job. *Occupational health services* is now the preferred term.

infant mortality: the death (*mortality*) of live-born children who have not reached their first birthday, usually measured as a rate: number of infant deaths per 1,000 *live births* in a given area or program and time period. The infant mortality rate is one common measure of *health status*. Infant mortality varies among countries at least partly because the definition is somewhat variable. See also *neonatal* and *perinatal mortality*.

informed consent: consent, preferably in writing, obtained from a patient for performance on the *patient* of specific medical, surgical or research procedures after the proposed procedure and risks involved have been fully explained in non-technical terms and understood. If the patient is a minor, or is incapable of understanding or communicating, such consent must be obtained from a close adult relative or legal guardian.

injury: traumatic (in *insurance*) or *iatrogenic* (in *malpractice*) damage to the body, of external origin, unexpected and undesigned by the injured person.

inpatient: a *patient* who has been *admitted* at least overnight to a hospital or other *health facility* (which is therefore responsible for his room and board) for the purpose of receiving diagnostic, treatment or other health services. Inpatient care means the care given inpatients.

input measure: a measure of the *quality* of services based on the number, type and quality of *resources* used in the production of the services. Medical services are often evaluated by measuring the education and training level of the provider, the reputation and *accreditation* of the institution, the number of health personnel involved, or the number of dollars spent, as proxy measures for the quality of the service. Input measures are generally recognized as inferior to *process and outcome measures* because they are indirect measures of quality and do not consider the actual results, or *outcomes*, of services. They are often used nonetheless because people are accustomed to their use, and they are easily obtained. See also *output measure*.

institutional health services: health services delivered on an *inpatient* basis in *hospitals, nursing homes*, or other inpatient institutions, and by *health maintenance organizations*; but may also refer to services delivered on an *outpatient* basis by departments or other organizational units of or sponsored by such institutions. The National Health Planning and Resources Development Act of 1974, P.L. 93-641 (section 1531(5) of the *PHS Act*) defines them as services and facilities subject under HEW *rules* to *section 1122* review, and requires that all institutional, but not non-institutional, health services be subject to *certificate-of-need* review and periodic review for *appropriateness*.

institutional licensure: a proposed *licensure* system (not presently in use in any State) under which medical care institutions would be generally licensed by the State and would then be free to hire and use personnel as each saw fit, whether or not they met usual, individual licensure requirements. Using this system, formal education would become only one of many criteria used in assigning employees to particular positions. Institutional licensure is a suggested remedy to the alleged rigidities of the individual personnel licensing and *certification* programs presently in use in the health field. Other criteria could include job experience, and in-service training. Arguments in its favor are that it would allow increased job mobility within

the health care field, and greater institutional efficiency. It would perhaps also foster teamwork, and require only one licensing body at the State level rather than the many health licensing agencies presently functioning in each State. Such a system would not end the need for separate licensure of independent practitioners, assumes that licensure can assure the quality of an institution's services, deprives the *patient* of any assurance that the individual serving him has met individual licensure requirements, and indentures individuals providing care to the institutions through which they are licensed.

insurable risk: a *risk* which has the following attributes: it is one of a large homogeneous group of similar risks; the *loss* produced by the risk is definable and quantifiable; the occurrence of loss in individual cases is accidental or fortuitous; the potential loss is large enough to cause hardship; the cost of insuring is economically feasible; the chance of loss is calculable; and it is sufficiently unlikely that loss will occur in many individual cases at the same time.

insurance: the contractual relationship which exists when one party, for a consideration, agrees to reimburse another for loss to a person or thing caused by designated contingencies. The first party is the *insurer*; the second, the *insured*; the contract, the *insurance policy*; the consideration, the *premium*; the person or thing, the *risk*; and the contingency, the *hazard* or *peril*. Generally, a formal social device for reducing the risk of losses for individuals by spreading the risk over groups. Insurance characteristically, but not necessarily, involves equitable contributions by the insured, pooling of risks, and the transfer of risks by contract. Insurance may be offered on either a *profit* or nonprofit basis, to *groups* or individuals. See also *social insurance* and *prepayment*.

insurance clause: the clause which indicates the parties to a health or other insurance contract, sets forth the type of *losses*, *benefits* or services covered, and defines the benefits to be paid.

insurance commissioner: the State official charged with the enforcement of laws pertaining to *insurance* in the respective States. The commissioner's title, status in government and responsibilities differ somewhat from State to State but all States have an official having such responsibilities regardless of his title. Sometimes called superintendent or director.

insurance policy: a written contract of *insurance*.

insurance pool: an organization of *insurers* or *reinsurers* through which particular types of *risks* are shared or pooled. The *risk* of high *loss* by any particular insurance company is transferred to the group as a whole (the insurance pool) with *premiums*, losses, and *expenses* shared in agreed amounts. The advantage of a pool is that the size of expected losses can be predicted for the pool with much more certainty than for any individual party to it. Pooling arrangements are often used for *catastrophic coverage* or

for certain high risk populations like the *disabled*. Pooling may also be done within a single company by pooling the risks insured under various different policies so that high losses incurred by one policy are shared with others. See also *assigned risk*.

insured: the individual or organization protected in case of *loss* under the terms of an *insurance policy*. The insured is not necessarily the *risk*, the person whose risk of loss from *accident* or *sickness* is protected against. In *group insurance* the employer is the insured, the employees are the risks.

insurer: the party to an *insurance policy* who contracts to pay *losses* or render services.

intensity of service: the quantities of services provided to patients in a hospital or some other identifiable setting. Intensity can be expressed in terms of a weighted index of services provided, or in terms of a set of statistics indicating the average number of laboratory tests, surgical procedures, X-rays, etc., provided per patient or per patient day. Intensity is a function of the type of program and its *case-mix*.

intensive care unit: a specialized *nursing* unit which concentrates in one area within a hospital seriously ill patients needing constant nursing care and observation. Some intensive care units limit their services to certain types of patients such as coronary care, surgical intensive care, and newborn intensive care units. See also *progressive patient care*.

intermediary: a public or private agency or organization selected by *providers* of health care which enters into an agreement with the Secretary of HEW under the *Hospital Insurance Program (Part A)* of *Medicare*, to pay *claims* and perform other functions for the Secretary with respect to such providers. Usually, but not necessarily, a *Blue Cross plan* or private insurance company. See also *carrier* and *fiscal agent*.

intermediary letter (IL): a letter from the *Bureau of Health Insurance* to the *intermediaries* in the *Medicare* program which provides them with *administrative* direction or *policy*. These letters form a numbered series in which the *Social Security Administration* has made much of the *policy* for the Medicare program over the last decade.

intermediate care facility (ICF): an institution recognized under the *Medicaid* program which is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care or treatment which a *hospital* or *skilled nursing facility* is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities. Public institutions for care of the *mentally retarded* or people with related conditions are also included. The distinction between "health-related care and

services" and "room and board" has often proven difficult to make but is important because ICFs are subject to quite different *regulation* and coverage than institutions which do not provide health-related care and services. An ICF/MR is an ICF which cares solely or particularly for the mentally retarded.

International Classification of Disease, Adapted for use in the United States (ICDA): a USPHS official adaptation of a system for classifying *diseases* and *operations* for the purpose of indexing hospital records developed by the World Health Organization. Diseases are grouped according to the problems they present. For example, the major infective and parasitic diseases are listed in one section and all malignant neoplasms in another section. A three digit numerical code is used to number the major disease categories. Subdivisions within categories are numbered with a four digit code. The ICDA is revised every ten years. The eighth version (known as ICDA-8) is now in use and ICDA-9 in preparation. A further revised and expanded version of ICDA-8, known as Hospital-ICDA, was developed by *CHPA* and is widely used in hospitals and the *Professional Activity Study*. This version is now in its second edition, H-ICDA-2.

internship: any period of on the job training which is part of a larger educational program. In *medicine, dentistry, podiatry* and some other health *professions*, a one year program of *graduate medical education* practically always coming in the year after graduation. Practically all *physicians* take internships although they are required for *licensure* in only 39 of the 55 licensing jurisdictions. An internship usually is required for granting of *staff privileges*. *Residencies* are increasingly beginning in the first year after graduation, gradually eliminating internships.

investigational new drug (IND): a *drug* available solely for experimental purposes intended to determine its *safety* and *effectiveness* and not yet approved by the FDA for marketing to the general public. *Prescription* of the drug is limited to those experts qualified by training and experience to investigate its safety and effectiveness. Use of the drug in humans requires approval by the FDA of an IND application which provides reports of animal toxicity tests, a description of proposed clinical trials, and a list of the names and qualifications of the investigators. See also *new drug application*, and *new drug*.

j

Joint Commission on Accreditation of Hospitals (JCAH): a private, non-profit organization whose purpose is to encourage the attainment of uniformly high *standards* of institutional medical care. Comprised of representatives of the American Hospital Association, American Medical Association, American College of Physicians, and American College of Surgeons, the organization establishes guidelines for the operation of hospitals and other *health facilities* and conducts survey and *accreditation* programs. A staff of medical inspectors will visit hospitals by invitation and examine the operation of the hospital, the organization of its medical staff and its

patient records. Hospitals with 25 or more beds are eligible for review. On the basis of inspection reports, the hospital may be granted "full accreditation" (for three years), "provisional accreditation" (one year), or none. Accreditation has been used by, or adopted as a requirement of specific public programs and funding agencies, e.g., hospitals participating in the *Medicare* program are deemed to have met most *conditions of participation* if they are accredited by the JCAH.

joint purchasing agreement: a formal agreement among two or more *health facilities* or programs to purchase professional services, equipment or *supplies*. The agreements simplify purchasing or result in *economies of scale* intended to lower costs to the programs. The purchased services or supplies may be shared or simply distributed among the programs.

joint underwriting association (JUA): an association consisting of all *insurers* authorized by a State to write a certain kind of *insurance*, usually some form of liability insurance such as *malpractice insurance*. Such associations may be required or voluntarily agree to write malpractice insurance on a self-supporting basis. They may write such insurance on an exclusive basis, which means individual carriers cannot write such insurance, or on a non-exclusive basis. The JUA approach has been used in State legislation to assure the availability of malpractice insurance. Examples of the powers given to such associations are included in the medical malpractice insurance legislation recently enacted in New York. There, the JUA can issue policies, develop rates, employ a service company to handle the insurance (including claims adjustment), assume *reinsurance* from its members, and cede reinsurance.

J visa: a special visa category authorized by the U.S. Information and Educational Exchange (Smith-Mundt) Act of 1948. It is a product of the concept of the educational exchange initiated by the Fulbright program. Individuals with J visas may be admitted to the United States for the purpose of pursuing a full-time program of study (such as *residency*), but must be absent from the United States for two years after their studies have ended before they can reenter as an immigrant. In 1970 legislation was passed which eliminated this requirement for *foreign medical graduates* coming to the United States on private funds as long as they were not from a country where their special skills were in short supply. However, waivers may be obtained by those physicians who are from countries where their skills are in short supply if the home country has not objected to their immigration to the United States. Waivers are rarely, if ever, denied, primarily for lack of objection from home countries. See also *labor certification* and *schedule A*.

k

Keogh Act plan: a plan, available since 1963, under the Self-Employed Individual's Tax Retirement Act (Keogh Act), which permits a self-employed individual (such as a private physician) to establish a formal retirement plan including himself and to obtain tax

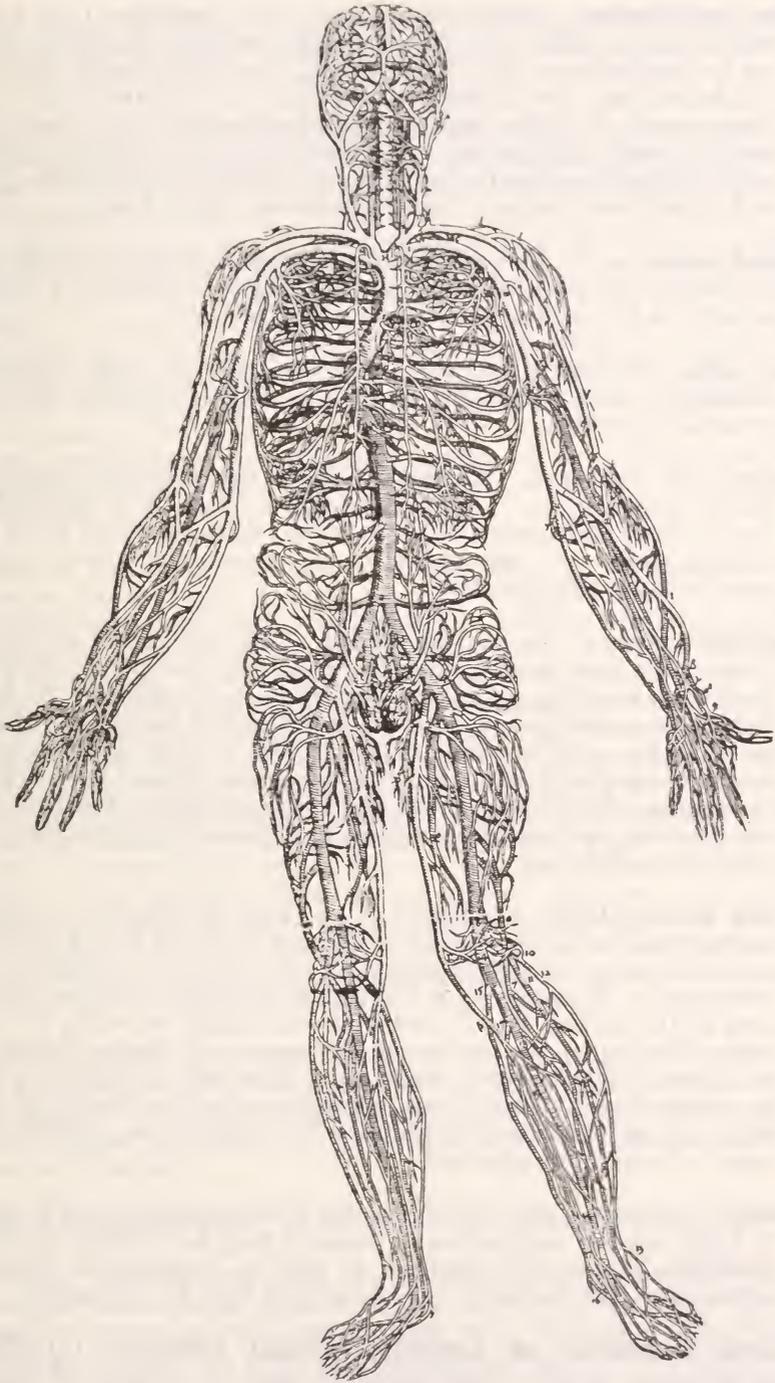
advantages similar to those available for qualified corporate pension plans. Self-employed individuals can annually set aside up to fifteen percent of earned *income* or \$7,500, whichever is less, and take a *tax deduction* for it.

Kerr-Mills: popular name for the Social Security Amendments of 1960 which expanded and modified the Federal government's existing responsibility for assisting the States in paying for medical care for the aged poor. The Act liberalized Federal sharing in *vendor payments* for medical care under the Federal/State old-age cash assistance program. It also created a new public assistance category—Medical Assistance for the Aged (MAA). The *medically indigent* eligible for assistance under this program were persons age 65 or over whose *incomes* were high enough that they were not eligible for Old Age Assistance but who needed help in meeting the costs of their medical care. The Federal share of medical payments ranged between 50 and 80 percent depending on the per capita income of the States with no limitation on the maximum amount of payment. The Social Security Amendments of 1965 established the *Medicaid* program, which substituted a single program of Federal assistance for medical vendor payments under the categorical cash assistance and MAA programs. The concept of medical indigency was extended to needy disabled, blind, and dependent children and their families. In July, 1970, Federal sharing in vendor payments became available only under Medicaid.

kiting: increasing the quantity of a *drug* ordered by a *prescription*. Either the *patient* or *pharmacist* may kite the quantity of the original prescription, for example, by adding zeros to the number shown on a prescription. When done by a pharmacist, he then provides the patient with the quantity originally prescribed but bills a *third party*, such as *Medicaid*, for the larger quantity. When done by a patient, it is usually because the patient is dependent upon the drug in question. See also *shorting* and *fraud*.

1

abeling: all labels and other written, printed, or graphic matter upon or accompanying a food, *drug*, *device*, or cosmetic, or any of their containers or wrappers (section 201(m) of the Federal Food, Drug, and Cosmetic Act). Labeling for all of these products is regulated by the FDA, while advertising for these products (with the exception of *prescription drugs*) is regulated by the Federal Trade Commission. Labeling cannot contain any false or misleading statements and must include adequate directions for use, unless exempt by regulation. Courts have taken a broad view of the term labeling in FDA cases: it includes all written material that is associated with a product (including leaflets, books, and reprints of journal articles or materials that explain or are designed to be used with the product), and point-of-purchase display material (such as placards and signs). Written material need not have been provided to the purchaser at the same time as the product to be considered labeling. See also *package insert*, *Physicians' Desk Reference* and *compendium*.



labor certification: *certification* by the U.S. Department of Labor which certain aliens (such as *foreign medical graduates*) seeking to immigrate to the United States in order to work must obtain before they may obtain a visa. People in occupations which the Department of Labor feels are in short supply throughout the country (such as physicians and nurses but not dentists) are given such certification after review of the applicant's qualifications (such as *ECFMG* certification). See also *schedule A* and *J visa*.

lapsed funds: in the Federal *budget*, unobligated *budget authority* that by law has ceased to be available for *obligation* because of the expiration of the period for which it was available.

last dollar coverage: *insurance* coverage without upper limits or maximums no matter how great the *benefits* payable. See also *first dollar coverage*.

legend: the statement, "Caution: Federal law prohibits dispensing without prescription," required by section 503(b)(4) of the Federal Food, Drug, and Cosmetic Act as a part of the *labeling* of all *prescription drugs* (and only such drugs). Legend drug is thus synonymous with prescription drug.

legislative history: the written record of the writing of an Act of Congress. It may be used in writing *rules* or by courts in interpreting the law, to ascertain or detail the intent of the Congress if the Act is ambiguous or lacking in detail. The legislative history is listed in the *slip law* and consists of the House, Senate and *conference committee reports* (if any), and the House and Senate floor debates on the law. The history, particularly the committee reports, often contains the only available complete explanation of the meaning and intent of the law.

length of stay (LOS): the length of an *inpatient's* stay in a hospital or other *health facility*. It is one measure of use of health facilities, reported as an average number of days spent in a facility per *admission* or discharge. It is calculated as follows: total number of days in the facility for all discharges and *deaths* occurring during a period divided by the number of discharges and deaths during the same period. In *concurrent review* an appropriate length of stay may be assigned each patient upon admission. Average lengths of stay vary and are measured for people with various ages, specific diagnoses, or sources of payment.

liability: something one is bound to do, or an obligation one is bound to fulfill, by law and justice. A liability may be enforced in court. Liabilities are usually financial or can be expressed in financial terms. Also, the probably cost of meeting such an obligation.

Liaison Committee on Graduate Medical Education (LCGME): a subgroup of the *Coordinating Council on Medical Education* intended to serve as the *accrediting* agency for *graduate medical education*; application to be officially designated in this role is expected to be submitted to the U.S. Office of Education. The committee includes representatives of the American Board of Medical

Specialties, American Hospital Association, American Medical Association, Association of American Medical Colleges, and Council on Medical Specialty Societies.

Liaison Committee on Medical Education (LCME): a joint committee of the American Medical Association and the Association of American Medical Colleges responsible for *accrediting* medical schools. Established in 1942, the LCME is recognized for this purpose by the U.S. Commissioner of Education and the National Commission on Accrediting. The committee is made up of six representatives of the AMA Council on Medical Education, six representatives of the AAMC Executive Council, two representatives of the public, and one representative of the Federal government. While all medical schools are now accredited, there are different types and grades of accreditation which are not constant among schools. In addition to accreditation the LCME and the two councils it represents have also been performing advisory functions for the medical schools with respect to their programs. See also *LCGME*, *CCME*, and *ECFMG*.

license: a permission granted to an individual or organization by competent authority, usually public, to engage in a *practice*, occupation or activity otherwise unlawful. Licensure is the process by which the license is granted. Since a license is needed to begin lawful practice, it is usually granted on the basis of examination and/or proof of education rather than measures of performance. License when given is usually permanent but may be conditioned on annual payment of a fee, proof of *continuing education*, or proof of competence. Common grounds for revocation of a license include incompetence, commission of a crime (whether or not related to the licensed practice) or moral turpitude. Possession of a medical license from one State may (*reciprocity*) or may not suffice to obtain a license from another. There is no national licensure system for health *professionals*, although requirements are often so nearly standardized as to constitute a national system; see *national boards* and *Federation Licensing Examination*. See also *accreditation*, *certification*, and *institutional licensure*.

licensed practical nurse (LPN): a *nurse* who has practical experience in the provision of *nursing care* but is not a graduate of a formal program of nursing education (see e.g., *diploma school*). The education, required experience, *licensure* and job responsibilities of LPNs are fairly variable.

licensed vocational nurse (LVN): see *licensed practical nurse*.

life costs: *mortality*, *morbidity* and suffering associated with a given medical procedure or *disease*. Life costs of *diagnosis* and *therapy* may be contrasted with their financial *costs*, the money required for their provision. Life costs of treating a disease can be compared with the mortality, morbidity and suffering (life costs) resulting from the untreated disease, while financial costs are compared with the various monetary costs of not treating the disease. Use of life costs in assessing the costs of medical procedures avoids the need for assigning dollar values to mortality and morbidity.

Life Safety Code: a fire safety code prepared by the National Fire Protection Association. The provisions of this Code (NFPA, 21st edition, 1967) relating to hospitals and nursing facilities must (except in instances where a waiver is granted) be met by facilities certified for participation under *Medicare* and *Medicaid*. The Secretary of HEW may accept a State's fire and safety code, in lieu of the 1967 edition of the Life Safety Code, if he finds that it is imposed by law and will provide adequate protection for *inpatients* of nursing facilities. The code is based on the Southern Standard Building Code which contains optimum (not minimum) standards.

life table: in *insurance*, a tabulated statement presenting *mortality* and survivor characteristics of a given population (employed men aged 20–25, for example). Used in *underwriting* to calculate *risks*.

lifetime reserve: in the *hospital insurance program* of *Medicare*, a reserve of 60 days of inpatient hospital care available over an individual's lifetime that the individual may use after he has used the maximum 90 days allowed in a single *benefit period*. See also *spell of illness*.

limits on liability: in *insurance*, limits on dollar coverage contained in an insurance policy. *Malpractice insurance* generally contains such limits on the amounts payable for an individual claim, or in the policy year, e.g. \$100,000 to \$200,000, and \$300,000 to \$600,000, respectively. Excess coverage describes insurance with limits higher than these conventional amounts. It may also be used to refer to limits on *professional liability* imposed by law. Several states have enacted legislation, for example, which would place a limit of \$500,000 on any malpractice award. Such laws are being challenged as to their legality and, in some instances, have been ruled unconstitutional.

Lister, Baron Joseph (1827–1912): the last and greatest of an interesting line of English Quaker physicians, and the father of modern antiseptic surgery. He applied Pasteur's germ theories of disease to surgery, showing that sterile conditions prevented surgical infections.

live birth: the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered live born. It should be noted that this definition includes no requirement that the product of conception be viable or capable of independent life and thus includes very early and patently non-viable fetuses. This has meant that the definition is often not strictly applied and suggests the need for the addition of a viability criteria or the use of a different term (e.g. viable birth) which includes such a criteria.

loading: in *insurance*, the amount added to the actuarial value of the *coverage* (expected or average amounts payable to the *insured*) to cover the expense to the *insurer* of securing and maintaining the business, i.e. the amount added to the pure premium needed to meet anticipated *liabilities* for *expenses*, contingencies, *profits* or special situations. Loading costs for *group health insurance* range from 5 to 25 percent of premiums; for individual health insurance they go as high as 40 to 60 percent.

lobbying: efforts by the provision of information, argument or other means by anybody, other than a citizen acting in his own behalf, to influence a governmental official in the performance of his duty. Federal legislation governing lobbying activities (title III of the Legislative Reorganization Act of 1946) does not define the terms lobbying or lobbyist. The Act requires registration by any person "who, by himself or through any agent or employee or other persons in any manner whatsoever, directly or indirectly, solicits, collects, or receives money or any other thing of value to be used principally to aid or the principle purpose of which person is to aid . . . the passage or defeat of any legislation by the Congress." Paid lobbyists are required to register with the Clerk of the House and the Secretary of the Senate and to file quarterly financial reports with the House Clerk. The Act has been subject to considerable criticism for apparent loopholes which allow many interests to avoid registering. The term derives from the frequent presence of lobbyists in the lobbies of Congressional and other governmental chambers.

locality: in *Medicare*, the geographic area from which a *carrier* derives *prevailing charges* for the purpose of making *reasonable charge* determinations. Usually, a locality is a political or economic subdivision of a State and should include a cross-section of the population with respect to economic and other characteristics. See also *catchment* and *health service areas*.

locality rule: in *malpractice*, a rule which bases the standard of care a *physician* owes a *patient* on the standard of care generally attained in a specific locality. The most restrictive form of the rule is that the measure of a physician's duty of care to a patient is that degree of care, skill, and diligence used by physicians, generally, in the same locality or community. A less restrictive form holds that a physician owes that degree of care to a patient which is exercised by physicians, generally, in the same or similar localities or communities. The rationale for the more expansive rule, being applied more widely by courts today, is that the earlier emphasis on locality is no longer appropriate in light of better communications, and the standardization of hospital procedures and physician *licensure* brought about by State statutes and regulations.

long-term care: health and/or personal care services required by persons who are chronically ill, aged, disabled, or retarded, in an institution or at home, on a long-term basis. The term is often used more narrowly to refer only to long-term institutional care such as that provided in *nursing homes*, homes for the retarded and mental

hospitals. *Ambulatory services*, like *home health care*, which also can be provided on a long-term basis, are seen as *alternatives to long-term institutional care*.

loss: in *insurance*, the basis for a *claim* under the terms of an *insurance policy*. Any diminution of quantity, quality or value of property, resulting from the occurrence of some *peril* or *hazard*.

low option: see *high option*.

m

mail-order insurance: health and other disability *insurance* secured in response to public or personal solicitation by mail and advertising. It usually requires no physical examination, but rather a statement of health completed by the *insured*, and becomes effective upon return of the application by mail and approval by the mail-order *insurer*. The scant health information required, the complexities of medical histories, and the relative difficulty of excluding *pre-existing conditions* have contributed to relatively high *premiums* and *loadings*, and low rates of claims recovery from mail-order insurance.

major medical: *insurance* designed to offset the heavy medical expenses resulting from catastrophic or prolonged *illness* or *injuries*. Generally, such policies do not provide *first dollar coverage*, but do provide benefit payments of 75 to 80 percent of all types of medical expenses above a certain base amount paid by the *insured*. Most major medical policies sold as private insurance contain maximums on the total amount that will be paid (such as \$50,000); thus, they do not provide *last dollar coverage* or complete protection against catastrophic costs. However, there is a trend toward \$250,000 limits or even unlimited plans. In addition, benefit payments are often 100 percent of expenses after the individual has incurred some large amount (\$500 to \$2,000) of *out-of-pocket* expenses.

major surgery: surgery in which the operative procedure is hazardous. Major surgery is irregularly distinguished from *minor surgery* according to whether or not it requires a general anesthetic, involves an amputation above the ankle or wrist, or includes entering one of the body cavities (abdomen, chest or head).

malingering: the willful, deliberate, and *fraudulent* feigning or exaggeration of the symptoms of *illness* or *injury*, done for the purpose of a consciously desired end such as collecting *insurance* or some other benefits.

malpractice: *professional* misconduct or lack of ordinary skill in the performance of a professional act. A practitioner is *liable* for damages or injuries caused by malpractice. Such liability, for some professions like medicine, can be covered by *malpractice insurance* against the costs of defending suits instituted against the professional and/or any damages assessed by the court, usually up to a maximum limit. Malpractice requires that the patient demonstrate

some *injury* and that the injury be negligently caused. See also *professional liability, charitable and governmental immunity, claims incurred and made policies, contingency fees, defensive medicine, discovery, New Jersey and locality rules, joint underwriting association, limits on liability, res ipsa loquiter, respondeat superior, screening panels, sponsored malpractice insurance, and warranty.*

malpractice insurance: *insurance* against the *risk* of suffering financial damage because of *malpractice.*

management: the organization and control of human activity directed toward specific ends. See *administration* for further discussion of these two closely related terms. Different kinds of management are sometimes described: e.g. by *exception*, in which only exceptions from defined *policy* are reported and acted on; and by *objective*, in which clearly stated objectives are used to guide the management process.

management information system: a system (frequently automated or computer based) which produces the necessary information in proper form and at appropriate intervals for the *management* of a program or other activity. The system should measure program progress toward *objectives* and report costs and problems needing attention. Special efforts have been made in the *Medicaid* program to develop information systems for each State program.

marginal cost: in health economics, the change in the total *cost* of producing services which results from a small or unit change in the quantity of services being produced. Marginal cost is the appropriate cost concept to consider when contemplating program expansion or contraction. *Economies of scale* will result from the expansion of a program when marginal cost is less than average or unit cost.

marginal tax rate: the tax rate, or percentage, which is applied on the last increment of *income* for purposes of computing Federal or other income taxes. For example, in 1974 a single individual with an adjusted gross income of \$3,000 would pay Federal income tax of \$310 plus 19% of the excess over \$2,000 (19% being the marginal tax rate). An individual with an income of \$16,500 would pay \$3,830 plus 34% of the excess over \$16,000 (34% being the marginal tax rate). In addition to income, the applicable marginal tax rate on a specific level of adjusted gross income may vary with a taxpayer's filing status. For example, on an adjusted gross income of \$12,000–\$14,000 in 1974 a single taxpayer would pay \$2,630 plus 29% of the excess over \$12,000; married taxpayers filing joint returns would pay \$2,260 plus 25% of the excess over \$12,000; married taxpayers filing separate returns would pay \$2,830 plus 36% of the excess over \$12,000; and unmarried heads of households would pay \$2,440 plus 27% of the excess over \$12,000. The marginal tax rate increases with income for *progressive taxes* and decreases for *regressive taxes.* The marginal tax rate is often referred to as an individual's tax bracket.

mark-up: in Congress, a meeting of a Congressional committee at which the committee itself writes law to recommend to the full Congress, makes decisions on *appropriations*, or otherwise makes *policy*. Usually takes place after public hearings on the subject matter. See also *executive session*.

maternal and child health services (MCH): organized health and social services for mothers (particularly as they *need family planning* and pregnancy related services), their children, and (rarely) fathers. Mothers and children are often considered particularly vulnerable populations with special health needs; their health to be a matter of high public priority; and particularly benefited by *preventive medicine*. Therefore such services are sometimes separately organized and funded from other health services. One example is the Maternal and Child Health Program operated by the Federal Government under the authority of title V of the Social Security Act.

maternity benefits: coverage under *insurance* for the costs of pregnancy, labor and delivery, and, in some cases, *family planning*, post-partum care and complications of pregnancy. Health insurance policies take different approaches and apply different conditions to maternity benefits. See also *exclusions*, and *flat, swap* and *switch maternity*.

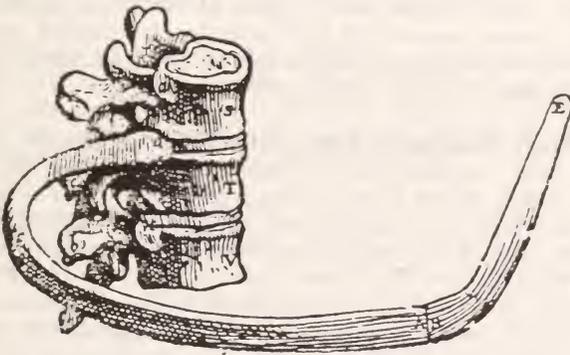
Maximum Allowable Cost Program (MAC): a Federal program which will limit reimbursement for *prescription drugs* under the *Medicare* and *Medicaid* programs, and Public Health Service projects to the lowest cost at which the drug is generally available. Specifically, the program limits reimbursement for drugs under programs administered by HEW to the lowest of the maximum allowable cost (MAC) of the drug, if any, plus a reasonable *dispensing fee*, the *acquisition cost* of the drug plus a dispensing fee, or the providers' *usual and customary charge* to the general public for the drug. The MAC is the lowest unit price at which a drug available from several sources or manufacturers can be purchased on a national basis.

McCarran-Ferguson Act: the act of March 9, 1945, (15 U.S.C. 1011-15) which declares a general policy that Federal laws which regulate or affect business and commerce are not to be interpreted as affecting the *insurance* business unless specifically provided for. Also known as the McCarran-Wiler Bill (S. 1508) and Public Law 15. Prior to a Supreme Court decision in 1944 insurance was not considered a matter of commerce and thus not subject to Federal law. When the Supreme Court found insurance to be a matter of commerce it became necessary to clarify the effect of existing Federal law on it. The Act has the effect of leaving regulation of insurance to the States unless specifically undertaken in Federal law.

Medex: *physician assistant* programs developed specifically for former military medical corpsmen with independent duty experience. They train physician assistants, especially for *general practitioners* in rural areas. Most Medex, as graduates of the programs are

called, have been trained to work with specific physicians. The first such program was begun in 1969 by Richard A. Smith at the University of Washington, in cooperation with the Washington State Medical Association. The programs generally consist of three months of university training and twelve months of preceptorship.

Medicaid (Title XIX): a Federally-aided, State operated and administered program which provides medical *benefits* for certain low-income persons in need of health and medical care. The program, authorized by title XIX of the Social Security Act, is basically for the *poor*. It does not cover all of the poor, however, but only persons who are members of one of the categories of people who can be covered under the welfare cash payment programs—the aged, the blind, the disabled, and members of families with dependent children where one parent is absent, incapacitated or unemployed. Under certain circumstances States may provide Medicaid coverage for children under 21 who are not *categorically related*. Subject to broad Federal guidelines, States determine the benefits covered, program eligibility, rates of payment for *providers*, and methods of administering the program. Medicaid is estimated to provide services to some 25 million people, with Federal-State expenditures of approximately \$12.5 billion in *fiscal year* 1975.



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Medicaid mill: a health program which serves, solely or primarily, *Medicaid* beneficiaries, typically on an *ambulatory* basis. The mills originated in the ghettos of New York City and are still found primarily in urban slums with few other medical *services*. They are usually organized on a for *profit* basis, characterized by their great productivity, and frequently accused of a variety of *abuses* (such as *ping-ponging* and *family ganging*).

Medi-Cal: California's *Medicaid* program.

Medical Assistance Program: the health care program for the *poor* authorized by title XIX of the Social Security Act, known as *Medicaid*.

medical audit: detailed retrospective review and evaluation of selected *medical records* by qualified *professional* staff. Medical audits are used in some *hospitals*, *group practices*, and occasionally in private, independent practices for evaluating professional performance by comparing it with accepted *criteria*, *standards* and current professional judgment. A medical audit is usually concerned with the care of a given *illness* and is undertaken to identify deficiencies in that care in anticipation of educational programs to improve it. See also *concurrent review* and *medical care evaluation studies*.

Medical Audit Program (MAP): an extension of the *Professional Activities Study (PAS)*, in which data are displayed in comprehensive quarterly reports by hospital department. The reports are for use by hospital clinical departments in conducting a comprehensive *medical audit* and in retrospective *utilization review*. See also *Commission on Professional and Hospital Activities*.

medical care evaluation studies (MCE studies): retrospective medical care review in which an in-depth assessment of the *quality* and/or nature of the use of selected health services or programs is made. Restudy of an MCE study assesses the *effectiveness* of corrective actions taken to correct deficiencies identified in the original study, but does not necessarily repeat or replicate the original study. *Utilization review* requirements under *Medicare* and *Medicaid* require *utilization review committees* in hospitals and skilled nursing facilities to have at least one such study in progress at all times. Such studies are also required by the *PSRO* program.

Medical College Admission Test (MCAT): a nationally standardized test generally required or strongly recommended by nearly all medical schools in the United States as part of their admission process. The results of the test are evaluated along with other evidence of student ability to handle medical school course work by admissions committees. The test, administered by the Psychological Corporation, is designed to provide objective measures of academic ability and achievement through tests of verbal ability, quantitative ability, science knowledge and general information. It cannot and does not claim to measure motivation, the nature or sincerity of interest in the study of medicine, or the personal characteristics that are of basic importance in the practitioner or teacher of medicine.

medical deduction: the Federal income *tax deduction* for expenditures on health insurance (one half of such expenditures up to a maximum of \$150) and other medical expenses in excess of three percent of *income*. In effect, the only *national health insurance* program in the United States, with a *deductible* of three percent of income and *coinsurance* of one minus the *marginal tax rate*. No standards are set for what type of health insurance must be purchased if expenditures are to be deductible. Deductible medical expenses are very broadly defined including the services of physicians, dentists, podiatrists, optometrists, chiropractors, and Christian Science practitioners; and equipment, *drugs*, *supplies*, and special diets prescribed by such people.

medical device: see *device*.

medical foundation: an organization of *physicians*, generally sponsored by a State or local medical association. Sometimes called a foundation for medical care. It is a separate and autonomous corporation with its own board of directors. Every physician member of the medical society may apply for membership in the foundation and, upon acceptance, participate in all its activities. A foundation is concerned with the delivery of medical services at reasonable cost. It believes in the free choice of a physician and hospital by the patient, *fee-for-service* reimbursement and local *peer review*. Many foundations operate as *prepaid group practices* or as an *individual practice association* for an *HMO*. While these are prepaid on a *capitation* basis for services to some or all of their patients, they still pay their individual members on a fee-for-service basis for the services they give. Some foundations are organized only for peer review purposes or other specific functions.

Medical Impairment Bureau (MIB): a clearinghouse of information on people who have applied for life *insurance* in the past. Any adverse medical findings on previous medical examinations are recorded in code and sent to companies subscribing to the service. Raises interesting *confidentiality* questions, especially with respect to information produced by medical examinations.

Medical Indemnity of America, Inc. (MIA): a *stock insurance company* organized in Ohio in 1950 by *Blue Shield plans* to serve as a national enrollment agency, to assist individual plans in negotiating contracts, and to serve large national accounts in which two or more plans are involved. See also *Health Service, Inc.*

medical indigency: the condition of having insufficient *income* to pay for adequate medical care without depriving oneself or *dependents* of food, clothing, shelter, and other essentials of living. Medical indigency may occur when a self-supporting individual, able under ordinary conditions to provide basic maintenance for himself and his *family*, is, in time of catastrophic illness, unable to finance the total cost of medical care. See also *medically indigent*, *spend down*, and *medically needy*.

medical laboratory assistant: an individual who works under the direct supervision of a *medical technologist*, pathologist, physician, or qualified scientist in performing routine laboratory procedures requiring basic technical skills and minimal independent judgment in chemistry, hematology, and microbiology. There were 9,700 certified laboratory assistants (CLA) *registered* in 1973. *Certification* is awarded by the Board of Registry following successful completion of an examination. The requirements for taking the certifying examination include a high school diploma or equivalent, either graduation from an AMA-approved school or completion of a basic military laboratory course, and a year of experience.

medically indigent: a person who is too impoverished to meet his medical expenses. It may refer to either persons whose *income* is low enough that they can pay for their basic living costs but not their routine medical care, or alternately, to persons with generally adequate income who suddenly face catastrophically large medical bills. See also *medical indigency*, *medically needy* and *spend down*.

medically needy: in the *Medicaid* program, persons who have enough *income* and *resources* to pay for their basic living expenses (and so do not need welfare) but not enough to pay for their medical care. Medicaid law requires that the standard for income used by a State to determine if someone is medically needy cannot exceed 133 percent of the maximum amount paid to a family of similar size under the welfare program for families with dependent children (AFDC). In order to be eligible as medically needy, people must fall into one of the categories of people who are covered under the welfare cash assistance programs; i.e., be aged, blind, disabled, or members of families with dependent children where one parent is absent, incapacitated or unemployed. They receive benefits if their income after deducting medical expenses (see *spend down*) is low enough to meet the eligibility standard. Thirty-two States now provide Medicaid coverage to the medically needy.

medically underserved area: a geographic location (i.e., an urban or rural area) which has insufficient *health resources* (manpower and/or facilities) to meet the medical *needs* of the resident population. *Physician shortage area* applies to a medically underserved area which is particularly short of physicians. Such areas are also sometimes defined by measuring the *health status* of the resident population rather than the supply of resources, an area with an unhealthy population being considered underserved. The term is defined and used several places in the *PHS Act* in order to give priority to such areas for Federal assistance.

medically underserved population: the population of an urban or rural area with a shortage of personal health services or another population group having a shortage of such services. A medically underserved population may not reside in a particular *medically underserved area*, or be defined by its place of residence. Thus migrants, Native Americans or the inmates of a prison or mental hospital may constitute such a population. The term is defined and used several places in the *PHS Act* in order to give such populations priority for Federal assistance, e.g., in the *HMO* and *NHSC* programs.

medical record: a record kept on *patients* which properly contains sufficient information to identify the patient clearly, to justify his *diagnosis* and *treatment*, and to document the results accurately. The purposes of the record are to serve as the basis for planning and continuity of patient care; provide a means of communication among physicians and any *professional* contributing to the patient's care; furnish documentary evidence of the patient's course of *illness* and treatment; serve as a basis for review, study, and evaluation;

serve in protecting the legal interests of the patient, hospital, and responsible practitioner; and provide data for use in research and education. Medical records and their contents are not usually available to the patient himself. The content of the record is usually *confidential*. Each different provider in a community caring for a given patient usually keeps an independent record of that care. See also *problem oriented medical record*.

medical record administrator: plans, designs, develops, and manages systems of patient administrative and clinical data, and patient *medical records*, in all types of health care institutions. An estimated 9,000 medical record administrators were active in 1973, of which 4,500 were *registered* record administrators. The minimum educational requirement for professional registration as a medical record administrator is a baccalaureate degree in medical record science or medical record administration in a program *accredited* by the American Medical Association in collaboration with the American Medical Record Association. The AMRA maintains a list of persons who have successfully completed the national registration examination that qualified them to use the professional designation of registered record administrator. Recent graduates must meet a *continuing education* requirement five years after initial registration. The administrator is the most highly trained of several types of medical records personnel, including the medical record technician (of whom there were 45,000 in 1973, 6,000 accredited).

medical review: review, required by *Medicaid*, by a team composed of physicians and other appropriate health and social service personnel of the condition and need for care, including a medical evaluation, of each *inpatient* in a *long-term care facility*. By law, the team must review the: care being provided in the facilities; adequacy of the services available in the facilities to meet the current health *needs* and promote the maximum physical well-being of the patients; *necessity* and desirability of the continued placement of such patients in the facilities; and feasibility of meeting their health care needs through alternate institutional or noninstitutional services. Medical review differs from *utilization review* in that it requires evaluation of each individual patient and an analysis of the *appropriateness* of his specific treatment in a given institution, whereas utilization review is often done on a sample basis, with special attention to certain procedures, conditions or *lengths of stay*. See also *continued stay review*.

Medical Services Administration (MSA): the bureau which *administers* the *Medicaid* program at the Federal level. It is part of the *Social and Rehabilitation Service*, which administers most of the welfare programs within the Department of Health, Education, and Welfare. It is an organization of approximately 200 people in Washington's central office and 100 people in the ten HEW regional offices. Direct administration of Medicaid programs is carried out by the States.

medical staff: collectively, the *physicians, dentists, and other professionals* responsible for medical care in a *health facility*, typically a hospital. Such staff may be full-time or part-time, employed by the hospital or not, and include all professionals who wish to be included (open staff) or just those who meet various standards of competence (closed staff). *Staff privileges* may or may not be permanent or conditioned on continued evidence of competence.

medical technologist: a specially trained individual who performs a wide range of complex and specialized procedures in all general areas of the clinical laboratory. An estimated 76,200 medical technologists were *certified* and active in 1973. Approximately two-thirds of all medical technologists are employed in hospital laboratories. Most others are employed in physicians' private laboratories, clinics, the armed forces, city, State and Federal health agencies, industrial medical laboratories, pharmaceutical houses, and numerous public and private research programs. The minimum educational requirement for one of several certification programs in medical technology is, for example, a baccalaureate degree with appropriate science course requirements plus a 12-month structured AMA-approved medical technology program and an examination; or a baccalaureate degree with appropriate science course requirements and experience. The medical technologist is the most highly trained of several types of clinical laboratory personnel, including the medical laboratory technician, and *medical laboratory assistant*.

medical trade area: an area from which one or more specified *providers* draw their *patients*; similar to *catchment area* except that it is defined by the patients rather than the provider.

Medicare (Title XVIII): a nationwide health insurance program for people aged 65 and over, for persons eligible for social security disability payments for over two years, and for certain workers and their dependents who need kidney transplantation or dialysis. Health insurance protection is available to *insured* persons without regard to *income*. Monies from *payroll taxes* and *premiums* from *beneficiaries* are deposited in special *trust funds* for use in meeting the expenses incurred by the insured. The program was enacted July 30, 1965, as title XVIII—Health Insurance for the Aged—of the Social Security Act, and became effective on July 1, 1966. It consists of two separate but coordinated programs: *hospital insurance* (Part A), and *supplementary medical insurance* (Part B).

medicine: the art and science of promoting, maintaining and restoring individual *health*, and of *diagnosing* and *treating disease*.

Medicredit: one of several proposed *national health insurance* plans which are designed to encourage the voluntary purchase of *qualified* private health insurance policies by granting *tax credits* against personal income taxes to finance, in part or in whole, the *premium* cost of such plans. In addition, the proposal would provide for the Federal payment of premiums for qualified policies for *poor* individuals or *families* with no tax liability. Originally proposed by the American

Medical Association, it is still sponsored by some Members of Congress although the AMA now sponsors another approach. See also *medical deduction*.

medigap policy: a *supplemental health insurance* policy designed to supplement *Medicare*.

member: a person who is eligible to receive, or is receiving, benefits from a *health maintenance organization* (usually) or *insurance policy* (occasionally; see *beneficiary*). Usually includes both people who have themselves *enrolled* or subscribed for benefits and their eligible *dependents*. See also *subscriber*, and *insured*.

mental disorder: either *mental illness* or *disease*, or *mental retardation*, a general term for abnormal functioning or capacity of the mind or emotions; the absence of *mental health*.

mental health: the capacity in an individual to form harmonious relations with others; to participate in, or contribute constructively to, changes in his social and physical environment; and to achieve a harmonious and balanced satisfaction of his own potentially conflicting instinctive drives—harmonious in that it reaches an integrated synthesis rather than the denial of satisfaction to certain instinctive tendencies as a means of avoiding the thwarting of others. This attempt at a definition should be compared with that of *health*. Mental health is a concept influenced by both biological and cultural factors and highly variable in definition, time and place. It is often operatively defined as the absence of any identifiable or significant *mental disorder*, and sometimes perversely used as a synonym for *mental illness* (for instance in speaking of coverage of 'mental health benefits' under *NHI*) apparently because it is thought to be a more genteel term. See also *CMHC* and *clinical psychologist*.

mental illness: all forms of *illness* in which psychological, intellectual, emotional or behavioral disturbances are the dominating feature. The term is relative and variable in different cultures, schools of thought and definitions. It includes a wide range of types (such as *psychic* and *physical*, *neurotic* and *psychotic*), and severities. It would be useful to distinguish *mental diseases* (those with an identifiable *physical cause*) and *mental illnesses* (those with no known cause and those with emotional, familial, social or other causes) but this is not regularly done. See also *mental health* and *mental disorders*.

mental retardation: the absence of normal mental development, usually measured by the intelligence quotient and considered to be present in individuals scoring less than 70 on the Stanford-Binet scale. Many synonyms are used: *mental deficiency*, *subnormality*, *handicap* and *disability*. Various types (*intellectual*, *emotional*) and degrees (*borderline*—68 to 85 on the Stanford-Binet, *mild*—57 to 67, *moderate*—36 to 51, *severe*—20 to 35, and *profound*—under 20) are described. Mental retardation is one type of *developmental disability* and *mental disorder*.

'me too' drug: a *drug* that is identical, similar, or closely related to a drug product for which a *new drug application* has been approved. Many 'me too' drugs on the market are essentially copies of approved *new drugs* but were introduced by the manufacturers without Food and Drug Administration approval on the theory that the NDA holder, or pioneer drug, had become generally recognized as *safe* and *effective*. Other 'me too' products are being marketed with abbreviated new drug applications (ANDAs), which require the submission of manufacturing, *bioavailability* and *labeling* information, but not data relating to safety and effectiveness, which are assumed to be established. See also *GRAS* and *GRAE*.

minor surgery: surgery in which the operative procedure is not hazardous: e.g., repair of lacerations, treatment of fractures, and biopsies. See also *major surgery*.

miscellaneous expenses: in connection with hospital *insurance*, hospital *charges* other than for room and board, such as X-ray, *drug*, laboratory, or whatever ancillary charges are not separately *itemized*.

modernization: remodeling, renovation or, sometimes, replacement of *health facilities* and equipment to bring them up to current construction standards, into compliance with fire and safety codes, or to meet contemporary health delivery *needs* and capabilities. Usually implies no increase in facility capacity, e.g., in the case of a hospital the total available number of *beds* would not be increased. Defined and supported under the *Hill-Burton* program (title XVI of the *PHS Act*).

morbidity: the extent of *illness*, *injury*, or *disability* in a defined population. It is usually expressed in general or specific rates of *incidence* or *prevalence*. Sometimes used to refer to any episode of *disease*. See also *mortality*.

mortality: *death*. Used to describe the relation of deaths to the population in which they occur. The mortality rate (death rate) expresses the number of deaths in a unit of population within a prescribed time and may be expressed as crude death rates (e.g., total deaths in relation to total population during a year) or as rates specific for *diseases* and, sometimes, for age, sex, or other attributes (e.g., number of deaths from cancer in white males in relation to the white male population during a year).

multiphasic screening: the combined use of a group or battery of *screening tests* as a *preventive* measure to attempt to identify any of the several *diseases* being screened for in an apparently healthy population.

multi-source drug: a *drug* that is available from more than one manufacturer or distributor, often under different *brand names*. Limits on reimbursement are more likely to be feasible for multi-source drugs than drugs available from only a single source. A

drug may not be available from more than one source because it is protected by a patent; only one company has obtained FDA marketing approval; or the demand for it is such that only one *supplier* has entered the market. See also *Maximum Allowable Cost Program*.

mutual benefit associations: fraternal or social organizations or corporations for the relief of members of the organization from specified *perils* or costs such as the costs of *illness*. Such associations pay *losses* with assessments on their members intended to liquidate specific losses rather than by fixed *premiums* payable in advance.

mutual insurance company: insurance companies with no capital stock, owned by the policyholders. Trustees of the company are chosen by the policyholders. Earnings over and above payment of *losses*, operating *expenses*, and *reserves* are the property of the policyholders and returned to them in some way such as dividends or reduced *premiums*. See also *stock insurance company*.

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narcotic drug: as set out in the Comprehensive Drug Abuse Prevention and Control Act of 1970, any of the following *drugs*, whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis: opium, coca leaves, and opiates; a compound, manufacture, salt, derivative or preparation of opium, coca leaves, or opiates; and a substance (and any compound, manufacture, salt, derivative, or preparation thereof) which is chemically identical with any of the substances referred to above. The term is very irregularly used, sometimes being any drug which dulls the senses and reduces pain, sometimes being any drug whose use is subject to special governmental control. Narcotics include heroin, morphine, demerol, and methadone. They do not, by the first definition, include marihuana, hallucinogens, amphetamines or barbiturates. The narcotics are among the most common causes of *drug dependence*.

national board examinations: standard national examinations developed and administered by the *National Board of Medical Examiners*. They are given in three parts which are generally taken during the second and final years of medical school and the *internship* year. Successful completion of the national boards is a requirement for *licensure* as a physician in some States and an acceptable alternative to the State's own medical examinations in other States. See also *Federation Licensing Examination*.

National Board of Medical Examiners (NBME): an organization, founded in 1915, which includes among its members representatives from the Federation of State Medical Boards of the United States, Council on Medical Education of the American Medical Association, Association of American Medical Colleges, American Hospital Association, Armed Services, United States Public Health Service, and Veterans Administration. Members at large are elected from

among leaders in medicine throughout the United States. The purposes of the Board are: to prepare and administer qualifying examinations of such high quality that legal agencies governing the *practice of medicine* within each State may, at their discretion, grant successful candidates a license without further examination (see *FLEX* and *national board examinations*); to consult and cooperate with the examining boards of the States; to consult and cooperate with medical schools and other organizations or institutions concerned with maintaining the advancing *quality* of medical education; to assist medical *specialty boards* and societies in establishing measurement of clinical knowledge and competence for purposes of *certification* and assessment; and to study and develop methods of testing and evaluating medical knowledge and competence. See also *CCME* and *LCME*.

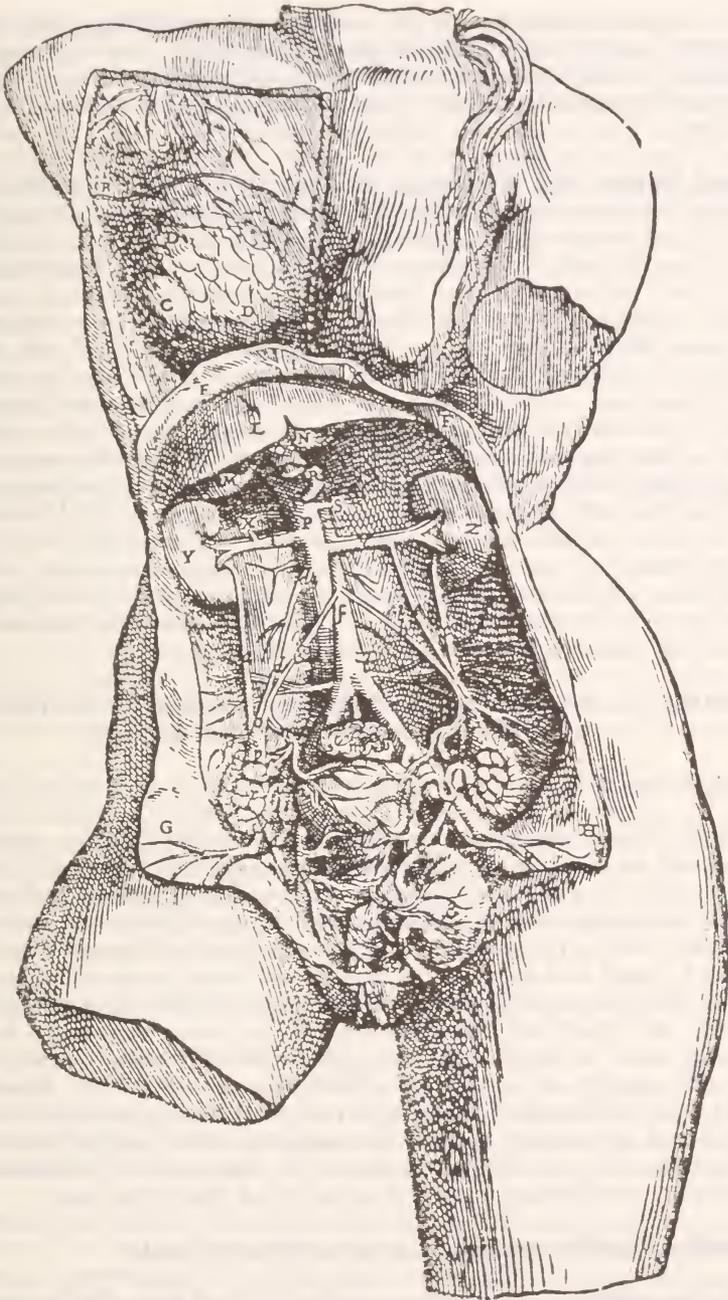
National Formulary (NF): a *compendium* of standards for certain *drugs* and preparations that are not included in the United States Pharmacopeia (USP). It is revised every five years, and recognized as a book of official *standards* by the Pure Food and Drugs Act of 1906.

national health insurance (NHI): a term not yet defined in the United States. See also *medical deduction*, *national health service*, *social insurance*, and *socialized medicine*.

national health service: often used synonymously with *national health insurance*. They are sometimes usefully distinguished by applying the former to health programs in which the national government directly operates a health system which serves some or all of its citizens and the latter to programs in which the government *insures* or otherwise arranges financing for health care without arranging for, owning or operating it (although NHI programs usually include some measure of *regulation* of the financed services). See also *social insurance* and *socialized medicine*.

National Health Service Corps (NHSC): a program which places U.S. Public Health Service personnel in areas with a critical shortage of health manpower (see *medically underserved population*) for the purpose of improving the delivery of health care and services to persons residing in such areas. The Corps was established by the Emergency Health Personnel Act of 1970, P.L. 91-623, as amended by the Emergency Health Personnel Act Amendments of 1972, P.L. 92-585 (section 329 of the *PHS Act*). The first Corps members were assigned in January, 1972. As of July, 1975, the Corps had a total of 551 health *professionals* placed in 268 communities in 42 States. The 551 professionals included 325 *physicians*, 80 *dentists*, and 146 *nurses* and other personnel. Of 465 sites approved for assignment of Corps personnel, 448 were rural and 17 were urban.

National Health Survey: a continuing *health survey* by the National Center for Health Statistics of HEW which includes studies to determine the extent of *illness* and *disability* in the population of the United States, describe the use of health services by Americans, and



gather related information. It conducts a continuing household interview survey of a sample of the population, surveys certain *medical records*, surveys a sample of the population through health examinations, and conducts related developmental and evaluative studies.

National Interns and Residents Matching Program (NIRMP): the official cooperative plan for first-year appointments in *graduate medical education* of the American Hospital Association, American Protestant Hospital Association, Association of American Medical Colleges, Catholic Hospital Association, American Medical Association, American Student Medical Association, and American Board of Medical Specialties. The program operates as a clearinghouse for matching preferences of medical students for *internships* and *residencies* with available positions in accord with hospital lists of preferences among graduating students. In order to participate in the program, hospital program directors sign the program's hospital agreement, which commits the institution to participate in the NIRMP as a corporate entity, and list with the NIRMP all programs and positions being made available to students. Positions in programs that are to be offered to physicians presently serving as interns, those in military service, and in other postgraduate activities need not be listed with the NIRMP under the agreement. The matching is carried out on a *confidential* basis.

naturopathy: a drugless system of *therapy*, making use of physical forces such as air, light, water, diet, heat and massage.

necessary: see *need*.

need: some thing or action which is essential, indispensable, required or cannot be done or lived without; a condition marked by the lack or want of some such thing or action. The presence or absence of a need can and should be measured by an objective *criterion* or *standard*. Needs may or may not be perceived or expressed by the person in need and must be distinguished from *demands*, expressed desires whether or not needed. Like *appropriateness*, need is frequently and irregularly used in health care with respect to *health facilities* and services (see *certificate-of-need*), and people (see *medically needy*). It is thus important to specify what thing or action's need is being considered, by what criteria the need is to be established, by whom (*provider*, *consumer*, or *third party*), and with what effect (since payment for services by *insurance* is, for instance, sometimes conditioned upon the necessity of their provision).

neighborhood health center: see *community health center*.

neonatal mortality: the *death (mortality)* of live born children who have not reached 4 weeks or 1 month of age, usually measured as a rate: number of neonatal deaths per 1,000 *live births* in a given area or program and time period. Early neonatal deaths (those occurring in the first week of life) are sometimes also reported. See also *infant* and *perinatal mortality*.

new drug: a drug for which pre-marketing approval is required by the Federal Food, Drug, and Cosmetic Act. A new drug is any drug which is not generally recognized, among experts qualified by scientific training and experience to evaluate the *safety* and *effectiveness* of drugs, as safe and effective for use under its prescribed conditions of use. Since 1962, most new *prescription drugs* have been subject to the *new drug application* and premarket approval process for new drugs. The vast majority of drugs marketed *over-the-counter*, however, have not been through the new drug approval process. See also *GRAS* and *GRAE*, *not new* and “*me too*” drugs.

new drug application (NDA): an application which must be approved by the FDA before any *new drug* is marketed to the general public which provides information designed to demonstrate *safety* and *effectiveness*. Once the application is approved, the drug may be *prescribed* by any *physician* or other health *professional* authorized to prescribe under State law. The NDA must include: reports of animal and clinical investigations; a list of ingredients including the active drug and any vehicle, excipient, binder, filler, flavoring, and coloring; a description of manufacturing methods and *quality control* procedures; samples of the drug; and the proposed *labelling*. Approval of an NDA must be based on valid scientific evidence that the drug is safe, and *adequate and well-controlled clinical studies* (such as *random controlled trials*) demonstrating that it is effective for its intended, i.e., labeled, uses. NDA also commonly refers to the FDA's approval of an application, i.e., the manufacturer's *license* to market the drug. See also *investigational new drug*.

New Jersey rule: a ruling by the Supreme Court of New Jersey which held that *contingency fees* must be scheduled according to the size of the award, with the percentage of the award going to the claimant's lawyer declining as the size of the award increases. For example, in New Jersey, lawyers may receive 50 percent of a \$1,000 settlement but only 10 percent of any amount recovered over \$100,000. A number of States have adopted variations of the New Jersey rule.

nonparticipating insurance company: see *stock insurance company*.

non-service-connected disability: in the Veterans' Administration health care program, a *disability* which was not incurred or aggravated in the line of duty during active military service. Care is available from the program for such disabilities on a bed—available basis after *service-connected disabilities* are cared for.

norm(s): numerical or statistical measure(s) of usual observed performance. For example, a norm for care of appendicitis would be the usual percentage of appendices removed in cases diagnosed as appendicitis which are shown by pathology to be diseased. A norm can be used as a *standard* but does not necessarily serve as one. Both norm and standard imply single, proper values rather than a range.

notch: a sudden and sharp discontinuity in health or financial *benefits* for individuals with slightly different *income*. In certain public and medical assistance programs, an additional dollar of *income* can mean a total loss of benefits. For example, in *Medicaid*, families just below the income eligibility standard receive fully subsidized coverage while families with only slightly more income and just above eligibility standards receive no benefits. Substantial incentives for families to restrict their incomes in order to remain eligible may result. *Spend down* provisions are used to compensate for notches. A notch may also occur when, without change in eligibility, *cost-sharing* requirements increase suddenly with a small change in income.

notifiable: applied to a *disease* which *providers* are required (usually by law) to report to Federal, State or local *public health* officials when *diagnosed* (such as tuberculosis, diphtheria and syphilis). Notifiable diseases are those of public interest by reason of their infectiousness, severity or frequency. See also *registration* and *quarantine*.

not new: a *drug* for which premarketing approval by the Food and Drug Administration is not, or no longer, required. A drug may become "not new" upon a ruling by the FDA that the safeguards applicable to approved *new drugs*, e.g., maintenance of records and submission of reports, are no longer required. See also "*me too*" *drug*.

nurse: an individual whose primary responsibility is the provision of *nursing care*. A nurse can be defined as a *professional* person qualified by education and authorized by law to *practice* nursing. This does describe a *registered nurse* but not all people who fit the initial definition (such as nurses aides). There are many different types, specialities and grades of nurses whose names are generally descriptive of their special responsibilities (such as charge or head, hospital, private or private duty, public health, and school nurses). See also *nurse anesthetist*, *midwife* and *practitioner*.

nurse anesthetist: a *registered nurse* prepared to work under supervision of an anesthesiologist or *physician* in administering anesthetic agents to *patients* before and after surgical and obstetrical *operations* and other medical procedures.

nurse midwife: a *registered nurse* who, by virtue of added knowledge and skill gained through an organized program of study and clinical experience recognized by the American College of Nurse-Midwives, has extended the lawful limits of her practice into the management and care of mothers and babies throughout the maternity cycle, so long as progress meets *criteria* accepted as normal.

nurse practitioner: a *registered nurse* qualified and specially trained to provide *primary care*, including primary health care in homes and in *ambulatory care* facilities, *long-term care* facilities and other health care institutions. Nurse practitioners generally function under supervision of a physician but not necessarily in his presence. They are usually salaried rather than being reimbursed on a *fee-for-service*

basis, although the supervising physician may receive fee-for-service reimbursement for their services. See also *physician assistant* and *Medex*.

nursing care: care intended to assist an individual, sick or well, in the performance of those activities contributing to *health* or its recovery (or to peaceful *death*) that he would perform unaided if he had the necessary strength, will or knowledge. This includes assisting *patients* in carrying out *therapeutic* plans initiated by *physicians* and other health *professionals* and assisting other members of the medical team in performing the nursing function and understanding health *needs* of patients. The specific content of nursing care varies in different countries and situations, and it is important to note that, as defined, it is not given solely by *nurses* but also by many other health workers. See also *nurse practitioner*, *anesthetist* and *midwife*.

nursing differential: a differential (8½ percent of routine *inpatient* nursing salary costs) added to the costs of such services to reflect the supposedly above average costs of providing routine inpatient *nursing care* to *Medicare* beneficiaries. Medicare reimburses hospitals more by this amount for nursing services than do other insurance programs which cover the general population. There has been much recent controversy over the need for the differential.

nursing homes: generally, a wide range of institutions, other than hospitals, which provide various levels of maintenance and personal or *nursing care* to people who are unable to care for themselves and who may have health problems which range from minimal to very serious. The term includes free standing institutions, or identifiable components of other *health facilities* which provide nursing care and related services, personal care, and residential care. Nursing homes include *skilled nursing facilities*, *intermediate care facilities*, and *extended care facilities* but not *boarding homes*.

o

objective: in health *planning*, a quantified statement of a desired future state or condition with a stated deadline for achieving the objective, such as an average access time for emergency medical services of less than 30 minutes by 1976, or development of an operational *PSRO* by 1977. Health planning specifies objectives which will, when implemented, achieve its *goals*. See also *policy* and *budget*.

obligations: in the Federal *budget*, amounts of orders placed, contracts awarded, services rendered, or other commitments of Federal *budget authority* made by Federal agencies during a given period which will require *outlays* of Federal funds during the same or some future period.

occupancy rate: a measure of *inpatient health facility* use, determined by dividing *available bed days* by *patient days*. It measures the average percentage of a hospital's *beds* occupied and may be institution-wide, or specific for one *department* or service.

occupational health services: health services concerned with the physical, mental and social well-being of man in relation to his work and working environment, and with the adjustment of man to his work and work to man. The concern is thus wider than the *safety* of the workplace, and includes *health* and job satisfaction. In the United States the principal Federal statute concerned with occupational health is the Occupational Safety and Health Act administered by the Occupational Safety and Health Administration (OSHA) and the National Institute of Occupational Safety and Health (NIOSH).

occupational therapist: a specially trained individual who evaluates the self-care, work and leisure performance skills of well and *disabled* clients of all age ranges; and plans and implements programs, and social and interpersonal activities designed to restore, develop and/or maintain the client's ability to satisfactorily accomplish those daily living tasks required of his specific age and necessary to his particular occupational role. There were 11,200 *registered* occupational therapists in 1972, an estimated 3,500 of whom were not in *practice*. About four-fifths of occupational therapists work in *hospitals*, others are employed in *nursing homes* and *extended or long-term care facilities, rehabilitation centers*, schools and camps for handicapped children, community health agencies, and educational and research institutions. Formal educational preparation of an occupational therapist requires at least four academic years of college or university work, leading to a baccalaureate degree, plus a minimum of 6 months' field work experience. Those persons already having a baccalaureate degree in a field other than occupational therapy may enroll in a post-baccalaureate program leading to a master's degree in occupational therapy or a certificate of *proficiency* in occupational therapy.

occupational therapy: medically directed *treatment* of physically and/or mentally *disabled* individuals by means of constructive activities designed and adapted by a *professionally* qualified *occupational therapist* to promote the restoration of useful function.

office visit: see *visit*.

official name: see *generic* and *established name*.

Old-age, Survivors, Disability and Health Insurance Program (OASHDI): a program administered by the *Social Security Administration* which provides monthly cash benefits to retired and *disabled* workers and their *dependents* and to survivors of *insured* workers; it also provides health insurance benefits for persons aged 65 and over, and for the disabled under age 65. The health insurance component of OASHDI was initiated in 1965 and is generally known as *Medicare*. Commonly known as social security, the legislative authority for the program is found in the Social Security Act, originally enacted in 1935. The program is an example of *social insurance*.

open-ended programs: in the Federal *budget*, entitlement programs for which eligibility requirements are determined by law, e.g., *Medicaid*. Actual *obligations* and resultant *outlays* are limited only by the number of eligible persons who apply for *benefits* and the actual benefits received. See also *entitlement authority*.

open enrollment: a period when new *subscribers* may elect to *enroll* in a health *insurance* plan or *prepaid group practice*. Open enrollment periods may be used in the sale of either *group* or *individual insurance* and be the only period of a year when insurance is available. Individuals perceived as high-risk (perhaps because of a *preexisting condition*) may be subjected to high *premiums* or *exclusions* during open enrollment periods. In the Health Maintenance Organization Act of 1973 (P.L. 93-222) the term refers to periodic opportunities for the general public, on a first come, first served basis, to join an *HMO*. The law presently requires that HMOs have at least one annual open enrollment period during which an HMO accepts, "up to its capacity, individuals in the order that they apply" unless the HMO can demonstrate to HEW that open enrollment would threaten its economic viability. In such cases, HEW can waive the open enrollment requirement for a period of up to three years.

operation: any medical procedure or act performed on the body with instruments or by the hands of a physician or surgeon. See also *major*, *minor* and *cosmetic surgery*.

ophthalmologist: a *physician specializing* in the *diagnosis and treatment* of all eye *diseases* and abnormal conditions including refractive errors. They may prescribe *drugs* and lenses, and perform surgery or other treatment. Ophthalmologists represented about 12 percent of all surgical specialists among non-Federal physicians in the United States during 1970. A State *Medicaid* plan must provide that there will be an examination by a physician skilled in diseases of the eye, or an *optometrist*, when a decision is to be made whether an individual is blind according to the State's definition. A State supervising ophthalmologist must review each eye examination report in making the State agency's decision that the applicant does or does not meet the State's definition of blindness, and determining if and when re-examinations are necessary. See also *optician*.

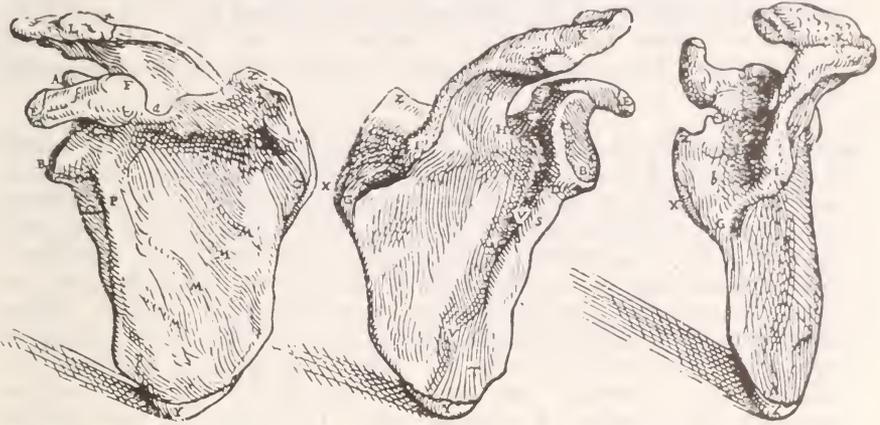
opportunity cost: in health economics, the value that resources, used in a particular way, would have if used in the best possible or another specified alternative way. When opportunity costs exceed the value the resources have in the way they are being used, they represent lost opportunities to get value from the resources. One opportunity cost of devoting physician time to *tertiary care* is the lost value of devoting the same time to *primary care*. Opportunity costs are the appropriate *cost* concept to consider when making resource allocation decisions. *Actual costs* often, but not always, can be assumed to represent (be proportional to) opportunity costs. See also *marginal cost*.

opticians: health workers who fit, supply, and adjust eye glasses according to *prescriptions* written by *ophthalmologists* or *optometrists* in order to correct a *patient's* optical or muscular vision defect. In some States, opticians also fit contact lenses. They do not examine the eyes or prescribe *treatment*. Licensing laws govern the practice of opticians in 18 States. Qualification laws for initial *licensure* usually includes successful completion of written, oral, and practical examinations. Apprenticeships are required in most licensing States, with an alternative being the completion of a one- or two-year training program.

optional services: services which may be provided or covered by a health program or *provider* and, if provided, will be paid for in addition to any *required services* which must be offered. In addition to the required services under *Medicaid*, if States elect to include any of the optional services in their programs, matching funds under *title XIX* are available. The optional services States may offer are the following: *prescribed drugs* (covered by 50 out of 53 States and jurisdictions); clinic services (offered by 41); *dental services* (41); eyeglasses (38); private duty *nursing* (21); *skilled nursing facility services* for individuals under 21 (42); care for patients under 21 in psychiatric hospitals (25); *intermediate care facility services* (49); *prosthetic devices* (43); *physical therapy* and related services (35); other *diagnostic, screening, preventive and rehabilitation services* (25); *optometrists' services* (37); *podiatrists' services* (39); *chiropractors' services* (27); care for persons 65 or older in institutions for *mental diseases* (41); and care for patients 65 or older in tuberculosis institutions (31). States may also offer any "medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their *practice* as defined by State law" that is not specifically excluded from coverage by title XIX (the exclusions are: care or services for inmates of public nonmedical institutions; *inpatient services* in a mental institution for individuals over 20 and under 65; and services for persons under 65 in a tuberculosis institution). See also *basic and supplemental health services*.

optometrist: a *practitioner* concerned with problems of vision. Optometrists examine the eyes and related structures to determine the presence of any abnormality, and *prescribe* and adapt lenses or other optical aids. They do not prescribe *drugs*, make definitive *diagnosis* of or *treat eye diseases*, or perform surgery. An *accredited* doctor of optometry degree requires a minimum of two years of pre-optometry college education and four years of *professional training* in a school of optometry. The degree and an optometry board examination are required by all States for licensure for the practice of optometry. Effective October 30, 1972, a State which previously covered optometric services under *Medicaid*, and which, in its Medicaid formal plan, specifically provides coverage for eye care under physicians' services which an optometrist is licensed to perform, must reimburse such care whether provided by a physician or an optometrist. Optometrists thus may not be excluded as potential providers in these States. See also *ophthalmologist* and *optician*.

orthoptics: a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision. See also *orthoptist*.



M

orthoptist: a specially trained individual who works under the supervision of an *ophthalmologist* in testing for certain eye muscle imbalances and teaching the *patient* exercises to correct eye coordination defects. According to the American Orthoptic Council there were approximately 450 orthoptists employed in 1973. The majority work in the private offices of ophthalmologists, while others are employed in hospitals and clinics. The American Orthoptic Council is the regulating board for orthoptists. The council administers the national board examination that is required for *certification*. To qualify to take the examination, a person needs a minimum of 2 years of college, and 15 months of training in a training center or 24 months preceptorship training.

Osler, Sir William (1849–1919): a Canadian-born *physician*, successively professor of *medicine* at McGill University, the University of Pennsylvania, Johns Hopkins University and the University of Oxford. Considered one of the greatest American physicians and one of the founders of modern academic medicine.

osteopathy: a school of healing based on the theory, originally propounded in 1874 by Dr. Andrew Taylor Still, that the normal body, when in correct adjustment, is a vital mechanical organism naturally capable of making its own responses to and defense against *diseases*, infections and other toxic conditions. The body is seen as structurally and functionally coordinate and interdependent, abnormality of either structure or function constituting disease. The *physician* of this school searches for, and if possible corrects any peculiar position of the joints or tissues, or peculiarity of diet or environment which is a factor in destroying the natural resistance. The measures he may use are physical, hygienic, medicinal, and

surgical. He is now distinguished from the *allopathic physician* mainly, if at all, by his greater reliance on manipulation. Osteopaths are licensed to perform medicine and surgery in all States, eligible for *graduate medical education* in either osteopathic or allopathic programs, reimbursed by *Medicare* and *Medicaid* for their services, supported under *health manpower* legislation, and generally treated identically with allopathic physicians. See also *homeopathy* and *naturopathy*.

outcome measure: a measure of the *quality* of medical care in which the standard of judgment is the attainment of a specified end result, or outcome. The outcome of medical care is measured with such parameters as improved *health*, lowered *mortality* and *morbidity*, and improvement in abnormal states (such as elevated blood pressure). Any disease has a "natural history" which medical care seeks to alter. To measure the *effectiveness* of a particular medical action in altering a disease's natural history is to carry out an outcome measure. Such measures are the only valid way to measure the effectiveness of medical care, and some say they are the only way to measure the quality of medical care. To carry out cost-benefit analyses of medical care such measures are necessary. However, they are difficult to devise, and have not often been done in comparing medical settings. It is possible to carry out a *random controlled trial* using outcome measures to compare the *therapeutic* effect of any *drug* or medical procedure on a disease to its "natural history" without *treatment*, or with a treatment already in use. Some argue that this should be done before any new medical procedure is put into use. See also *input, process* and *output measures*.

outlays: in the Federal *budget*, actual expenditures of Federal funds, including checks issued, interest accrued on the public debt, or other payments (minus refunds and reimbursements). Total budget outlays consist of the sum of the outlays from *appropriations* and other funds included in the budget universe, less offsetting receipts. Off-budget Federal agencies are not included in the budget universe and their outlays are excluded from total budget outlays. While *budget authority* is usually *obligated* in the *fiscal year* for which it is appropriated, it may be outlaid, once obligated, over several years.

out-of-pocket payments or costs: those borne directly by a *patient* without benefit of *insurance*, sometimes called direct costs. Unless *insured*, these include patient payments under *cost-sharing* provisions.

outpatient: a *patient* who is receiving *ambulatory care* at a hospital or other *health facility* without being *admitted* to the facility. Usually does not mean people receiving services from a *physician's* office or other program which does not also give *inpatient* care. Outpatient care refers to care given outpatients, often in organized programs.

outpatient medical facility: a facility designed to provide a limited or full spectrum of *health* and medical services (including health education and maintenance, *preventive services*, *diagnosis*, *treatment*, and *rehabilitation*) to individuals who do not require hospitalization or institutionalization (*outpatients*).

output measures: variously used synonymously with measures of the productivity of health programs and manpower, *process measures* or *outcome measures*.

over-the-counter drug (OTC drug): a *drug* which is advertised and sold directly to the public without *prescription* (e.g., aspirin).

ownership disclosure: disclosure by a health program of all ownership interests in the program. By law, each *skilled nursing facility* participating in *Medicare* and *Medicaid* must supply ownership information to the State survey agency and each *intermediate care facility* must supply such information to the State licensing agency. Full and complete information must be supplied on the identity of: each person having (directly or indirectly) an ownership interest of ten percent or more in such facility; in the case of a facility organized as a corporation, each officer and director of the corporation; and in case the facility is organized as a partnership, each partner. Any changes which affect the accuracy of this information must be promptly reported.

P

package insert: the *labeling* approved by the Food and Drug Administration for a *prescription drug* product, which accompanies the product when shipped by the manufacturer to the pharmacist, but usually does not accompany the dispensed prescription. The package insert is directed at the prescribing *professional*, principally the *physician*, and states the *appropriate* uses of a drug, the mode of administration, dosage information, contraindications, and warnings. The legal effect of prescribing the drug in ways not described in the package insert is unclear. See also *compendium* and *Physicians' Desk Reference*.

panel: see *registry*.

para-medical personnel: those *health manpower* who are not *doctors*. It includes medical technicians, health aides, record keepers, family health workers, nutritionists, *dental hygienists*, *physician assistants*, and health associates, but there seems to be no agreed upon list of included occupations. See also *allied health personnel*.

parity: in epidemiology, the classification of women by their number of *live-born* children (e.g., a woman of parity 4 has had four live-born children). In medical usage, the classification of women by the total number of births they have had, including both live births and *stillbirths*; or the total number of times a woman has been pregnant minus the number of *abortions* and/or miscarriages occurring up to 28 weeks of gestation.

partial hospitalization: formal programs of care in a hospital or other institution for periods of less than 24 hours a day, typically involving services usually provided to *inpatients*. There are two principal types: night hospitalization for *patients* who need hospitalization

but can work or attend school outside the hospital during the day; and day hospitalization for people who require in-hospital *diagnostic* or *treatment* services but can safely spend nights and weekends at home.

participating insurance company: see *mutual insurance company*.

participation (participating): a *physician* participates in an *insurance* plan when he agrees to accept the plan's preestablished fee or *reasonable charge* as the maximum amount which can be collected for services rendered. A non-participating physician may charge more than the insurance program's maximum allowable amount for a particular service. The patient is then liable for the excess above the allowed amount. This system was developed in the private sector as a method of providing the *insured* with specific health care services at no *out-of-pocket* costs. The term is used more loosely in *Medicare* and *Medicaid* to mean any physician who accepts reimbursement from either program. Approximately half of Medicare claims are paid to physicians who participate by accepting *assignment*. Any physician accepting Medicaid payments must accept them as payment in full. A hospital or other health program is called a participating *provider* when it meets the various requirements of, and accepts reimbursement from, a public or private health insurance program. See also *conditions of participation and penetration*.

Partnership for Health: a synonym for the *comprehensive health planning* program. The first set of amendments to the program were made in 1967 by P.L. 90-174 which was given the *short title*, Partnership for Health Amendments of 1967, and hence the name.

patient: one who is receiving health services; sometimes used synonymously with *consumer*. See also *inpatient*, *outpatient*, and *private* and *service patient*.

patient days: a measure of institutional use, usually measured as the number of *inpatients* at a specified time (e.g., midnight). See also *occupancy rate*.

patient mix: the numbers and types of *patients* served by a *hospital* or other health program. Patients may be classified according to their homes (see *patient origin study*), socioeconomic characteristics, *diagnoses*, or severity of *illness*. Knowledge of a program's patient mix is important for *planning* and comparative purposes. See also *scope of services*.

patient origin study: a study, usually undertaken by an individual health program or a *health planning* agency, to determine the geographic distribution of the homes of the *patients* served by one or more health programs. Such studies help define *catchment* and *medical trade areas*, and are useful in locating and planning the development of new services.

payroll deduction: a specified amount taken out of pay to finance a *benefit*. Payroll deductions may be either a set *payroll tax*, as the social security tax, or a required payment for a benefit, for example, a *group health insurance premium*. A payroll deduction generally refers to any amount withheld from the earnings of an employee.

payroll tax: a tax *liability* imposed on an employer, or employee, related to the amount of the company payroll or individual pay, the revenues from which are used to finance a specific *benefit*. In the health field, payroll tax is often used synonymously with the social security tax. That tax, it is important to note, is not applied on total payroll, but rather on the wages of each employee up to a set maximum. In 1975, for example, the tax rate was 5.85 percent on the employer and 5.85 percent on the employee of the first \$14,100 of employee earnings. Of this amount of tax rate, 0.9 percent was to finance hospital insurance, the other 4.95 percent was for other social security programs. Under the law, both the tax rate and the wage base are adjusted periodically. In January 1976, the taxable wage base increases to \$15,300; the tax rate remains the same. The ceiling on wages to which the tax is applied means that the tax rate varies with income in a *regressive* manner. A person with an income of \$7,000 or \$14,100 pays 5.85 percent of his earnings in social security tax but a person with an income of \$28,200 pays only 2.425 percent in social security taxes—he pays 5.85 percent on the first \$14,100 he earns, but nothing on the rest. A government requirement that an employer pay a set portion of the *premium* on *group health insurance* benefits for his employees is in reality a payroll tax on the employer, although it is often not recognized as such. Since the amount paid by the employer would be a set amount per employee not related to the amount of an individual's earnings, its impact as a tax would be regressive.

peer review: generally, the evaluation by *practicing physicians* or other *professionals* of the *effectiveness* and *efficiency* of services ordered or performed by other practicing physicians or other members of the profession whose work is being reviewed (peers). Frequently refers to the activities of the *Professional Standards Review Organizations* (PSRO) which in 1972 were required by P.L. 92-603 to review services provided under the *Medicare*, *Medicaid*, and *Maternal and Child Health* programs. Local PSROs, which receive Federal guidance and funding from HEW, are staffed by local physicians, osteopaths, and non-physicians. Their duties include the establishment of *criteria*, *norms* and *standards* for *diagnosis* and *treatment* of *diseases* encountered in the local PSRO jurisdiction, and review of services that are inconsistent with the established norms, e.g., hospital stays longer than the normal *length of stay*. The norms may be *input*, *process*, or *outcome measures*. Peer review has been advocated as the only possible form of *quality* control for medical services because it is said that only a physician's professional peers can judge his work. It has been criticized as having inherent conflict of interest, since, it is said, a physician will not properly judge those who will judge him, and also as not adequately reflecting *patient* objectives and points of view.

penetration: in marketing *insurance* or *HMOs*, the percentage of possible *subscribers* who have in fact contracted for *benefits* (subscribed). *Participation* is sometimes used synonymously. See also *saturation*.

per diem cost: literally, *cost* per day. Refers, in general, to hospital or other *inpatient* institutional costs per day or for a day of care. Hospitals occasionally *charge* for their services on the basis of a per diem rate derived by dividing their total costs by the number of inpatient days of care given. Per diem costs are therefore averages and do not reflect true cost for each patient. With this approach patients who use few hospital services (typically those at the end of a long stay) subsidize those who need much care (those just *admitted*). Thus the per diem approach is said to give hospitals an incentive to prolong hospital stays.

peril: *cause* of a possible *loss*; such as an *accident*, *death*, *sickness*, *fire*, *flood*, or *burglary*. See also *insurance* and *hazard*.

perinatal mortality: *death (mortality)* during the late prenatal period (variously defined, conventionally occurring after the 28th week of gestation or with a fetus weighing over 1,000 grams, including *stillbirths*), birth process and the early *neonatal* period, and usually measured as a rate: number of perinatal deaths per 1,000 *live births* in a given area or program and time period. See also *health status*, and *infant* and *neonatal mortality*.

persistency: in *insurance*, the rate at which policies written in a given line of insurance or for *members* of a given *group* are maintained in force until the completion of the terms of the policies.

personal health services: all those health services provided to specific individuals. Contrasted with environmental and community health, *public health*, *consultation and education services* and health education, which are all usually directed at populations, not individuals, and are undertaken to promote healthful environments, behavior or lifestyles.

personal physician: the *physician* who assumes responsibility for the comprehensive medical care of an individual on a continuing basis. The physician obtains *professional* assistance when needed for services he is not qualified to provide, and coordinates the care provided by other professional personnel in light of his knowledge and understanding of the *patient* as a whole. While personal physicians will have an interest in the patient's *family* as they affect his patient, the personal physician may not serve the entire family directly, e.g., a pediatrician may serve as a personal physician for children, while an internist or other *specialist* may serve in this capacity for adults. Personal physician is sometimes more simply defined for any given patient as the one the patient designates as his personal or principal physician. See also *family physician* and *private patient*.

pharmaceutical: see *drug*.

pharmacist: a *professional* person qualified by education and authorized by law (usually by obtaining a *license*) to *practice pharmacy*.

pharmacy: the science, art and *practice* of preparing, preserving, compounding, dispensing and giving *appropriate* instruction in the use of *drugs*; a place where pharmacy is practiced. See also *druggist*.

physical therapist: a specially trained and *licensed* individual who uses physical agents, biomechanical, and neurophysiological principles, and assistive devices in relieving pain, restoring maximum function, and preventing *disability* following *disease*, *injury* or loss of a bodily part. The number of persons employed as physical therapists reached 16,500 in 1973. It is estimated that approximately 8,000 are employed in *hospitals*, while others are employed by *rehabilitation* centers, schools, or societies for crippled children, and *public health* agencies. A license is required to practice physical therapy in the 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands. To obtain a license, an applicant must have a baccalaureate degree or certificate from an approved school of physical therapy and pass a State board examination, where required.

physician: a *professional* person qualified by education and authorized by law (usually by having obtained a *license*) to *practice medicine*.

physician assistant (PA): a specially trained, and *licensed* (when necessary) or otherwise *credentialed*, individual who performs tasks, which might otherwise be performed by *physicians* themselves, under the direction of a supervising physician. Also known as physician extenders and by many other essentially synonymous terms. Many were paramedics initially trained by the military (e.g. corpsmen and pharmacists' mates) and later further trained in medical schools to assist physicians in civilian health services (see *Medex*). Other examples of similar occupations are dentists' assistants, *nurse practitioners*, *nurse midwives*, psychiatric therapy assistants and rehabilitative personnel. Physician assistants are usually salaried rather than reimbursed on a *fee-for-service* basis, although the supervising physicians may receive fee-for-service for their services.

physician extender: see *physician assistant*.

physicians' and surgeons' professional liability insurance: *malpractice insurance*.

Physicians' Desk Reference (PDR): An annual *compendium* of information concerning *drugs*, primarily *prescription*, and *diagnostic* products published primarily for *physicians* and widely used as a reference document by physicians, other *health manpower* and patients. The information is primarily that included in the *labeling*, or *package insert*, for the drug required by the Food and Drug Administration and covers indications, effects, dosages, administration, and any relevant warnings, hazards, contraindications, side

effects and precautions. The PDR is distributed free or at reduced cost to many physicians and other providers through the patronage of the drug manufacturers which have paid by the column-inch for having information on their products included. It is the only readily available source of identifying photographs of drugs. The drugs are listed by *brand name* for each manufacturer, and are indexed by manufacturer, brand name, drug classification, and *generic* and *chemical name*.

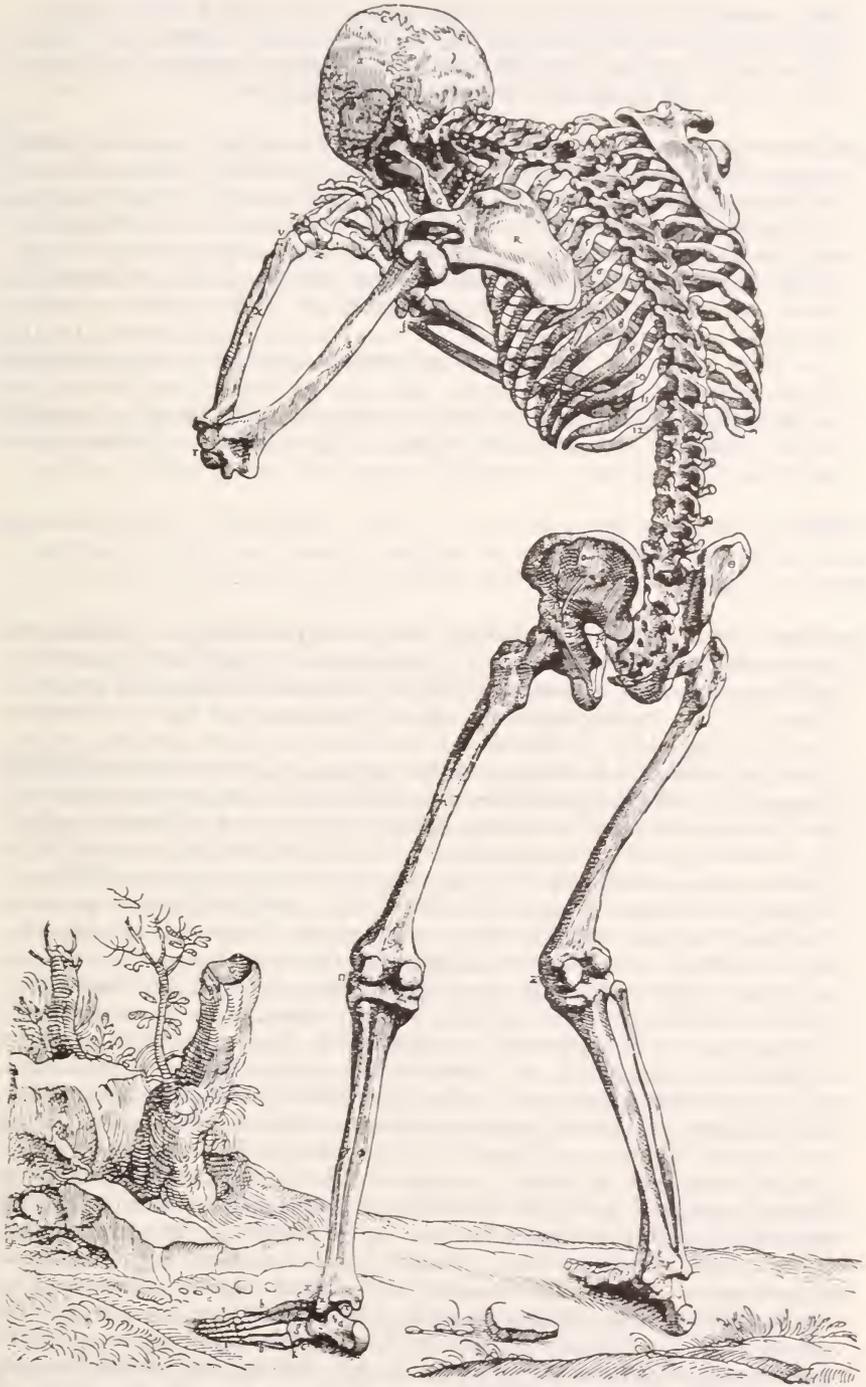
physician shortage area: an area with an inadequate *supply* of *physicians*, usually defined as an area having a physician to population ratio less than some standard, such as 1 to 4,000. See also *medically underserved area*.

ping-ponging: the practice of passing a *patient* from one *physician* to another in a health program for unnecessary cursory examinations so that the program can charge the patient's *third-party* for a physician *visit* to each physician. The practice and term originated and is most common in *Medicaid mills*.

placebo: an inactive or inert substance, preparation or procedure (such as an injection of sugar water) used in *random controlled trials* to determine the *efficacy* of the substance, treatment or preparation being tried (and usually indistinguishable from it), or given to please or gratify a *patient* or *physician*. In many controlled trials of pain medicines (such as of Darvon) the placebo gives much, and as much, relief from pain perceived by the patient as does the pain medicine. See also *Hawthorne effect*.

planning: the conscious design of desired future states (described in a plan by its *goals* and *objectives*, and description and selection among alternative means of achieving the goals and objectives), and the conduct of the activities necessary to the designing (such as data gathering and analysis) and the activities necessary to assure that the plan is achieved. There are many different definitions of planning and descriptions of different types, including: long-range or perspective (covering 15 or more years); mid-range or strategic (5-15 years); short-term or tactical (1-3 years, see *budget*); *health facilities* or *manpower*; community or program; *categorical* or *comprehensive health*; normative (based on *norms* or *standards* with legal basis); and inductive or deductive (used when the planning is done *locally* and consolidated and used at State and Federal levels (bubbled up), or vice versa (trickled down), respectively). The extent to which planning is responsible by definition for implementation of the plans is controversial, as is its relation to *management*. See also *health planning* and *policy*.

podiatrist: a health *professional* responsible for the examination, *diagnosis*, *prevention*, *treatment*, and care of conditions and functions of the human foot. A podiatrist performs surgical and other operative procedures, *prescribes* corrective *devices*, and prescribes and administers *drugs* and *physical therapy*. *Medicare* regulations state that the doctor of podiatry is considered a "physician", but only



with respect to functions he is legally authorized to perform as such by the State in which he performs them. However, certain types of foot treatment or care are excluded, whether performed by a doctor of medicine or a doctor of podiatry.

policy: a course of action adopted and pursued by a government, party, statesman, or other individual or organization; any course of action adopted as proper, advantageous or expedient. The Congress makes policy principally by writing legislation and conducting oversight activities. The term is sometimes used less actively, to describe any stated position on matters at issue, i.e., an organization's policy statement on *national health insurance*. In *insurance*, a written contract of insurance between an *insurer* and the *insured*. In the executive branch of the Federal government, policies are documents which interpret or enlarge upon *rules*, and are sometimes referred to as guidelines. Policies bear the same relationship to rules (regulations) as rules do to law, except that, unlike regulations, they do not have the force of law.

pool: see *insurance pool*.

poor: see *poverty*.

poverty: the condition of having an inadequate supply of money, *resources*, goods, or means of subsistence. A difficult concept to define in practice, there is no single national definition of poverty. Three of the most commonly cited measures are the low income level developed by the Bureau of the Census, *income* poverty guidelines published by the Community Services Administration of HEW (formerly the OEO guidelines), and the lower budget developed by the Bureau of Labor Statistics. Each of these uses a different method to measure poverty and arrives at a different dollar result. The Census low-income level is the measure accepted by the Office of Management and Budget for official data on low income persons. In 1974 this level was \$2,487 for one person, \$3,191 for two persons, and \$5,008 for four persons. Eligibility for food stamps is based on a formula which uses these low income thresholds. The Community Services Administration (CSA) poverty guidelines are essentially the Census low income levels rounded off to the nearest \$10 for easier application, primarily in determining eligibility for participation in programs initiated under the Economic Opportunity Act. The Bureau of Labor Statistics income levels for an urban *family* and retired couple are based on a budget for a "modest but adequate" standard of living. In essence, the budget represents a detailed listing of items to meet the normal needs of a family or retired couple as judged adequate by the experts drawing up this hypothetical budget. These items are *indexed* to the Consumer Price Index. The lower budget for autumn, 1974, (published in June, 1975) was \$4,228 for a couple, and \$9,198 for an urban four-person family. Income eligibility for welfare programs provides a different definition of poverty. Under the Aid for Families with Dependent Children (AFDC) program the poverty levels vary significantly by State. Under the *Supplemental Security Income*

(SSI) program a nationwide standard has been established. This is \$157.70 a month for a single individual and \$236.60 for a couple. *Medicaid* income levels are based on, but are not necessarily equivalent to, the levels established under AFDC and SSI.

poverty area: an urban or rural geographic area with a high proportion of low *income families*. Normally, average income is used to define a *poverty* area, but other indicators, such as housing conditions, illegitimate birth rates and incidence of juvenile delinquency are sometimes added to define geographic areas with poverty conditions. The term is defined precisely, albeit confusingly, in P.L. 93-641 (section 1633(15) of the *PHS Act*.)

practical nurse: see *licensed practical nurse*.

practice: the use of one's knowledge in a particular *profession*. The practice of *medicine* is the exercise of one's knowledge in the promotion of *health* and *treatment of disease*.

preadmission certification: review of the need for proposed *inpatient* service(s) prior to time of *admission* to an institution. See also *concurrent review* and *prior authorization*.

pre-existing condition: an *injury* occurring, *disease* contracted, or physical condition which existed prior to the issuance of a health insurance policy. Usually results in an *exclusion* from coverage under the policy for costs resulting from the condition.

premium: the amount of money or consideration which is paid by an *insured* person or policyholder (or on his behalf) to an *insurer* or *third party* for insurance coverage under an *insurance policy*. The premium is generally paid in periodic amounts. It is related to the actuarial value of the *benefits* provided by the policy, plus a *loading* to cover administrative costs, *profit*, etc. Premium amounts for employment related insurance are often split between employers and employees (see *contributory insurance*); under current tax law, one-half of the amount spent on premiums by employees up to a maximum of \$150 is deductible (see *medical deduction*) for income tax purposes for those who itemize deductions. Premiums paid by the employer are non-taxable *income* for the employee. Premiums are paid for coverage whether benefits are actually used or not; they should not be confused with *cost-sharing*, like *copayments* and *deductibles* which are paid only if benefits are actually used.

prepaid group practice: an arrangement where a formal association of three or more physicians provides a defined set of services to persons over a specified time period in return for a fixed periodic *prepayment* made in advance of the use of service. See also *group practice*, *medical foundation* and *health maintenance organization*.

prepaid health plan (PHP): generically, a contract between an *insurer* and a *subscriber* or group of subscribers whereby the PHP provides a specified set of health *benefits* in return for a periodic *premium*.

The term now usually means organizational entities in California which provide services to Medi-Cal (the name for California's *Medicaid* program) beneficiaries under contract with the State of California. In the latter instance, provision was made under the Medi-Cal Reform Program of 1971 for Medi-Cal administrators to contract with groups of medical providers to supply specified services on a prepaid, per capita basis. These entities have been the subject of much controversy regarding the *cost* and *quality* of their services, see *skimping*.

prepayment: inconsistently used, sometimes synonymous with *insurance*, sometimes refers to any payment ahead of time to a *provider* for anticipated *services* (such as an expectant mother paying in advance for maternity care), sometimes distinguished from insurance as referring to payment to organizations (such as *HMOs*, *prepaid group practices* and *medical foundations*) which, unlike an insurance company, take responsibility for arranging for and providing needed services as well as paying for them.

prescription: a written direction or order for the preparation and administration of a *drug* or other remedy by a *physician*, *dentist* or other practitioner licensed by law to administer such drug. Prescriptions may be written as orders in hospitals and other institutions for drugs to be given *inpatients*, or given to *outpatients* to be filled by a *pharmacist*. The prescription properly specifies the drug to be given, the amount of the drug to be dispensed, and the directions necessary for the patient to use the drug.

prescription drug: a *drug* available to the public only upon *prescription*. The availability of such drugs is thus limited because the drug is considered dangerous if used without a *physician's* supervision. See also *ethical* and *over-the-counter drugs*.

President's budget: in the Federal *budget*, the budget for a particular *fiscal year* specifying proposed *budget authority*, *obligations* and *outlays* transmitted to the Congress by the President in accordance with the Budget and Accounting Act of 1921, as amended. Some elements of the budget, such as the estimates for the legislative branch and the judiciary, are included without review by the Office of Management and Budget or approval by the President. The budget is presently submitted in January for the fiscal year beginning during the calendar year. See also *Congressional budget*.

prevailing charge: a *charge* which falls within the range of charges most frequently used in a *locality* for a particular medical *service* or procedure. The top of this range establishes an over-all limitation on the charges which a *carrier*, which considers prevailing charges in reimbursement, will accept as *reasonable* for a given service, without adequate special justification. Current *Medicare rules* state that the limit of an area's prevailing charge is to be the 75th percentile of the *customary charges* for a given service by the *physicians* in a given area. For example, if customary charges for an appendectomy in a locality were distributed so that 10 percent of the services were

rendered by physicians whose customary charge was \$150, 40 percent by physicians who charged \$200, 40 percent who charged \$250, and 10 percent who charged \$300 or more, then the prevailing charge would be \$250, since this is the level that, under Medicare regulations, would cover at least 75 percent of the cases. See also *actual charges* and *fractionation*.

prevalence: the number of cases of *disease*, infected persons, or persons with some other attribute, present at a particular time and in relation to the size of the population from which drawn. It is a measurement of *morbidity* at a moment in time, for example, the number of cases of hemophilia in the country as of the first of the year. The prevalence of arthritis is high relative to its *incidence*. Prevalence equals incidence times average case duration.

preventive medicine: care which has the aim of preventing *disease* or its consequences. It includes health care programs aimed at warding off illnesses (e.g., immunizations), early detection of disease (e.g., Pap smears), and inhibiting further deterioration of the body (e.g., exercise or prophylactic surgery). Preventive *medicine* developed subsequent to bacteriology, and was concerned in its early history with specific medical control measures taken against the agents of infectious diseases. With increasing knowledge of nutritional, malignant and other *chronic diseases*, the scope of preventive medicine has been extended. It is now operatively assumed that most if not all problems are preventable at some stage of their development. Preventive medicine is also concerned with general preventive measures aimed at improving the healthfulness of our environment and our relations with it through such things as avoidance of hazardous substances, modified diet, and *family planning*. In particular, the promotion of health through altering behavior, especially by health education, is gaining prominence as a component of preventive care. See also *public health* and *consultation and education services*.

primary care: basic or general health care which emphasizes the point when the *patient* first seeks assistance from the medical care system and the care of the simpler and more common *illnesses*. The primary care *provider* usually also assumes ongoing responsibility for the patient in both *health* maintenance and *therapy* of illness. It is comprehensive in the sense that it takes responsibility for the overall coordination of the care of the patient's health problems, be they biological, behavioral or social. The appropriate use of *consultants* and community resources is an important part of effective primary care. Such care is generally provided by *physicians*, but is increasingly provided by other personnel such as family *nurse practitioners*. See also *family* and *personal physician*, *secondary* and *tertiary care*, and *general practice*.

primary payer: denotes *insurer* obligated to pay *losses* prior to any liability of other, secondary insurers. Under current law, *Medicare* is a primary payer with respect to *Medicaid*; for a person eligible under both programs, Medicaid pays only for *benefits* not covered under Medicare, or after Medicare benefits are exhausted. See also *duplication* and *coordination of benefits*.

primary reserve: that part of an *insurance company's reserves* set aside for *losses* incurred but not reported (IBNR).

prior authorization: requirement imposed by a *third party*, under some systems of *utilization review*, that a *provider* must justify before a *peer review* committee, insurance company representative, or State agent the *need* for delivering a particular *service* to a *patient* before actually providing the service in order to receive reimbursement. Generally, prior authorization is required for non-emergency services which are expensive (involving a hospital stay, *preadmission certification*, for example) or particularly likely to be overused or *abused* (many State *Medicaid* programs require prior authorization of all *dental* services, for instance).

prior determination: similar to *prior authorization* but less restrictive in that payment will be made if prior authorization is not sought, provided that it would have approved the *service as needed*.

private patient: a *patient* whose care is the responsibility of an identifiable, individual health *professional* (usually a *physician*) who is paid directly (by the patient or a *third-party*) for his *service* to the patient. The physician is called a *personal physician* and the patient is his private patient. Private patients are contrasted with public, service or ward patients whose care is the responsibility of a health program or institution. Public patients are often cared for by an individual practitioner paid by the program (such as a member of the *house staff*) but the program, rather than the individual, is paid for the care. The distinction is important to third-party payers (including *Medicare*) because situations arise in which payment is made to both a program and an individual practitioner for the same services. The term occasionally refers to a patient occupying a room in an institution by himself (a private room). See also *private practice*.

private practice: medical *practice* in which the practitioner and his practice are independent of any external *policy* control. It usually requires that the practitioner be self-employed, except when he is salaried by a partnership in which he is a partner with similar practitioners. It is sometimes wrongly used synonymously with either *fee-for-service* practice (the practitioner may sell his services by another method; i.e., *capitation*); or *solo practice* (*group practice* may be private). Note that physicians practice in many different settings and there is no agreement as to which of these does or does not constitute private practice. *Regulation*, which does exert external control, is not generally felt to make all practice public. The opposite of private practice is not necessarily public, in the sense of employment by government. Practitioners salaried by private *hospitals* are not usually thought to be in private practice. (The professional staff thought this a difficult concept to define but the 13-year-old son of a physician got it started, saying, "That's easy. Practice of your own, charging what you want.") See also *private patient* and *general practice*.

probationary period: see *waiting period*.

problem oriented medical record (POMR): a *medical record* in which the information and conclusions contained in the record are organized to describe each of the *patient's* problems. The description properly includes subjective, objective and significant negative information, discussion and conclusions, and *diagnostic* and *treatment* plans with respect to each problem. The record, which was developed by Lawrence Weed, M.D., has gained increasing acceptance and can be contrasted with the traditional medical record which is differently and less formally organized, usually recording all information from each source (history, physical exam and laboratory) together without regard to the problems which the information describes.

procedure: see *service*.

process measure: an indicator of the *quality* of medical care used to assess the activities of *health manpower* and programs in the management of *patients*. Process measures document the process of care used for various populations or diagnoses; for example, the fraction of people with hypertension who receive an intravenous pyelogram or the percentage of cases of strep throat which are cultured before *treatment*. They do not necessarily measure the results of care although they measure the use of *diagnostic* and treatment methods which are thought or proven to be *effective*. Generally, such measures indicate the degree of conformity with *standards* established by peer groups or with expectations formulated by leaders in the profession. See also *input*, *outcome* and *output measures*.

professional: a term with no consistent or agreed upon meaning. Most occupational groups in the health field aspire to being considered professions. There are a number of usual components: formal education and examination are required for membership in the profession; *certification* or *licensure* is required for membership, reflecting community sanction or approval; there exist regional or national professional associations; there is a code of ethics governing the activities of individuals in the profession; there is a body of systematic scientific knowledge and technical skill required; and the members function with a degree of autonomy and authority, under the assumption that they alone have the expertise to make decisions in their area of competence. *Medicine* is often considered the occupation which most closely approaches the prototype of a profession.

Professional Activity Study (PAS): a shared-computer *medical record* information system purchased by hospitals from the *Commission on Professional and Hospital Activities* (CPHA) in Ann Arbor, Michigan, a nonprofit computer center. Information flows into the system through a *discharge abstract* completed by the hospital medical record *department* on every discharged *patient*. The patient information is displayed back to the hospital in a series of monthly, semi-annual, and annual reports which compare its average *lengths of stay*, number and types of tests used, and *autopsy* rates for given



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diagnostic conditions with those of other hospitals of similar size and scope of services (good examples of *process measures*). See also *ICDA*.

professional liability: obligation of *providers* or their professional liability *insurers* to pay for damages resulting from the providers' acts of omission or commission in *treating patients*. The term is sometimes preferred by providers to medical *malpractice* because it does not necessarily imply negligence. It is also a term which more adequately describes the obligations of all types of *professionals*, e.g. lawyers, architects and other health providers, as well as physicians.

professional liability insurance: see *malpractice insurance*.

Professional Standards Review Organization (PSRO): a physician-sponsored organization charged with comprehensive and ongoing review of *services* provided under the *Medicare*, *Medicaid* and

Maternal and Child Health programs. The purpose of this review is to determine for purposes of reimbursement under these programs whether services are: medically *necessary*; provided in accordance with professional *criteria, norms* and *standards*; and, in the case of institutional services, rendered in an *appropriate* setting. The requirement for the establishment of PSROs was added by the Social Security Amendments of 1972, P.L. 92-603, to the Social Security Act as part B of title XI. PSRO areas have been designated throughout the country and organizations in many of these areas are at various stages of implementing the required review functions. See also *peer* and *medical review*.

proficiency testing: assesses technical knowledge and skills related to the performance requirements of a specific job, whether such knowledge and skills were acquired through formal or informal means. Section 241 of the Social Security Amendments of 1972, P.L. 92-603, requires the Secretary of HEW, in carrying out his functions relating to qualifications for *health manpower*, to develop and conduct a program to determine the proficiency of individuals in performing the duties and functions of practical *nurses*, therapists, medical technologists and cytotechnologists, *radiologic technologists*, psychiatric technicians, or other health care technicians and technologists. The program is to use formal testing of the proficiency of individuals, and is not to deny any individual, who otherwise meets the proficiency requirements for any health care specialty, a satisfactory proficiency rating solely because of his failure to meet formal educational or *professional* membership requirements. Proficiency examinations are to determine the necessary work qualifications of health personnel (therapists, technologists, technicians and others) who do not otherwise meet the formal educational, professional membership, or other specified criteria established under *Medicare regulations* so that *services* provided by these individuals will be eligible for payment. See also *equivalency testing*.

profile: a longitudinal or cross-sectional aggregation of medical care data. *Patient* profiles list all of the *services* provided to a particular patient during a specified period of time. *Physician*, hospital, or population profiles are statistical summaries of the pattern of *practice* of an individual physician, a specific hospital, or the medical experience of a specific population. Diagnostic profiles are a subcategory of physician, hospital, or population profiles with regard to a specific condition or *diagnosis*.

profit: the gain made by the sale of a good or *service* after deducting the value of the labor, materials, rents, interest on *capital* and other expenses involved in the production of the good or service. Economists define profit as return to (or on) capital investment, and distinguish normal (competitive) and excessive (more than competitive) profit. Profit in the sense of a profit-making or *proprietary* institution is present when any of the net earnings of the institution inure to the benefit of any individual. The concept of profit is very hard to define operationally or in detail, and unreasonable or exces-

sive profit even more so. It is important to recognize that reasonable profit on investments must vary with the risks involved in the investment. Profit bears a close relationship to the balance of *supply* and *demand*, being a measure of unmet demand.

progressive patient care: a system under which *patients* are grouped together in units depending on their *need* for care as determined by their degree of *illness* rather than by consideration of medical *specialty*. There are three conventional levels or stages of progressive patient care: intensive care, that needed for critically ill patients; intermediate care, that intermediate between intensive and minimal; and minimal care or self-care, which seems self-explanatory. Except for the development of *intensive care units*, the concept of progressive patient care does not appear to have had much impact on the organization of *hospitals* and other health programs.

progressive tax: a tax which takes an increasing proportion of *income* as income rises, such as the Federal personal income tax. Incremental increases in taxable income are subject to an increased *marginal tax rate*. See also *regressive* and *proportional tax*.

project grant: a grant of Federal funds to a public or private agency or organization for a specified purpose authorized by law, such as development of an *emergency medical services system*, or conduct of a *continuing education* program. The making of project grants is usually discretionary with HEW. Applicants are chosen on the basis of merit, often competitively, and the amount of the grant is based on *need* (the estimated cost of achieving the purpose); all of which contrasts with the usual practice with *formula grants*.

proportional tax: a tax which takes a constant proportion of *income* as income changes. The social security *payroll tax* is proportional up to the \$14,100 limit on income to which it applies. See also *progressive* and *regressive tax*.

proprietary: *profit* making; owned and operated for the purposes of making a profit, whether or not made.

proprietary hospital: a *hospital* operated for the purpose of making a *profit* for its owners. Proprietary hospitals are often owned by *physicians* for the care of their own and others' *patients*. There is also a growing number of investor-owned hospitals, usually operated by a parent corporation which operates a chain of such hospitals.

prospective reimbursement: any method of paying *hospitals* or other health programs in which amounts or rates of payment are established in advance for the coming year and the programs are paid these amounts regardless of the costs they actually incur. These systems of reimbursement are designed to introduce a degree of constraint on *charge* or *cost* increases by setting limits on amounts paid during a future period. In some cases, such systems provide incentives for improved *efficiency* by sharing savings with institutions that perform at lower than anticipated costs. Prospective

reimbursement contrasts with the method of payment presently used under *Medicare* and *Medicaid* where institutions are reimbursed for actual expenses incurred, i.e., on a *retrospective* basis. See also *section 222*.

prospective study: an inquiry planned to observe events that have not yet occurred; compare with a *retrospective study* which is planned to examine events which have already occurred.

provider: an individual or institution which gives medical care. In *Medicare*, an institutional provider is a *hospital, skilled nursing facility, home health agency, or certain providers of outpatient physical therapy services*. These providers receive *cost-related reimbursement*. Other Medicare providers, paid on a *charge* basis, are called *suppliers*. Individual providers include individuals who *practice* independently of institutional providers. The term must sometimes be distinguished from *consumer*, for instance when requiring consumer representation in a health program. For these purposes P.L. 93-641 defines the term for individuals as follows (section 1531(3) of the PHS Act):

(3) The term "provider of health care" means an individual—

(A) who is a direct provider of health care (including a *physician, dentist, nurse, podiatrist, or physician assistant*) in that the individual's primary current activity is the provision of health care to individuals or the *administration* of facilities or institutions (including hospitals, *long-term care facilities, outpatient facilities and health maintenance organizations*) in which such care is provided and, when required by State law, the individual has received *professional* training in the provision of such care or in such administration and is *licensed* or *certified* for such provision or administration; or

(B) who is an indirect provider of health care in that the individual—

(i) holds a *fiduciary* position with, or has a fiduciary interest in, any entity described in subclause (II) or (IV) of clause (ii);

(ii) receives (either directly or through his spouse) more than one-tenth of his gross annual *income* from any one or combination of the following:

(I) fees or other compensation for research into or instruction in the provision of health care.

(II) entities engaged in the provision of health care or in such research or instruction.

(III) producing or supplying *drugs* or other articles for individuals or entities for use in the provision of, research into or instruction in the provision of health care.

(IV) entities engaged in producing drugs or such other articles.

(iii) is a member of the immediate *family* of an individual described in subparagraph (A) or in clause (i), (ii), or (iv) of subparagraph (B); or

(iv) is engaged in issuing any policy or contract of individual or group health *insurance* or hospital or medical service benefits.

prudent buyer principle: the principle that *Medicare* should not reimburse a *provider* for a *cost* that is not a *reasonable cost* because it is in excess of the amount that a prudent and cost-conscious buyer would be expected to pay. For example, an organization that does not seek the customary discount on bulk purchases could, through the operation of this principle, be reimbursed for less than the full purchase price.

psychosomatic illness: *disease* that shows a physical dysfunction or lesion in which psychological and other non-physical factors play a *causative* role, e.g. asthma, vasomotor rhinitis, peptic ulcer, colonic disorders, arterial hypertension, chronic urticaria, coronary disease and hyperthyroidism. These should be distinguished from *mental disorders* and from the psychic effects of diseases which are not psychically caused.

psychosurgery: *surgery* which is done for the purpose of changing the *patient's* personality, thought, emotions or behavior, rather than for the *treatment* of a physical *disease*. The term is used irregularly: for instance, sometimes referring to all surgery done on the human brain for whatever purpose.

psychotropic drug: any *drug* which affects psychic function, behavior or experience. These include, but are not limited to, those which produce *drug dependence*.

public accountability: see *accountable*.

public health: the science dealing with the protection and improvement of community *health* by organized community effort. Public health activities are generally those which are less amenable to being undertaken or less *effective* when undertaken on an individual basis, and do not typically include direct *personal health services*. Immunizations, sanitation, *preventive medicine*, *quarantine* and other *disease* control activities, *occupational health* and safety programs, assurance of the healthfulness of air, water and food, health education, and *epidemiology* are recognized public health activities.

Public Health Service Act (PHS Act): one of the principal Acts of Congress providing legislative authority for Federal health activities (42 U.S.C. 201-300). Originally enacted July 1, 1944 (and sometimes referred to as the Act of July 1), the PHS Act was, when enacted, a complete codification of all the accumulated Federal *public health* laws. Since that time many of the Acts written in the health area, particularly by the Committee on Interstate and Foreign Commerce, have actually been amendments to the PHS Act; revising, extending or adding new authority to it (such as the HMO Act of 1973, P.L. 93-222, which added a new title XIII, and the Health Revenue Sharing and Health Services Amendments of 1975, P.L. 94-63, which revised many existing sections of the Act). A compilation of the PHS Act, as amended, and related Acts is published for public use by the Committee on Interstate and Foreign Commerce. Generally, the Act contains authority for

public health programs, biomedical research, health manpower training, family planning, emergency medical services systems, HMOs, regulation of drinking water supplies, and health planning and resources development. See also quotes.

public patient: see *service* and *private patient*.

q

qualification: meeting *standards* for program eligibility, *licensure*, reimbursement or other *benefits*. Thus a qualified educational program meets *accreditation* standards, a qualified *HMO* (for the benefit of mandated *dual-choice* under section 1310 of the *PHS Act*) meets the standards imposed by the *HMO Act*, and a qualified *provider* for reimbursement by an *insurance* program meets its *conditions of participation*.

quality: the nature, kind or character of someone or something; hence, the degree or grade of excellence possessed by the person or thing. Quality may be measured: with respect to individual medical *services*, the various services received by individual or groups of *patients*, individual or groups of *providers*, or health programs or *facilities*; in terms of technical competence, humanity, *need*, *acceptability*, *appropriateness*, *inputs*, structure, *process*, or *outcomes*; using *standards*, *criteria*, *norms*, or direct quantitative or qualitative measures. To avoid the frequent vagueness of the term it is thus necessary to specify who or what is being considered, what aspect of it is being measured, and how it is being assessed. See also *efficacy*, *effectiveness*, *PSRO*, *QAP*, and *tissue, medical, peer* and *utilization review*.

quality assurance: activities and programs intended to assure the *quality* of care in a defined medical setting or program. Such programs must include educational or other components intended to remedy identified deficiencies in quality, as well as the components necessary to identify such deficiencies (such as *peer* or *utilization review* components) and assess the program's own *effectiveness*. A program which identifies quality deficiencies and responds only with negative sanctions, such as denial of reimbursement, is not usually considered as a quality assurance program, although the latter may include use of such sanctions. Such programs are required of *HMOs* and other health programs assisted under authority of the *PHS Act* (e.g., section 1301(c)(8)). See also *QAP*.

Quality Assurance Program for Medical Care in the Hospital (QAP): a program developed by the American Hospital Association for use by *hospital administrations* and medical staffs in the development of a hospital program to assure the *quality* of the care given in the hospital.

quarantine: the limitation of freedom of movement of susceptible persons or animals that have been exposed to a communicable *disease*, in order to prevent spread of the disease; the place of deten-

tion of such persons or animals; or the act of detaining vessels or travelers suspected of having communicable diseases at ports or places for inspection or disinfection. See also *public health*.

quid pro quo: something required in return for another thing of like value. Used in the consideration of *health manpower* legislation to refer to requirements of health *professional* schools set as conditions of their receiving Federal *capitation* payments.

quotes: in Congress, material in a law which amends another, earlier Act of Congress is placed in quotes, and material which does not (new, free-standing legislative authority) is not. Thus material amending another law (such as the *Public Health Service Act*) is said to be 'in the quotes'.

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radiologic technologist or technician: an individual who maintains and safely uses equipment and supplies necessary to demonstrate portions of the human body on X-ray film or fluoroscopic screen for diagnostic purposes, and may supervise and/or teach other radiologic personnel. An estimated 100,000 persons were employed either full-time or part-time as radiologic technologists in 1973: approximately one-third by hospitals, while the remainder work for independent X-ray laboratories, multi-specialty clinics, in *physician's* offices, and in government agencies. American Medical Association Council on Medical Education approved radiologic technology programs are conducted by hospitals and medical schools and by community colleges with hospital *affiliation*. Programs are open to high school graduates, although a few require 1 or 2 years of college or graduation from a school of *nursing*. The length of the training varies from a minimum of 2 years in a hospital radiology *department*, or a junior college in affiliation with one or more hospitals offering an associate degree, to a 4-year university course.

random controlled trial (RCT): an experimental *prospective study* for assessing the effects of a particular *drug* or medical *procedure* in which subjects (human or animal) are assigned on a random basis to either of two groups, experimental and control. The experimental group receives the drug or procedure while the control group does not. A series of laboratory tests and clinical examinations are performed on both groups in an attempt to detect any difference, usually using the *double blind technique*. The goals of these studies for drugs are to determine: how the drug is absorbed, metabolized and eliminated; levels of the drug that are tolerated; any obvious toxic effects; long-run toxic and carcinogenic effects; the *effectiveness* of the drug in prevention or control of a *disease* or symptom; and the *safe* and *appropriate* dosage of the drug for the various *patients* in whom it will be used.

rating: in *insurance*, the process of determining rates, or the cost of insurance, for individuals, *groups* or classes of *risks*.

reasonable charge: for any specific *service* covered under *Medicare*, the lower of the *customary charge* by a particular *physician* for that service and the *prevailing charge* by physicians in the geographic area for that service. Reimbursement is based on the lower of the *reasonable* and *actual charges*. For example, suppose the prevailing charge for a fistulectomy is \$100 in a certain *locality*, i.e., this is the 75th percentile of the customary charges for that service by the physicians in that locality. Dr. A's actual charge is \$75, although he customarily charges \$80 for the procedure; Dr. B's actual charge is his customary charge of \$85; Dr. C's is his customary charge of \$125; Dr. D's is \$100, although he customarily charges \$80; and there are no special circumstances in any case. The reasonable charge for Dr. A would be \$75 since the reasonable charge cannot exceed the actual charge, even if it is lower than his customary charge and below the prevailing charge for the locality. The reasonable charge for Dr. B would be \$85, because his customary charge is lower than the prevailing charge for that locality. The reasonable charge for Dr. C would be \$100, the prevailing charge for his locality. The reasonable charge for Dr. D would be \$80, because that is his customary charge which is lower than the actual charge in this particular case. His reasonable charge cannot exceed his customary charge in the absence of special circumstances, even though his actual charge of \$100 is the same as the prevailing charge. Generically, the term is used for any charge payable by an *insurance* program which is determined in a similar, but not necessarily identical fashion. See also *comparability provision* and *section 224*.

reasonable cost: generally the amount which a *third party* using *cost-related reimbursement* will actually reimburse. Under *Medicare* reasonable costs are costs actually incurred in delivering health services excluding any part of such incurred costs found to be unnecessary for the *efficient* delivery of *needed* health services (see section 1861 of the Social Security Act). The law stipulates that, except for certain *deductible* and *coinsurance* amounts that must be paid by *beneficiaries*, payments to hospitals shall be made on the basis of the reasonable cost of providing the covered services. The Secretary of HEW has prescribed *rules* setting forth the method or methods to be used and the items to be included in determining the reasonable cost of covered care. The regulations require that costs be apportioned between Medicare beneficiaries and other hospital *patients* so that neither group subsidizes the costs of the other. The items or elements of cost, both *direct* and *indirect*, which the regulations specify as reimbursable are known as *allowable costs*. Such costs are reimbursable on the basis of a hospital's actual costs to the extent that they are reasonable and are related to patient care. Under certain conditions the following items may be included as allowable costs: *capital depreciation*; interest expenses; educational activities; research costs related to patient care; unrestricted grants, gifts and income from endowments; value of services of non-paid workers, compensation of owners; payments to related organizations; return on equity *capital* of *proprietary* providers; and the *inpatient* routine *nursing differential*. *Bad debts* may only be included to the extent institutions fail in good faith efforts to collect the debts. See also *section 223*.

reciprocity: in *licensure of health manpower*, the recognition by one State of the licenses of a second State when the latter State extends the same recognition to licenses of the former State. Licensing requirements in the two States must usually be equivalent before formal or informal reciprocal agreements are made. Reciprocity is often used interchangeably with the term *endorsement*. Theoretically, licensure by endorsement requires only that the qualifications of the licensee, or the standards required for licensure in the original licensing State, be deemed equivalent to the licensure requirements of the State in which licensure is being sought; and not that the two States have a reciprocal arrangement.

recurring clause: a provision in some health *insurance* policies which specifies a period of time during which the recurrence of a condition is considered a continuation of a prior period of *disability* or *hospital* confinement rather than a separate *spell of illness*.

referral: the practice of sending a *patient* to another practitioner or to another program for *services* or *consultation* which the referring source is not prepared or qualified to provide. In contrast to referral for consultation, referral for services involves a delegation of responsibility for patient care to another practitioner or program, and the referring source may or may not follow up to ensure that services are received.

Regional Medical Program (RMP): a program of Federal support for regional organizations, called regional medical programs, which seek in their regions to improve the care for heart *disease*, cancer, strokes and related diseases. The legislative authority, created by P.L. 89-239, is found in title IX of the *PHS Act*. The programs were heavily oriented towards initiating and improving *continuing education*, *nursing services*, and *intensive care units*. Some features of the RMP program were combined into the new *health planning* program authorized by P.L. 93-641 (see *health systems agencies*).

registered nurse: a *nurse* who has graduated from a formal program of nursing education (see *diploma school*, *associate degree* and *baccalaureate programs*) and been *licensed* by appropriate State authority. Registered nurses are the most highly educated of nurses with the widest scope of responsibility, including, at least potentially, all aspects of *nursing care*. See also *licensed practical nurse*, *nurse practitioner* and *nurse anesthetist*.

registration: the process by which qualified individuals are listed on an official roster maintained by a governmental or non-governmental agency. Standards for registration may include such things as successful completion of a written examination given by the *registry*, membership in the *professional* association maintaining the registry, and education and experience such as graduation from an approved program or equivalent experience. Registration is a form of *credentialing*, similar to *certification*. Registration is also used to describe the recording of *notifiable diseases*, or the listing and follow-up of *patients* with such diseases.

registry: a list of individuals who have given explicit indication (for instance by contracting for *membership*) that they use or rely upon a given health *professional* or program (whose registry it is) for the *services* that the professional or program is able to provide. Panel is sometimes used in preference to registry with respect to individual practitioners. The nature of the actual financial and other relationships between a program and the people on its registry are quite variable. Registry also refers to an organization which conducts a *registration* program for *health manpower* or the list of individuals such an organization has registered. See also *catchment area*, *enrollment* and *roster*.

regressive tax: a tax which takes a decreasing proportion of *income* as income rises, such as sales taxes and the social security *payroll tax* on earnings above the maximum to which the tax applies. This tax is a constant percentage of income up to the maximum level (wage base), or a *proportional tax* up to that level. See also *progressive tax* and *marginal tax rate*.

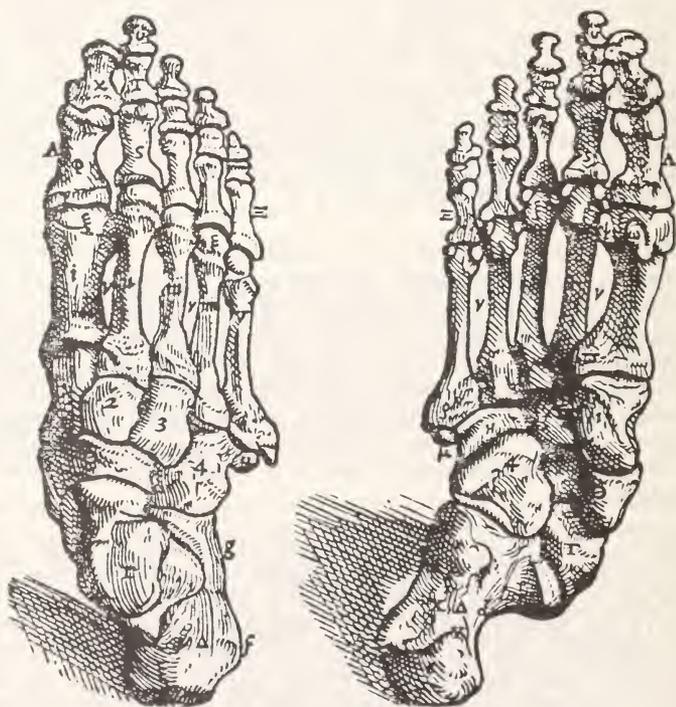
regulation: the intervention of government in the health care or health *insurance* market to control entry into or change the behavior of participants in that marketplace through specification of rules for the participants. This does not usually include programs which seek to change behavior through financing mechanisms or incentives. It also does not include private *accreditation* programs although they may be relied upon by government regulatory programs, as is the *Joint Commission on Accreditation of Hospitals* under *Medicare*. Regulatory programs can be described in terms of their purpose (control *charges*), who is regulated (*hospitals*), who regulates (State government), and method (prospective rate review). Regulatory programs include some *certification*, some *registration*, *licensure*, *certificate of need*, and the *ESP*, *MAC* and *PSRO* programs. Also, a synonym for a *rule* published by the executive branch of the Federal government implementing a law.

rehabilitation: the combined and coordinated use of medical, social, educational and vocational measures for training or re-training individuals *disabled* by *disease* or *injury* to the highest possible level of functional ability. Several different types of rehabilitation are distinguished (vocational, social, medical and educational). Habilitation is used for similar activities undertaken for individuals born with limited functional ability as compared with people who have lost abilities because of disease or injury (see *developmental disability*). A rehabilitation center is a health program specializing in rehabilitation.

reinsurance: the practice of one insurance company buying *insurance* from a second company for the purpose of protecting itself against part or all of the *losses* it might incur in the process of honoring the *claims* of its policyholders. The original company is called the ceding company; the second is the assuming company or reinsurer. Reinsurance may be sought by the ceding company for several reasons: to protect itself against losses in individual cases beyond a certain amount, where competition requires it to offer policies providing coverage in excess of these amounts; to offer protection

against catastrophic losses in a certain line of insurance, such as aviation accident or polio insurance; or to protect against mistakes in *rating* and *underwriting* in entering a new line of insurance such as *major medical*.

relative value scale or schedule (RVS): a coded listing of *physician* or other *professional services* using units which indicate the relative value of the various services they perform: taking into account the time, skill and overhead cost required for each service; but not usually considering the relative cost-effectiveness of the services, the relative *need* or *demand* for them, or their importance to people's *health*. The units in this scale are based on median *charges* by physicians. Appropriate conversion factors are used to translate the abstract units in the scale to dollar fees for each service. Given individual and local variations in *practice*, the relative value scale can be used voluntarily as a guide to physicians in establishing *fees for services*, and as a guide for insurance *carriers* and government agencies in determining appropriate reimbursement (e.g., use of relative value scales under *Medicare* where there is no *customary* or *prevailing charge* for a covered service). An example is the scale prepared and revised periodically by the California Medical Association which includes independent scales for medicine, anesthesia, surgery, radiology and pathology. Relative value scales can contain biases favoring certain specialties (such as surgery) or types of services (highly technical or specialized) over others. See also *fractionation*.



reliability: in research, the reproducibility of an experimental result, i.e. how closely a second go-around would yield the same answer whether or not correct. See also *validity*.

required services: *services* which must be offered by a health program in order to meet some external *standard*. Under *Title XIX* of the Social Security Act, each State must offer certain *basic health services* before it can qualify as having a *Medicaid* program (and thus for eligibility for Federal matching funds). The required services are: *hospital services*; laboratory and x-ray services; *skilled nursing facility services* for individuals 21 and over; *early and periodic screening, diagnosis and treatment services* for individuals under 21; *family planning services*; *physicians' services*; and *home health care services* for all persons eligible for skilled nursing facility services. It is important to note that, within these requirements, States may determine the scope and extent of *benefits* (limiting hospital care to 30 days a year, etc.). States may offer additional services in their Medicaid program; called *optional services* because they are offered at the option of the State.

rescission: in the Federal *budget*, enacted legislation cancelling *budget authority* previously provided by Congress. Rescissions proposed by the President must be transmitted in a special message to the Congress. Under section 1012 of the Congressional Budget and Impoundment Control Act of 1974, unless Congress approves a rescission bill within forty-five days of continuous session, the budget authority in question must be made available for *obligation*. In *insurance*, cancellation, with repayment of *premiums*, of a policy.

research: conscious action to acquire deeper knowledge or new facts about scientific or technical subjects. Several different types are distinguished by their concern (such as *biomedical* and *health services*) or method.

reserves: balance sheet accounts set up to report the *liabilities* faced by an insurance company under outstanding *insurance policies*. Their purpose is to secure as true a picture as possible of the financial condition of the organization (by permitting conversion of disbursements from a paid to an accrual basis). The company sets the amount of reserves in accord with its own estimates, State laws, and recommendations of supervisory officials and national organizations. Regulatory agencies can accept the reserves or refuse them as inadequate or excessive. For *Blue Cross plans*, for example, reserves are set aside to cover average monthly *claims* and operating expenses for some period of time. Reserves, while estimated, all are obligated amounts and have four principal components: reserves for known liabilities not yet paid; reserves for losses incurred but unreported; reserves for future benefits; and other reserves for various special purposes, including *contingency reserves* for unforeseen circumstances.

residency: a prolonged (usually one or more complete years) period of on the job training which may either be a part of a formal educational program or be undertaken separately after completion of a formal program, sometimes in fulfillment of a requirement for *credentialing*. In *medicine, dentistry, podiatry* and some other health professions residencies are the principal part of *graduate medical education*, beginning either after graduation (increasingly) or *internship* (traditionally), lasting two to seven years, and providing *specialty* training. Most *physicians* now take residencies in one of the 23 specialties in which they are offered, although they are not required for *licensure*. Residencies are needed for *board eligibility*.

res ipsa loquitur: literally, "the facts speak for themselves." In *malpractice*, a legal doctrine or presumption that, when an *injury* occurs to a plaintiff through a situation under the sole and exclusive control of the defendant and where such injury would not normally occur if the one in control had used due care, then it is presumed the defendant is negligent. Applies, for example, in the classic case of a surgeon who leaves a sponge in the abdomen.

resources: sources of support available to an individual in addition to his regular earned or unearned *income*. Generally resources refer to an individual's wealth or property (including cash savings, stocks and bonds, a home, other real estate, the cash value of life insurance, an automobile or jewelry) which could be converted to cash if necessary. Existing programs for the *poor* generally set a limit on the total amount of resources an individual or *family* may have and still be eligible. Most existing resource tests exempt a home of reasonable value, on the basis that it would not be reasonable to require selling a home to qualify for *benefits*. Also used to mean the *providers, institutions, health manpower* and *facilities* used for provision of health services in the total health care system.

respondeat superior: in *malpractice*, a form of vicarious *liability* whereby an employer is held liable for the wrongful acts of an employee even though the employer's conduct is without fault. Before liability predicated on *respondeat superior* may be imposed upon an employer, it is necessary that a master/servant (i.e., controlling) relationship exist between the employer and employee and that the wrongful act of the employee occur within the scope of his employment. The doctrine of *respondeat superior* does not absolve the original wrongdoer, the employee, of liability for his wrongful act. Not only may the *injured* party sue the employee directly, but the employer may seek indemnification from him.

retention: see *risk charge*.

retrospective reimbursement: payment to *providers* by a *third party carrier* for *costs* or *charges* actually incurred by *subscribers* in a previous time period. This is the method of payment used under *Medicare* and *Medicaid*. See also *prospective reimbursement*.

retrospective study: an inquiry planned to observe events that have already occurred (a *case-control* study is usually retrospective); compare with a *prospective study* which is planned to observe events that have not yet occurred.

rider: a legal document which modifies the protection of an *insurance policy*, either expanding or decreasing its *benefits*, or adding or *excluding* certain conditions from the policy's coverage.

risk: generally, any chance of *loss*. In *insurance*, designates the individual or property *insured* by an *insurance policy* against loss from some *peril* or *hazard*. Also used to refer to the probability that the loss will occur. See also *insurable risk* and *at risk*.

risk charge: the fraction of a *premium* which goes to generate or replenish *surpluses* which a *carrier* must develop to protect against the possibility of excessive *losses* under its policies. *Profits*, if any, on the sale of insurance are also taken from the surpluses developed using risk charges. The risk charge is sometimes referred to as the retention or retention rate.

Rolfing: see *structural integration*.

roster: a list of *patients* served by a given health *professional* or program (whose roster it is). The roster may be derived from a *registry* or list of *encounters* but the listing of an individual on a roster does not necessarily imply any ongoing relationship between the program and the individual. See also *catchment area*.

rule: in the executive branch of the Federal Government, an agency statement of general or particular applicability and future effect designed to implement, interpret or prescribe law or *policy*, or describing the organization, procedure or practice requirements of an agency. Commonly also called a regulation. Rules are published in the *Federal Register*. The process of writing a rule is called a rule-making. A rule, once adopted in accordance with the procedures specified in the Administrative Procedure Act (Title V, U.S.C.), has the force of law.

S

safety: the probability that use of a particular *drug*, *device* or medical *procedure* will not cause unintended or unanticipated hurt, *disease* or *injury*. Safety is, in this context, a relative concept which must be balanced against the *effectiveness* of the drug or procedure in question. Drugs or procedures known to cause hurt, disease or injury when used are not usually thought of as unsafe if the benefits they give exceed the damage. The Federal Food, Drug, and Cosmetic Act requires a demonstration of safety for drugs marketed for human use. No similar requirement exists for most other medical procedures paid for or regulated under Federal or State law.

saturation: in marketing *insurance* or *HMOs*, the point at which further *penetration* is improbable or excessively costly.

scarcity area: an area lacking an adequate *supply* of a particular type of health *service* (*physicians*) or all health services. Essentially synonymous with *medically under-served area*.

schedule A: the list of occupations which the Department of Labor considers to be in short *supply* throughout the United States for purposes of *labor certification*. All occupations now listed on schedule A are health occupations, but some health occupations (such as *dentists*) are not listed.

scheduled benefit provision: see *allocated benefit provision*.

Scientology: a religious movement begun in 1952 which teaches immortality and reincarnation, and claims a sure psychotherapeutic method for freeing the individual from personal problems, increasing human abilities, and speeding recovery from *sickness, injury* and *mental disorder*.

scope of services: the number, type and intensity or complexity of *services* provided by a *hospital* or health program. Scope of services is measured, in a number of quite different ways, so that the capacity and nature of different programs may be compared. A program's scope of services should reflect, and be adequate to meet, the *needs* of its *patient mix*.

screening: the use of quick, simple *procedures* to identify and separate apparently well persons who have, or have a risk of having, a *disease* from those who probably do not have the disease. It is used to identify suspects for more definitive diagnostic studies. Multiple screening (or multiphasic screening) is the combination of a battery of screening tests for various diseases performed by technicians under medical direction and applied to large groups of apparently well persons. See also *sensitivity, specificity, and preventive medicine*. Screening also refers to initial, cursory *claims review* by insurance companies intended to identify claims which are obviously not covered or deficient in some way.

screening clinic: a *clinic* where an initial assessment of *patients* seeking care is done to determine what *services* they *need*, with what priority, and, sometimes, where *treatment* of minor problems is done. See also *triage*.

screening panels: in *malpractice*, screening panels are used as fact finding bodies during the early stages of a malpractice dispute. There are two basic types of screening panels in use: *physicians'* defense panels, which seek to develop the best possible defense for the physician who faces a real or potential malpractice claim; and joint physician and lawyer panels whose purpose is to look at the facts of the case for both the physician and the plaintiff and decide on its merits.

scut work: a term used by *housestaff* and others in hospitals to describe work they dislike, usually trivial in nature, paperwork, or work which could be done by anybody else.

secondary care: *services* provided by medical *specialists* who generally do not have first contact with *patients* (e.g., cardiologists, urologists, dermatologists). In the United States, however, there has been a trend toward self-referral by patients themselves for these services, rather than *referral* by *primary care* providers. This route is quite different from the path usually followed in England, for example, where all patients first seek care from primary care providers and are then referred to secondary and/or tertiary providers, as *needed*. See also *tertiary care*.

section 222: a section of the Social Security Amendments of 1972, P.L. 92-603, which authorizes the Secretary of HEW to undertake, with respect to *Medicare*, studies, experiments or demonstration projects on: *prospective reimbursement* of facilities, ambulatory surgical centers (*surgicenters*), intermediate care and *homemaker services* (with respect to the *extended care benefit* under Medicare); elimination or reduction of the three-day prior hospitalization requirement for *admission* to a *skilled nursing facility*; determination of the most appropriate methods of reimbursing the services of *physicians' assistants* and *nurse practitioners*; provision of day care services to older persons eligible under Medicare and *Medicaid*; and possible means of making the services of *clinical psychologists* more generally available under Medicare and Medicaid. Studies, experiments and demonstration projects are now in progress in most of these areas.

section 223: a section of the Social Security Amendments of 1972, P.L. 92-603, which requires the Secretary to establish limits on overall *direct* or *indirect costs* which will be recognized as *reasonable* under *Medicare* for comparable *services* in comparable *facilities* in an area. The Secretary is also permitted to establish maximum acceptable costs in such facilities with respect to items or groups of services (for example, food or standby costs). The *beneficiary* is liable (except in the case of *emergency care*) for any amounts determined as excessive (except that he may not be charged for excessive amounts in a facility in which his admitting *physician* has a direct or indirect ownership interest). Under *rules* issued for this section, reimbursement for hospital *inpatient* routine service costs is limited, effective July 1, 1975, to a figure derived from the 80th percentile (plus 10 percent of the median) for each class of hospitals. Classification of hospitals is based on whether the hospital is located in a Standard Metropolitan Statistical Area (SMSA) or not, per capita *income* in the area, and hospital *bed* capacity. The total number of hospital classes is 32.

section 224: a section of the Social Security Amendments of 1972, P.L. 92-603, which places a limit for purposes of *Medicare* and *Medicaid* reimbursement on *charges* recognized as *reasonable*. The law recognizes as reasonable those charges which fall within the 75th percentile of all charges for a similar *service* in a *locality*. Increases in *physicians' fees* allowable for Medicare purposes are *indexed* to a factor which takes into account increased costs of *practice* and the increase in general earnings levels in an area. Under recently issued *regulations* the index factor for fiscal 1976 is 1.179.

This means that 17.9 percent is the maximum allowable increase under Medicare in any *prevailing charge* for physicians services in fiscal 1976 over the corresponding charge for the same service in the same locality in the base year, fiscal 1973. Charges for physician services under *Medicaid* may not exceed this amount. Section 224 further provided that, with respect to reasonable charges for medical *supplies* and equipment, only the lowest charges at which supplies and equipment of similar *quality* are widely and consistently available in a locality may be recognized.

section 314(d): a section of the *PIHS Act* which authorizes *formula grants* by the Federal government to the States for their unrestricted use in funding State and local health programs and activities. Therefore sometimes called a health revenue sharing program. For some years the annual amount *appropriated* has been \$90 million.

section 1122: a section of the Social Security Act added by P.L. 92-603. The section provides that payments will not be made under *Medicare* or *Medicaid* with respect to certain disapproved *capital* expenditures determined to be inconsistent with State or local health plans. P.L. 93-641, the National Health Planning and Resources Development Act of 1974, requires States participating in the section 1122 program to have the new *State health planning and development agency* serve as the section 1122 agency for purposes of the required review. See also *capital expenditure review* and *certificate-of-need*.

self-insure: the practice of an individual, group of individuals, employer, or organization assuming complete responsibility for *losses* which might be *insured* against, such as *malpractice* losses, or medical expenses and other losses due to *illness*. In such cases, medical expenses would most likely be financed out of current *income*, personal savings, a fund developed for the purpose, and/or some other combination of personal assets. Self-insurance is contrasted to the practice of purchasing *insurance*, by the payment of a *premium*, from some *third party* (an insurance company or government agency).

sensitivity: a measure of the ability of a *diagnostic* or *screening* test, or other predictor to correctly identify the positive (or sick) people, the proportion of true positive cases (sick people) correctly identified as positive. $\text{Sensitivity} = \frac{\text{true positives}}{\text{true positives} + \text{false negatives}}$. A test may be quite sensitive without being very *specific*.

service: a unit of health care. It is interesting that there is no standard term for a single unit of health care, whatever that unit may be. Both *service* and *procedure* are often used to refer to units of health care, i.e., a health service or a medical procedure, but neither has any constant definition. *Service* is sometimes used synonymously with *encounter*, but they should be differentiated, since an encounter may include several services. It is also used synonymously with *department*, a quite different meaning.

service area: see *medical trade* and *catchment area*.



service benefits: those received as a result of *prepayment* or *insurance*, whereby payment is made directly to the *provider of services* or the hospital or other medical care programs for covered services provided by them to eligible persons. Service benefits may be full service benefits, meaning that the plan fully reimburses the hospital, for example, for all services provided during a period so that the patient has no *out-of-pocket* expenses. Full service benefits may also be available when the program itself provides the service as in a *prepaid group practice*. Partial service benefits cover only part of the expenses, the remainder to be paid by the beneficiary through some form of *cost-sharing*. See also *indemnity benefits* and *vendor payment*.

service-connected disability: in the Veterans Administration health care program, a *disability* incurred or aggravated in the line of duty in active military service. In this context disability includes *disease*. These disabilities are the primary concern of the program. See also *nonservice-connected* and *adjunct disability*.

service patient: a *patient* whose care is the responsibility of a health program or institution (usually a *hospital*). Service patients are often cared for by an individual practitioner paid by the program (typically a member of a hospital's *housestaff*), but the program, not the individual, is paid for the care. Sometimes called a public or ward patient. See also *private patient*.

shared services: the coordinated, or otherwise explicitly agreed upon, sharing of responsibility for provision of medical or non-medical *services* on the part of two or more otherwise independent hospitals or other health programs. The sharing of medical services might include, for example, an agreement that one hospital provide all pediatric care needed in a community and no obstetrical services while another undertook the reverse. Examples of shared non-medical services would include joint laundry or dietary services for two or more nursing homes. Common laundry services purchased by two or more health programs from one independent retailer of laundry services are not usually thought of as shared services unless the health programs own or otherwise control the retailer.

shorting: dispensing a quantity of a *drug* which is less than the quantity *prescribed* for the purpose of increasing *profit* by charging for the prescribed amount. See also *kiting* and *fraud*.

short title: in Congress, the shorter, less formal common title given an Act of Congress by its authors. Health Maintenance Organization Act of 1973 (P.L. 93-222), and National Health Planning and Resources Development Act of 1975 (P.L. 93-641) are short titles. Not all Acts have short titles. The long title, also known as the purpose clause, is a more formal statement of the Act's purposes, and is rarely used.

sickness: used synonymously with *disease* and *illness*, generally not clearly defined. Common in the *insurance* field.

skilled nursing facility (SNF): under *Medicare* and *Medicaid*, an institution (or a distinct part of an institution) which has in effect a transfer agreement with one or more *participating hospitals* and which:

is primarily engaged in providing skilled nursing care and related services for *patients* who require medical or *nursing care*, or *rehabilitation* services for the rehabilitation of *injured, disabled* or *sick* persons;

has formal policies, which are developed with the advice of a group of *professional* personnel, including one or more *physicians* and one or more *registered nurses*, to govern the skilled nursing care and related medical or other services it provides;

has a physician, a registered professional nurse or a medical staff responsible for the execution of such policies;

has a requirement that the health care of every patient be under the supervision of a physician, and provides for having a physician available to furnish *necessary* medical care in case of an emergency;

maintains *medical records* on all patients;

provides 24-hour nursing service and has at least one registered professional nurse employed full time. Effective October 30, 1972, the 1972 Amendments permit the Secretary of HEW, to the extent that this provision may be deemed to require that any skilled nursing facility engage the services of a registered professional nurse for more than 40 hours a week, to waive the requirement if he finds that certain conditions are met;

provides *appropriate* methods and procedures for the dispensing and administering of *drugs* and *biologicals*;

has in effect a *utilization review* plan which meets the requirements of the law;

in the case of an institution in any State in which State or applicable local law provides for the *licensing* of institutions of this nature, is licensed pursuant to such law, or is approved, by the agency of the State or *locality* responsible for licensing institutions of this nature, as meeting the *standards* established for such licensing;

has in effect an overall plan and *budget*, including an annual operating budget and a three-year *capital* expenditures plan;

effective July 1, 1973, supplies full and complete information to the Secretary as to the identity of each person having (directly or indirectly) an ownership interest of ten percent or more in the facility, in the case of a skilled nursing facility organized as a corporation, of each officer and director of the corporation, and in the case of a skilled nursing facility organized as a partnership, of each partner; and promptly reports any changes which would affect the current accuracy of the information so required to be supplied;

effective July 1, 1973, cooperates in an effective program that provides for a regular program of independent *medical review* of the patients in the facility to the extent required by the programs in which the facility participates (including medical evaluation of each patient's need for skilled nursing facility care);

effective July 1, 1973, meets such provisions of the *Life Safety Code* as are applicable to *nursing homes*; except that the Secretary may waive, for such periods as he deems *appropriate*, specific pro-

visions of the Code that if rigidly applied would result in unreasonable hardship for a nursing home, but only if such waiver will not adversely affect the *health* and *safety* of the patients (except, the provisions of the Code will not apply in any State if the Secretary finds that in the State there is in effect a fire and safety code, imposed by State law, that adequately protects patients in nursing facilities); and

meets any other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof as the Secretary may find necessary. Effective October 30, 1972, the Secretary is prohibited from requiring, as a *condition of participation*, that a skilled nursing facility furnish medical social services to its patients. However, when these services are provided, it is expected that they conform to recognized standards (see section 1861 of the Social Security Act).

skimming: the practice in health programs paid on a *prepayment* or *capitation* basis, and in health insurance, of seeking to *enroll* only the healthiest people as a way of controlling program *costs* (since income is constant whether or not services are actually used). Contrast with *adverse selection*. Sometimes known as creaming. See also *skimping*.

skimping: the practice in health programs paid on a *prepayment* or *capitation* basis of denying or delaying the provision of services *needed* or *demande*d by *enrolled members* as a way of controlling costs (since income is constant whether or not services are actually used). The classic example is the denial or delay of a cataract extraction. See also *skimming* and *adverse selection*.

sliding scale deductible: a *deductible* which is not set at a fixed amount but rather varies according to *income*. A family is usually required to spend all (a *spend-down*) or a set percentage of their income above some base amount (for example, all or 25 percent of any income over \$5,000) as deductible before a member can receive medical care benefits. There may be a maximum amount on the deductible. The sliding scale concept can also be applied to *coinsurance* and *copayments*.

slip law: in Congress, the final version of an Act of Congress and its first official publication. Each public law is printed in the form of a slip law which also lists, but does not include, the *legislative history* of the Act, whatever earlier Act may be amended by the new law, as it is amended, or any explanation or interpretation of the law. See also *Public Health Service Act*.

Social and Rehabilitation Service (SRS): the *administration* within HEW which manages welfare and related programs including *Medicaid*, which is the responsibility of SRS's *Medical Services Administration*. Since SRS is not under the direction of HEW's Assistant Secretary for Health, this means that Medicaid is administered separately from the Department's other health programs.

social insurance: a device for the pooling of *risks* by their transfer to an organization, usually governmental, that is required by law to provide *indemnity* (cash) or *service benefits* to or on behalf of covered persons upon the occurrence of certain pre-designated *losses*. Social insurance is usually characterized by all of the following conditions: coverage is *compulsory* by law; except during a transition period following its introduction, eligibility for benefits is derived, in fact or in effect, from contributions having been made to the program by or in respect of the claimant or the person as to whom the claimant is a *dependent*; there is no requirement that the individual demonstrate inadequate financial *resources*, although a *qualified* status may need to be established; the methods for determining the benefits are prescribed by law; the benefits for any individual are not usually directly related to contributions made by or in respect of him but instead usually redistribute *income* so as to favor certain groups such as those with low former wages or a large number of dependents; there is a definite plan for financing the benefits that is designed to be adequate in terms of long-range considerations; the cost is borne primarily by contributors which are usually made by covered persons, their employers, or both; the plan is administered or at least supervised by the government; and the plan is not established by the government solely for its present or former employees. Examples in this country include social security, railroad retirement, and *workman's* and *unemployment compensation*. In other countries, health insurance is often a government sponsored social insurance program.

socialized medicine: a medical care system where the organization and provision of medical care *services* are under direct government control, and *providers* are employed by or contract for the provision of services directly with the government; also a term used more generally, without recognized or constant definition, referring to any existing or proposed medical care system believed to be subject to excessive governmental control.

Social Security Administration (SSA): the *administration* within HEW which manages the social security program including *Medicare*, which is the responsibility of the SSA's *Bureau of Health Insurance*. Since SSA is not under the direction of HEW's Assistant Secretary for Health, this means that Medicare is administered separately from the Department's other health programs.

social services designee: a person identified in an *extended care*, or *long-term care facility* to provide social services, under the direction of a *social work consultant*. A designee should have at least two years of college education and, preferably, a B.A. degree. State *licensure* is not required in any State because the function of social service designee is not itself an occupation, but a role specified in *Medicare regulations* and assigned to an otherwise employed member of the facility staff.

social worker: a *professionally* trained person providing social services, either as a member of a health team, a social service section of a *health facility*, or on a *consultant* basis. Social services are provided to enable a *patient, family* members, or others to deal with problems of social functioning affecting the *health* or well-being of the patient. Most trained social workers now hold a master's degree in social work (MSW). The B.A. in social work (BSW) is a beginning professional degree. It is estimated that there are some 120-140,000 trained social workers in the current social service labor force of about 300,000 social service workers. Approximately 30,000 of that larger number are employed in health related settings. Social workers increasingly are engaging in private and independent *practice*, on both a full-time and part-time basis. Eighteen states (including Puerto Rico) now regulate social work, with six *licensing* independent practice specifically. An estimated 30,000 social workers are engaged in some degree of independent practice. The National Association of Social Workers (NASW) requires that social workers engaging in independent practice have at least an MSW and two years of professionally supervised practice in the methods to be employed in independent practice.

solo practice: lawful *practice* of a health occupation as a self-employed individual. Solo practice is thus by definition *private practice* but is not necessarily *general practice* or *fee-for-service* practice (solo practitioners may be paid by *capitation*, although fee for service is far more common). Solo practice is common among *physicians, dentists, podiatrists, optometrists* and *pharmacists*; less common and sometimes illegal in other professions (are all solo practitioners *professionals*?).

specialist: a *physician, dentist* or other health *professional* who limits his *practice* to a certain branch of medicine or dentistry related to: specific *services* or procedures, e.g., *surgery, radiology, pathology*; certain age categories of *patients*, e.g., *pediatrics, geriatrics*; certain body systems, e.g., *dermatology, orthopedics, cardiology*; or certain types of *diseases*, e.g., *allergy, psychiatry, periodontics*. Specialists, usually have special education and training related to their practice and may or may not be *certified* as specialists by the related *specialty board*. See also *board eligible* and *certified, general practice, secondary care* and *RVS*.

specialty boards: organizations that *certify physicians* and *dentists* as *specialists* or subspecialists in various fields of medical and dental practice. The standards for certification relate to length and type of training and experience and include written and oral examination of applicants for specialty certification. The boards are not educational institutions and the certificate of a board is not considered a degree. Specialties and their boards are recognized and approved by the American Board of Medical Specialties in conjunction with the AMA Council on Medical Education. See also *board certified* and *board eligible*.

specificity: a measure of the ability of a *diagnostic* or *screening* test, or other predictor to correctly identify the negative (or healthy)

people; the proportion of true negative cases (healthy people) correctly identified as negative. Specificity = $\frac{\text{true negatives}}{\text{true negatives} + \text{false positives}}$. A test may be quite specific without being very *sensitive*.

specified disease insurance: *insurance* which provides *benefits*, usually in large amounts or with high maximums, toward the expense of the *treatment* of the specific *disease* or diseases named in the policy. Such policies are rarely written these days, being more common in the past for such diseases as polio and spinal meningitis, but coverage of end-stage renal disease under *Medicare* can be thought of as an example.

speech pathologist: a specially trained individual who evaluates, *habilitates*, and performs research related to speech and language problems; and plans, directs, and conducts remedial programs designed to restore or improve the communication efficiency of children or adults with language and speech impairments whether arising from physiological and neurological disturbances, defective articulation or foreign dialect. Approximately 26,500 persons were employed as speech pathologists and *audiologists* in 1973. *Licensure* usually requires a master's degree. The American Speech and Hearing Association awards a *certificate* of clinical competence which requires academic training at the master's degree level, one year of experience in the field, and the passing of a national examination. At the close of 1973, 10,135 persons held certificates of clinical competence in speech pathology. Nearly half of the ASHA members are employed in elementary or secondary schools and a large majority are engaged in clinical work—either *diagnostic* or *therapeutic*. Some speech pathologists are also trained as audiologists.

speech therapy: the study, examination, appreciation and *treatment* of defects and *diseases* of the voice, of speech and of spoken and written language, as well as the use of appropriate substitutional *devices* and treatment. See also *speech pathologist*.

spell of illness: in *Medicare*, the *benefit period* during which Part A hospital insurance benefits are available. A benefit period begins the first time an *insured* person enters a *hospital* after his *hospital* insurance begins. It ends after he has not been an *inpatient* in a hospital or *skilled nursing facility* for 60 days in a row. During each benefit period the insured individual is entitled to up to 90 days of hospital care, 100 days in a skilled nursing facility, and 100 home health visits. An additional *lifetime reserve* of 60 hospital days may be drawn upon when more than 90 days of hospital care is needed in a benefit period. There is no limit to the number of benefit periods an insured person may have. The spell of illness concept means that the program may pay for more than 90 days in a hospital in a given year, because with a new spell of illness, the benefit becomes available again. Where a spell of illness continues for a long period of time, as over a several year period, the program pays less than 90 days of care per year, because it does not pay in the second or third year if there has not been a break in the spell of illness. Additionally, under *Medicare*, the *deductible* is tied to

each spell of illness. Thus an individual who is hospitalized three times in a year, each in a separate spell of illness, has to pay the deductible of the cost of an inpatient hospital day three times.

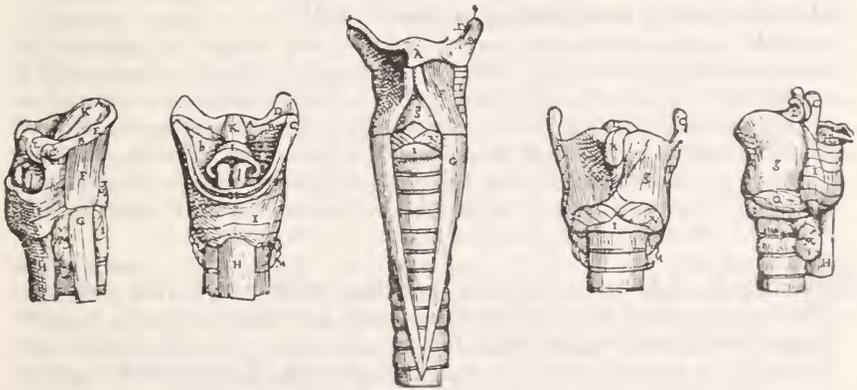
spend down: a method by which an individual establishes eligibility for a medical care program by reducing gross *income* through incurring medical expenses until net income (after medical expenses) becomes low enough to make him eligible for the program. The individual, in effect, spends income down to a specified eligibility standard by paying for medical care until his bills become high enough in relation to income to allow him to qualify under the program's *standard of need*, at which point the program *benefits* begin. The spend-down is the same as a *sliding scale deductible* related to the over-all income level of the individual. For example, if persons are eligible for program benefits if their income is \$200/month or less, a person with a \$300/month income would be covered after spending \$100 *out-of-pocket* on medical care; a person with an income of \$350 would not be eligible until he incurred medical expenses of \$150. The term spend-down originated in the *Medicaid* program. An individual whose income makes him ineligible for welfare but is insufficient to pay for medical care, can become Medicaid-eligible as a *medically needy* individual by spending some income on medical care. Medicaid only covers an individual if aged, blind, disabled, or a member of a family where one parent is absent, incapacitated, or unemployed—that is, fitting one of the categories of individuals who are covered under the welfare cash payment programs.

sponsored malpractice insurance: a *malpractice insurance* plan which involves an agreement by a *professional society* (such as a State medical society) to sponsor a particular *insurer's* medical *malpractice* insurance coverage, and to cooperate with the insurer in the *administration* of the coverage. The cooperation may include participation in marketing, claims review, and review of ratemaking. Until 1975, this was the predominant approach to coverage. In 1975, a number of *carriers* with such arrangements announced they were withdrawing from them. They have been replaced by professional society operated plans, *joint underwriting associations*, State insurance funds and other arrangements.

staff privilege: the privilege, granted by a *hospital*, or other *inpatient* health program, to a *physician*, or other independent practitioner, to join the hospital's *medical staff* and hospitalize *private patients* in the hospital. A practitioner is usually granted privileges after meeting certain *standards*, being accepted by the medical staff and board of trustees of the hospital, and committing himself to carry out certain duties for the hospital such as teaching without pay, or providing emergency or *clinic services*. Most community and other private hospitals in this country are staffed by physicians who are private practitioners and obtain access to hospital facilities in this manner. It is common for a physician to have staff privileges at more than one hospital. On the other hand, since hospitals accept a limited number of physicians, some practitioners are excluded

and end up with no access to hospital facilities, having no staff privileges. The standards used to determine staff privileges sometimes include evaluation by the county medical society, which may give preference to or require membership in that society, which in turn may require membership in the American Medical Association. This practice is formally opposed by the AMA. Some hospitals limit privileges for certain services to *board eligible* or *certified* physicians. Full time, or *hospital-based physicians*, and physicians working in a system such as a *prepaid group practice* with its own hospital are not usually thought of as having staff privileges. Sometimes called admitting, hospital, practice, or clinical privilege. Many hospitals have several different types or grades of staff privileges with names like active, associate, courtesy or limited. However, these names have irregular and unsystemized meaning, although the real differences between the different types of privileges deserve a decent nomenclature.

standards: generally, a measure set by competent authority as the rule for measuring quantity or *quality*. Conformity with standards is usually a condition of *licensure*, *accreditation*, or payment for *services*. Standards may be defined in relation to: the actual or predicted effects of care; the performance or credentials of *professional* personnel; and the physical plant, governance and *administration of facilities* and programs. In the *PSRO* program, standards are professionally developed expressions of the range of acceptable variation from a *norm* or *criterion*. Thus, the criteria for care of a urinary tract infection might be a urinalysis and urine culture and the standard might require a urinalysis in 100 percent of cases and a urine culture only in previously untreated cases.



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State comprehensive health planning agency (State CHP or 314(a) agency): a *health planning agency* assisted under section 314(a) of the *PHS Act*, added by P.L. 89-749, the Comprehensive Health Planning and Public Health Service Amendments of 1966. The

agencies develop State *comprehensive health planning* programs, with the assistance of a health planning council broadly representative of public and private health organizations in the State with a majority of *consumers* among its members. P.L. 89-749 has been superceded by P.L. 93-641, the National Health Planning and Resources Development Act of 1974, which authorizes assistance for *State health planning and development agencies* to replace 314(a) agencies. These agencies will prepare an annual State health plan and a medical facilities plan (*Hill-Burton*). The State agency will also serve as the designated *section 1122* review agency and *administer a certificate-of-need* program.

State cost commissions: State agencies assigned various health *services cost* and *charge regulation* or review responsibilities. The duties of a commission may include assuring that: total hospital costs are reasonably related to total services offered; aggregate rates bear a reasonable relationship to aggregate costs; and rates are applied equitably to preclude any possibility of discriminatory pricing among various services and patients of a hospital.

State health planning and development agency (SHPDA): section 1521 of the *PHS Act*, added by P.L. 93-641, requires the establishment of State health planning and development agencies in each State. As a replacement for existing *State CHP agencies*, SHPDAs will prepare an annual preliminary State health plan and the State medical facilities plan (*Hill-Burton*). The agency will also serve as the designated review agency for purposes of *section 1122* of the Social Security Act and administer a *certificate-of-need* program.

statement of managers: see *conference*.

Statewide health coordinating council (SHCC): a State council of *providers* and *consumers* (who shall be in the majority) required by section 1524 of the *PHS Act*, added by P.L. 93-641. Each SHCC generally will supervise the work of the *State health planning and development agency*, and review and coordinate the plans and *budgets* of the State's *health systems agencies* (HSA). It will also annually prepare a State health plan from HSA plans and the preliminary plans of the State agency. The SHCC will also review applications for HSA planning and resource development assistance.

stillbirth: the delivery of a fetus that died before or during delivery. The term is used to refer to either such a delivery or such a fetus. Some definitions are limited to fetuses of an age or weight that are potentially or usually viable (e.g., 1,000 grams). A fetal *death* is sometimes synonymous, sometimes limited to those which occur before delivery. See also *perinatal mortality*.

stock insurance company: a company owned and controlled by stockholders and operated for the purpose of making a *profit*, and contrasted with a *mutual insurance company*. In the former the profits go to the owners, in the latter they go the *insured*.

structural integration: a deep-massage technique, developed by Ida P. Rolf, Ph. D., which is designed to help a person realign the body by altering the length and tone of myofascial tissues. Practitioners of Rolfing, as the technique is commonly known, believe that misalignment resulting from inaccurate learning about posture, as well as emotional and physical trauma, may have a detrimental effect on an individual's *health*, energy, self-image, perceptions, and muscular efficiency.

structural measure: see *input measure*.

subluxation of the spine: an incomplete or partial dislocation of two adjacent vertebrae. Normally the vertebral bodies are squarely situated atop one another; however, when such things as trauma or certain forms of arthritis intervene, one vertebral body may shift with respect to its neighbor. When the shift does not completely abolish contact between the two normally adjacent surfaces but does alter their position with respect to one another, the abnormally positioned vertebra is said to be subluxed or partially dislocated. *Services of chiropractors* are covered under *Medicare* only when such subluxation is demonstrated on an X-ray.

subrogation: a provision of an *insurance policy* which requires an *insured* individual to turn over any rights he may have to recover damage from another party to the *insurer*, to the extent to which he has been reimbursed by the insurer. Some experts have argued that private health insurance (including *Blue Cross* or *group insurance*) should have subrogation rights similar to those in most property insurance policies, e.g., auto, fire. Having paid the *hospital* bill of a policyholder, the health insurance company could assume his right to sue the party whose negligence might have caused the hospitalization, and be reimbursed for its outlay to the policyholder. Subrogation rights could help insure prompt payment of medical expenses without *duplication of benefits*. (Refer to *Michigan Hospital Service v. Sharpe*, 339 Mich. 357, 63 N.W. 2d., 638, 1954 for ruling on subrogation by Michigan Supreme Court.) Others respond that subrogation is time consuming, expensive and may not offer companies adequate protection against loss. Few insurers use it voluntarily and some *insurance commissioners* forbid its use.

subscriber: often used synonymously with either *member* or *beneficiary* but in a strict sense means only the individual (*family* head or employee) who has elected to contract for, or participate in (subscribe to) an *insurance* or *HMO* plan for either himself or himself and his eligible *dependents*.

substitution: the filling of a *prescription* by a *pharmacist* with a *drug* product *therapeutically* and *chemically equivalent* to, but not, the one prescribed. Many States have *anti-substitution laws* which prohibit the pharmacist from filling a prescription with any product other than the specific product of the manufacturer whose *brand name* is used on the prescription. See also *maximum allowable cost* and *generic name*.

supplemental health insurance: health *insurance* which covers medical expenses not covered by separate health insurance already held by the *insured*, e.g. which supplements another insurance policy. For example, many insurance companies sell insurance to people covered under *Medicare* which covers either the costs of *cost-sharing* required by Medicare, services not covered, or both. Where *cost-sharing* is intended to control *utilization*, the availability of supplemental health insurance covering cost-sharing limits its *effectiveness*.

supplemental health services: the *optional services* which *HMOs* may provide in addition to *basic health services* and still *qualify* for Federal assistance. They are defined in section 1302(2) of the *PHS Act*.

supplemental security income (SSI): a program of *income* support for low-income aged, blind and disabled persons, established by title XVI of the Social Security Act. SSI replaced State welfare programs for the aged, blind and disabled on January 1, 1972, with a Federally-administered program now paying a monthly basic *benefit* nationwide of \$158 for an individual and \$237 for a couple. States may supplement this basic benefit amount. Approximately 4 million people currently receive benefits under the program. Receipt of a Federal SSI benefit or a State supplement under the program is often used to establish *Medicaid* eligibility.

Supplementary Medical Insurance Program (Part B, SMI): the voluntary portion of *Medicare* in which all persons entitled to the *hospital insurance program* (Part A) may *enroll*. The program is financed on a current basis from monthly *premiums* (presently \$6.70) paid by persons insured under the program and a matching amount from Federal *general revenues*. About 95 percent of eligible people are enrolled. During any calendar year, the program will pay (with certain exceptions) 80 percent of the *reasonable charge* (as determined by the program) for all covered *services* after the *insured* pays a \$60 *deductible* on the costs of such services. Covered services include *physician* services, *home health care* (up to 100 visits), medical and other health services, *outpatient* hospital services, and laboratory, pathology and radiologic services. Any individual over 65 may elect to enroll in Part B. However individuals not eligible for Part A who elect to buy into Part A must also buy into Part B. State welfare agencies may buy Part B coverage for elderly and disabled public assistance recipients and pay the premiums on their behalf. The program contracts with *carriers* to process *claims* under the program. The carriers determine amounts to be paid for claims based on reasonable charges. The name, Part B, refers to part B of title XVIII of the Social Security Act, the legislative authority for the program.

supplementation: partial payment for a portion of the cost of *nursing home* care by the *patient* or his *family*. Supplementation was, prior to 1972, a common requirement in State *Medicaid* programs in several of the southern States; the practice was stopped in response to a directive of the Senate Finance Committee set forth in the

report on the 1967 Social Security Amendments. Supplementation should not be confused with the practice of requiring an individual to contribute his excess income to assist in payment for his nursing home care. Generally, under Medicaid, a nursing home must agree to accept reimbursement from the State as the full amount of its payment for *service*. As an example of the present Medicaid approach, a State may negotiate to pay \$500 a month for nursing home care. If the individual has \$125 in income of his own, he is allowed to retain \$25 for personal incidental expenses and pays \$100 to help meet the \$500 rate for his care. The State then pays the other \$400. Under a system of supplementation, however, a State pays a rate but the nursing home does not agree to accept that amount as full payment; accepting supplementation of the State rate by the individual or his family. The amount the homes collect in supplement is not under the control of the State. Supplementation generally was used where the State rate was admittedly not sufficient to pay for the cost of the care.

supplier: generally, any institution, individual or agency that furnishes a medical item or *service*. In *Medicare*, suppliers are distinguished from *providers*, including *hospitals*, and *skilled nursing facilities*. Institutions classified as providers are reimbursed by *intermediaries* on a *reasonable cost* basis while suppliers, including *physicians*, nonhospital laboratories and ambulance companies, are paid by *carriers* on the basis of *reasonable charges*.

supplies: inexpensive medical items, usually of a disposable nature, such as bandages, tongue depressors, rubbing alcohol, etc. Supplies should be distinguished from permanent and durable *capital goods* (those whose use lasts over a year).

supply: in health economics, the quantity of *services* supplied as the price of the service varies, *income* and other factors being held constant. For most services increases in price induce increases in supply, and for all they ration existing supply. Increases in *demand* (but not, necessarily, in *need*) normally induce an increase in price.

surgery: any operative or manual procedure undertaken for the *diagnosis* or *treatment* of a *disease* or other disorder; the branch of *medicine* concerned with diseases which require or are responsive to such treatment; or the work done by a surgeon (one who practices surgery). See also *operation*, *psychosurgery*, and *major*, *minor*, *elective* and *cosmetic surgery*.

surgicenter: a *facility* which serves *outpatients* requiring surgical *treatment* exceeding the capability of the *physician's* office but not requiring hospitalization as an *inpatient*. Also known as ambulatory surgery, day surgery, and in-and-out surgery.

surplus: in *insurance*, the excess of a company's assets (including any *capital*) over *liabilities*. Surpluses may be used for future dividends, expansion of business, or to meet possible unfavorable future developments. Surpluses may be developed and increased

intentionally by including an amount in the *premium* in excess of the pure premium needed to meet anticipated liabilities known as a *risk charge*. Surpluses are sometimes earmarked in part as *contingency reserves* and in part as unassigned surplus.

swap maternity: a provision in group health insurance plans providing immediate *maternity benefits* to a newly covered woman but terminating coverage on pregnancies in progress upon termination of a woman's coverage. See also *switch* and *flat maternity*.

switch maternity: a provision in group health insurance plans providing *maternity benefits* to female employees only when their husbands are covered in the plan as their *dependents*. Has the effect of denying maternity benefits to single women. See also *flat* and *swap maternity*.

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tax: to assess or determine judicially the amount of levy for the support of certain government functions for public purposes. A charge or burden, usually pecuniary, laid upon persons or property for public purposes; a forced contribution of wealth to meet the public needs of a government. See also *tax credit* and *deduction*, and *regressive*, *proportional* and *progressive tax*.

tax credit: a reduction of *tax* liability for Federal *income tax* purposes. Several *national health insurance* proposals allow businesses and/or individuals to reduce their taxes dollar for dollar for certain defined medical expenses. The effect of using a tax credit approach rather than a *tax deduction* is to give persons and businesses an equal benefit for each dollar expended on health care. A tax credit favors lower over higher income people while a tax deduction is worth more the higher the *marginal tax rate*. See also *Medicredit*.

tax deduction: a reduction in the *income* base upon which Federal *income tax* is calculated. Health insurance expenditures are deductible by businesses as a business expense. Since the tax rate for most large businesses is 48 percent, this means there is a reduction of tax liability of nearly \$1 for each \$2 the business spends on health insurance. It is estimated that Federal tax receipts will be reduced by approximately \$3.7 billion in 1976 because of business deductions of health insurance costs. Individuals also may take a *medical deduction* on their personal income tax of one-half the cost of health insurance *premiums* up to \$150 plus all medical expenses and premiums that exceed 3 percent of income. Approximately \$2.6 billion in revenues will be lost to the Federal government as *tax expenditures* because of the individual medical expense deductions in 1976. Since the *marginal tax rate* is related to income and is higher for higher income persons and businesses, the value of a tax deduction for income spent on medical care increases as income increases; thus, the subsidy is effectively greater for the higher income person or more profitable corporation. See also *tax credit*.

tax expenditure budget: in the Federal *budget*, an enumeration of revenue losses resulting from *tax expenditures*. Section 301 of the Congressional Budget and Impoundment Control Act of 1974 requires that estimated levels of tax expenditures be presented by major *functions* in the *Congressional* and *Presidential budgets*.

tax expenditures: revenues lost to government because of any form of legal *tax* reduction or tax forgiveness, including *tax credits* and *deductions*. The term emphasizes that such revenues foregone for specific purposes (such as subsidizing private purchase of health insurance through the Federal income tax deduction for health insurance) are budgetarily equivalent to actual Federal expenditures. See also *tax expenditure budget*.

teaching hospital: a *hospital* which provides *undergraduate* or *graduate medical education*, usually with one or more medical, dental or osteopathic (AMA, ADA or AOA approved) *internship* and *residency* programs and *affiliation* with a medical school. Hospitals which educate *nurses* and other health personnel without training physicians are not generally thought of as teaching hospitals. Nor are those which have only programs of *continuing education* for practicing *professionals*. See also *housestaff* and *affiliated hospital*.

teaching physician: a *physician* who has responsibilities for the training and supervision of medical students, *interns*, and *residents*. Teaching physicians are often, but not necessarily, salaried by the institution in which they teach. A common arrangement is that a physician in *private practice* must donate a certain amount of time for teaching and supervision in return for being granted *staff privileges*. Appropriate reimbursement of the activities of these physicians has been a subject of considerable controversy. Under *Medicare*, hospitals are reimbursed under the *hospital insurance program* for the costs they incur in compensating physicians for teaching and supervisory activities and in paying the salaries of residents and interns in approved teaching programs; in addition, *reasonable charges* are paid under the *supplementary medical insurance program* for teaching physicians' *services to patients*. This potential double payment resulted in attempts in 1972 to change the Medicare reimbursement formula, but uncertainty regarding an equitable reimbursement arrangement delayed implementation of any changes and has resulted in Congressional authorization for a large scale study of the subject by the Institute of Medicine; study results are due in March, 1976.

tertiary care: *services* provided by highly specialized *providers* (e.g., neurologists, neurosurgeons, thoracic surgeons, *intensive care units*). Such services frequently require highly sophisticated technological and support facilities. The development of these services has largely been a function of diagnostic and therapeutic advances attained through basic and clinical *biomedical research*. See also *primary* and *secondary care*.

therapeutic equivalents: *drug* products with essentially identical effects in *treatment* of some *disease* or condition. Such products are sometimes, but not necessarily, *chemically equivalent* or *bioequivalent*. Therapeutic equivalents are sometimes defined as chemically equivalent, and drugs with the same treatment effect, which are not chemically equivalent, called clinically equivalent. This is a useful distinction but inconsistently used.

therapy: the *treatment* of *disease*.

third-party payer: any organization, public or private, that pays or *insures* health or medical expenses on behalf of *beneficiaries* or recipients (e.g. *Blue Cross* and *Shield*, commercial insurance companies, *Medicare*, and *Medicaid*). The individual generally pays a *premium* for such coverage in all private and some public programs. The organization then pays bills on his behalf; such payments are called third party payments and are distinguished by the separation between the individual receiving the *service* (the first party), the individual or institution providing it (the second party) and the organization paying for it (the third party). See also *service* and *indemnity benefits*.

tissue committee: a committee, which usually functions in a *hospital* setting, and reviews and evaluates all *surgery* performed in the hospital on the basis of the extent of agreement among the preoperative, postoperative, and pathological *diagnoses*; and on the relevance and acceptability of the procedures undertaken for the diagnosis. The name derives from the use of pathologic findings from tissue removed at surgery as a key element in the review. See also *tissue review*.

tissue review: a review and evaluation of *surgery* performed in a *hospital* on the basis of agreement or disagreement among the preoperative, postoperative and pathological *diagnoses*. In particular, the pathological or tissue diagnosis is used to determine if the procedure was necessary. Studies have shown that hospitals with *tissue committees* have lower rates of unnecessary surgery than those without such committees.

Title XVIII: the title of the Social Security Act which contains the principal legislative authority for the *Medicare* program, and therefore a common name for the program.

Title XIX: the title of the Social Security Act which contains the principal legislative authority for the *Medicaid* program, and therefore a common name for the program.

tracers: selected conditions or *diseases* chosen for appraisal in programs which seek to assess the *quality* of medical care because it is believed that the quality of care given for the tracers is typical or representative of the quality of care given generally or to all diseases.

trade name: *see brand name*.

treatment: the *management* and care of a *patient* for the purpose of combating *disease* or disorder.

triage: commonly used to describe the sorting out or screening of *patients* seeking care, to determine which *service* is initially required and with what priority. A *patient* coming to a *facility* for care may be seen in a triage, screening or walk-in *clinic*. Here it will be determined, possibly by a triage *nurse*, whether, for example, the patient has a medical or surgical problem, or requires some non-physician service such as *social work* consultation. Such rapid assessment units may merely refer patients to the most appropriate treatment service, or may also give treatment for minor problems. Originally used to describe the sorting of battle casualties into groups who could wait for care, would benefit from immediate care, and were beyond care.

trolley car policy: a facetious name for an *insurance policy* which is so hard to collect *benefits* upon that it is as though it provided benefits only for *injuries* resulting from being hit by a trolley car. Typically used of *mail order insurance*.

trust funds: funds collected and used by the Federal government for carrying out specific purposes and programs according to terms of a trust agreement or statute, such as the social security and unemployment trust funds. Trust funds are administered by the government in a *fiduciary* capacity for those benefitted and are not available for the general purposes of the government. Trust fund receipts whose use is not anticipated in the immediate future are generally invested in interest bearing government securities and earn interest for the trust fund. The *Medicare* program is financed through two trust funds—the Federal Hospital Insurance Fund which finances Part A, and the Federal Supplementary Medical Insurance Trust Fund which finances Part B. See also *social insurance*, *funded*, and *Congressional* and *Presidential budgets*.

turkey: deprecating *housestaff* term for an *inpatient* who they feel does not need hospital *admission*. Such patients are not usually *malingers*.

u

undergraduate medical education: medical education given before receipt of the M.D. or equivalent degree, usually the four years of study in medical, osteopathic, dental or podiatric school leading to a degree. This use contrasts with that in general education where undergraduate education refers to college education leading to the bachelor degree.

underwriting: in *insurance*, the process of selecting, classifying, evaluating and assuming *risks* according to their *insurability*. Its fundamental purpose is to make sure that the group insured has the same probability of *loss* and probable amount of loss, within reasonable limits, as the universe on which *premium* rates were based. Since premium rates are based on an expectation of loss, the underwriting process must classify risks into classes with about the same expectation of loss.

underwriting profit: that portion of the earnings of an insurance company that comes from the function of *underwriting*. It excludes earnings from investments (other than interest earnings required by law or regulation to be assumed to have been earned for purposes of determining the *reserves* held) either in the form of income from securities or sale of securities at a *profit*. The remainder is found by deducting incurred *losses* and expenses from earned *premium*.

unemployment insurance: a form of *social insurance* that operates by means of a *payroll tax*, the revenues from which are used to pay calculated *benefits* for defined periods to people who qualify (usually by virtue of accumulated amounts of covered employment) as being unemployed, as defined in the law. Of interest because people receiving unemployment insurance do not usually continue to receive *group health insurance* coverage obtained through their most recent place of employment.

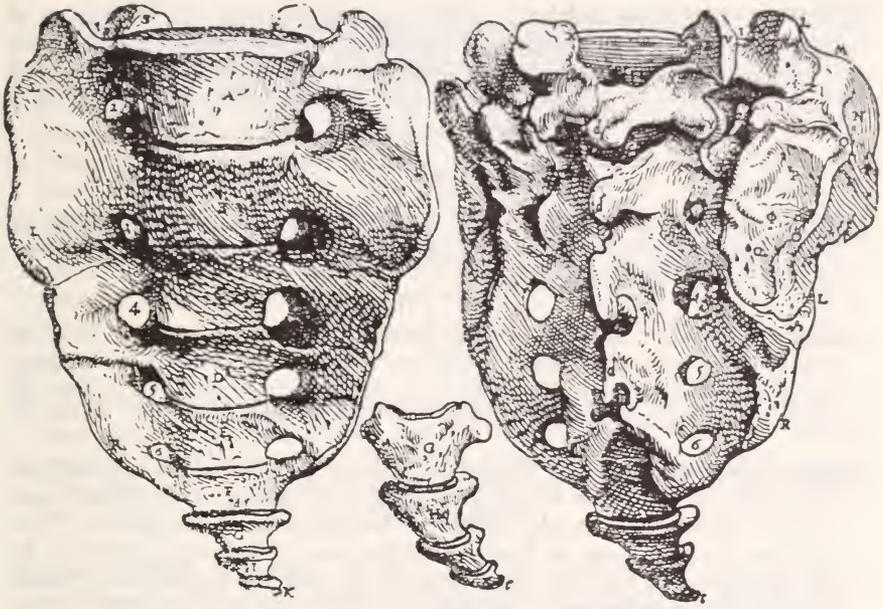
uniform cost accounting: the use of a common set of accounting definitions, procedures, terms, and methods for the accumulation and communication of quantitative data relating to the financial activities of several enterprises. The American Hospital Association, for example, encourages the use of its Chart of Accounts as a system which can be employed by *hospitals* in the United States.

Uniform Hospital Discharge Data Set (UHDDS): a defined set of data which give a minimum description of a *hospital* episode or *admission*. Collection of a UHDDS is required upon discharge for all hospital stays reimbursed under *Medicare* and *Medicaid*. The UHDDS was defined in a policy statement of the Secretary of HEW (HEW publication number HSM 73-1451, series 4, no. 14, as extended by a policy statement approved 6/24/74) and includes data on the age, sex, race and residence of the *patient*, *length of stay*, *diagnosis*, responsible *physicians*, *procedures* performed, disposition of the patient and sources of payment. The *PSRO* program uses a slightly larger data set called the PSRO Hospital Discharge Data Set (PHDDS). The Uniform Hospital Discharge Abstract (UDHA) used to collect the UHDDS is one example of a *discharge abstract*.

Uniform Individual Policy Provisions: a set of provisions regarding the nature and content of individual health *insurance* policies, developed in a recommended model law by the NAIC and adopted (with minor variations) by almost all jurisdictions and permitted in all.

United States Pharmacopeia (USP): a legally recognized *compendium* of *standards* for *drugs*, published by the United States Pharmacopeial Convention, Inc., and revised periodically. It includes also assays and tests for the determination of strength, *quality* and purity. See also *National Formulary*.

usual charge: see *customary charge*.



S

usual, customary and reasonable plans (UCR): health *insurance* plans that pay a *physician's* full charge if: it does not exceed his usual charge; it does not exceed the amount customarily charged for the service by other physicians in the area (often defined as the 90 or 95 percentile of all charges in the community), or it is otherwise *reasonable*. In this context, usual and customary charges are similar, but not identical, to *customary* and *prevailing charges*, respectively, under *Medicare*. Most private health insurance plans, except for a few *Blue Shield plans*, use the UCR approach.

utilization: use. Utilization is commonly examined in terms of patterns or rates of use of a single *service* or type of service, e.g., *hospital care*, *physician visits*, *prescription drugs*. Measurement of utilization of all medical services in combination is usually done in terms of dollar expenditures. Use is expressed in rates per unit of population *at risk* for a given period, e.g., number of *admissions* to hospital per 1,000 persons over 65 per year, or number of visits to a physician per person per year for *family planning* services.

utilization review (UR): evaluation of the *necessity*, *appropriateness* and *efficiency* of the use of medical *services*, procedures and *facilities*. In a hospital this includes review of the appropriateness of *admissions*, services ordered and provided, *length of stay*, and discharge practices, both on a concurrent and retrospective basis. Utilization review can be done by a *utilization review committee*, *PSRO*, *peer review group*, or public agency. See also *medical review*.

utilization review committee: a staff committee of an institution or a group outside the institution responsible for conducting *utilization review* activities for that institution. *Medicare* and *Medicaid* require as a *condition of participation* that *hospitals* have a utilization review committee in operation.

v

validity: the degree to which data or results of a study are correct or true; the extent to which a situation as observed reflects the true situation. See also *reliability*.

vendor: a *provider*; an institution, agency, organization or individual practitioner who provides health or medical *services*. *Vendor payments* are those payments which go directly to such institutions or providers from a *third party* program like *Medicaid*.

vendor payment: used in public assistance programs to distinguish those payments made directly to *vendors* of service from those cash income payments made directly to assistance recipients. The vendors, or providers of health services, are reimbursed directly by the program for services they provide to eligible recipients. Vendor payments are essentially the same as *service benefits* provided under health *insurance* and *prepayment* plans.

visit: an *encounter* between a *patient* and a health *professional* which requires either the patient to travel from his home to the professional's usual place of practice (an *office visit*), or vice versa (a *housecall* or home visit).

visiting nurse association or visiting nurse service (VNA): a *voluntary health agency* which provides *nursing* services in the home, including health supervision, education and counseling; bedside care; and the carrying out of *physicians'* orders using *nurses* and other personnel such as home health aides who are specifically trained for specific tasks of personal bedside care. These agencies had their origin in the visiting or district nursing provided to sick poor in their homes by voluntary agencies, such as the New York City Mission, in the 1870s. The first visiting nurse associations were established in Buffalo, Boston and Philadelphia in 1886-87. See also *home health agency*.

vital statistics: statistics relating to births (*natality*), *deaths* (*mortality*), marriages, *health* and *disease* (*morbidity*). Vital statistics for the United States are published annually by the National Center for Health Statistics of the Health Resources Administration in the Department of Health, Education, and Welfare.

voluntary health agency: any non-*profit*, non-governmental agency, governed by lay and/or *professional* individuals, organized on a national, State, or local basis, whose primary purpose is health-

related. The term usually designates agencies supported primarily by voluntary contributions from the public at large, and engaged in a program of service, education, and research related to a particular *disease, disability*, or group of diseases and disabilities; for example, the American Heart Association, American Cancer Society, National Tuberculosis Association, and their State and local affiliates. The term can also be applied to such agencies as non-profit *hospitals, visiting nurse associations*, and other local service organizations which have both lay and professional governing boards, and are supported by both voluntary contributions, and charges and fees for services provided.

w

Wagner-Murray-Dingell Bill: one of the original *national health insurance* proposals, first introduced by Congressmen Wagner, Murray and Dingell in the 1940s. It is still updated and introduced in each Congress by Congressman John Dingell of Michigan who succeeded his father, the original sponsor, in office.

waiting period: a period of time an individual must wait either to become eligible for *insurance* coverage, or to become eligible for a given *benefit* after overall coverage has commenced (see *exclusions*). This does not generally refer to the amount of time it takes to process an application for insurance, but rather is a defined period before benefits become payable. Some policies will not pay *maternity benefits*, for example, until nine months after the policy has been in force. Another common waiting period occurs in *group insurance* offered through a place of employment where coverage may not start until an employee has been with a firm over 30 days. For disabled persons to be covered under *Medicare*, there is a waiting period of two years; a person must be entitled to social security *disability* benefits for two years before medical benefits start.

waiver of premium: a provision included in some policies which exempts the *insured* from paying *premiums* while he is *disabled* during the life of the contract.

warranty: in *malpractice*, actions against *physicians* are normally based on negligence, but in certain circumstances the plaintiff can bring his action on the basis of a warranty. A warranty arises if the physician promises or seems to promise that the medical procedure to be used is *safe* or will be *effective*. One of the advantages to bringing an action on warranty grounds, rather than for negligence, is that the statute of limitations is usually longer. A warranty action may be brought and maintained if there is an express warranty offered by the physician to the *patient*.

working capital: the sum of an institution's investment in short-term or current assets including cash, marketable (short-term) securities, accounts receivable, and inventories. Net working *capital* is defined as the excess of total current assets over total current liabilities.

workmen's compensation programs: State *social insurance* programs which provide cash *benefits* to workers or their *dependents injured, disabled, or deceased* in the course, and as a result, of employment. The employee is also entitled to benefits for some or all of the medical services necessary for treatment and restoration to a useful life and possibly a productive job. These programs are mandatory under State laws in all States.

Z

zoonoses: those *diseases* and infections which are naturally transmitted between vertebrate animals and man.

ABBREVIATIONS AND ACRONYMS

(Alphabet Soup Expanded)

Parties to the discussion of health care and national health insurance use, and are exposed to, a confusing jumble of abbreviations and acronyms. This list gives the common meaning or meanings of many of these. Most, but not all, of those listed are defined in the dictionary where they are listed in their expanded form rather than as abbreviations or acronyms. The reader should be warned that some have more than one meaning (HSA), are already out of date for some reason (HSMHA, a recently reorganized and no longer existing part of HEW), or are used inconsistently.

A	AACHP	American Association for Comprehensive Health Planning.
	AAMC	Association of American Medical Clinics, Association of American Medical Colleges.
	A&H	accident and health insurance.
	AAPS	American Association of Physicians and Surgeons.
	AB	aid to the blind.
	ACFMR	Accreditation Council for Facilities for the Mentally Retarded.
	ADA	American Dietetic Association, American Dental Association.
	ADAMHA	Alcohol, Drug Abuse, and Mental Health Administration.
	AFDC	aid to families with dependent children.
	AGPA	American Group Practice Association.
	AHA	American Hospital Association.
	AHEC	area health education center.
	AHIP	Assisted Health Insurance Plan.
	AIP	annual implementation plan.
	AMA	American Medical Association.
	AMPAC	American Medical Political Action Committee.
	ANA	American Nurses Association.
	AOA	American Optometric Association, American Osteopathic Association.
	APA	Administrative Procedures Act.
	APhA	American Pharmaceutical Association.
	APHA	American Public Health Association, American Protestant Hospital Association.
	APTD	aid to the permanently and totally disabled.
	ASTHO	Association of State and Territorial Health Officials.

B	BA	budget authority.
	BCA	Blue Cross Association.
	BHI	Bureau of Health Insurance.
	BHM	Bureau of Health Manpower.
	BHPRD	Bureau of Health Planning and Resources Development.
	Blue sheet	Drug Research Reports.
	BNDD	Bureau of Narcotics and Dangerous Drugs.
	BQA	Bureau of Quality Assurance.
	BS	Blue Shield.
C	C&Y	children and youth project under the Maternal and Child Health Program.
	CAP	community action program.
	CBO	Congressional Budget Office.
	CCME	Coordinating Council for Medical Education.
	CCU	coronary care unit.
	CDC	Center for Disease Control (formally the Communicable Disease Center).
	CER	capital expenditure review.
	CHAMPUS	Civilian Health and Medical Program of the Uniformed Services.
	CHAMPVA	Civilian Health and Medical Program of the Veterans Administration.
	CHC	community health center.
	CHIP	Comprehensive Health Insurance Plan.
	CHN	community health network.
	CHP	comprehensive health planning.
	CHSS	Cooperative Health Statistics System.
	CL	current liabilities.
	CMHC	community mental health center.
	CMS	Council of Medical Staffs.
	Co	coinsurance.
	COB	coordination of benefits.
	COTH	Council of Teaching Hospitals.
	COTRANS	Coordinated Transfer Application System.
	CPA	certified public accountant.
	CPHA	Commission on Professional and Hospital Activities.
	CPI	Consumer Price Index.
	CPT	Current Procedural Terminology.
D	DD	developmental disability.
	DDS	doctor of dental surgery.
	DEA	Drug Enforcement Administration.
	DES	diethylstilbestrol.
	DESI	Drug Efficacy Study Implementation.
	DI	double indemnity.
	DO	doctor of osteopathy.
	DOA	dead on arrival.
	DVM	doctor of veterinary medicine.

E	ECF	extended care facility.
	ECFMG	Educational Commission for Foreign Medical Graduates.
	EHIP	Employee Health Insurance Plan.
	EHSDS	experimental health service delivery system.
	EMCRO	experimental medical care review organization.
	EMSS	emergency medical services system.
	EPSDT	early and periodic screening, diagnosis and treatment.
	ER	emergency room.
	ESP	Economic Stabilization Program.
F	FDA	Food and Drug Administration.
	FEHBP	Federal Employees Health Benefits Program.
	FFP	Federal financial participation.
	FHIP	Federal or Family Health Insurance Plan.
	FICA	Federal Insurance Contributions Act.
	FLEX	Federation Licensing Examination.
	FMC	foundation for medical care.
	FMG	foreign medical graduate.
	FNP	family nurse practitioner.
	FY	fiscal year.
G	GHA	Group Health Association of Washington, D.C.
	GHAA	Group Health Association of America.
	GP	general practitioner.
	GRAE	generally recognized as effective.
	GRAS	generally recognized as safe.
H	HASP	Hospital Admission and Surveillance Program.
	HCC	health care corporation.
	HEW	Department of Health, Education, and Welfare.
	HI	Hospital Insurance Program of Medicare.
	HIAA	Health Insurance Association of America.
	HIBAC	Health Insurance Benefits Advisory Council.
	HIMA	Health Industry Manufacturers Association.
	HIP	Health Insurance Plan of Greater New York, Inc.
	HMEIA	health manpower education initiative award.
	HMO	health maintenance organizations.
	H.R. 1	The Social Security Amendments of 1972, P.L. 92-603; the AHA's NHI proposal in the 94th Congress.

	HRA	Health Resources Administration.
	HSA	health service area, Health Services Administration, health systems agency.
	HSI	Health Service, Inc.
	HSMHA	Health Services and Mental Health Administration.
	HSP	health systems plan.
	HUP	Hospital Utilization Project of Pennsylvania.
I	IBNR	incurred but not reported.
	ICDA	International Classification of Diseases, Adapted.
	ICF	intermediate care facility.
	ICF/MR	intermediate care facility for the mentally retarded.
	ICU	intensive care unit.
	IL	intermediary letter.
	IND	investigational new drug.
	IOM	Institute of Medicine of the National Academy of Sciences.
	IPA	individual practice association.
	IPR	independent professional review.
J	JCAH	Joint Commission on Accreditation of Hospitals.
	JUA	joint underwriting association.
L	LCGME	Liaison Committee on Graduate Medical Education.
	LCME	Liaison Committee on Medical Education.
	LOS	length of stay.
	LPN	licensed practical nurse.
	LVN	licensed vocational nurse.
M	MAC	maximum allowable cost.
	M&I	maternal and infant care project under the Maternal and Child Health Program.
	MAP	Medical Audit Program.
	MCAT	Medical College Admission Test.
	MCH	maternal and child health.
	MCHR	Medical Committee for Human Rights.
	MEDLARS	Medical Literature and Analysis Retrieval System.
	MIA	Medical Indemnity of America, Inc.
	MIB	Medical Impairment Bureau.
	MMIS	Medicaid management information system.
	MR	mentally retarded.
	MSA	Medical Services Administration.

N	NABSP	National Association of Blue Shield Plans
	NACo	National Association of Counties.
	NAIA	National Association of Insurance Agents.
	NAIC	National Association of Insurance Commissioners.
	NAMH	National Association for Mental Health.
	NARC	National Association of Retarded Citizens.
	NARD	National Association of Retail Druggists
	NBME	National Board of Medical Examiners.
	NCHS	National Center for Health Statistics.
	NCHSR	National Center for Health Services Research.
	NDA	new drug application.
	NF	National Formulary.
	NHI	national health insurance.
	NHSC	National Health Service Corps.
	NIH	National Institutes of Health.
	NIMH	National Institute of Mental Health.
	NIRMP	National Interns and Residents Matching Program.
	NLN	National League for Nursing.
	NMA	National Medical Association.
	NP	nurse practitioner.
NPRM	notice of proposed rulemaking.	
O	OAA	old age assistance.
	OASDHI	Old Age, Survivors, Disability and Health Insurance Program.
	OC	oral contraceptive.
	OEO	Office of Economic Opportunity.
	OMB	Office of Management and Budget.
	OPD	outpatient department.
	OR	operating room.
	OSHA	Occupational Safety and Health Act.
	OT	occupational therapy or therapist.
	OTA	Office of Technology Assessment.
OTC	over-the-counter drug.	
P	PA	physician assistant, Proprietary Association.
	PAHO	Pan American Health Organization.
	Part A	Hospital Insurance Program of Medicare.
	Part B	Supplementary Medical Insurance Program of Medicare.
	PAS	Professional Activities Survey.
	PCMR	President's Committee on Mental Retardation.
	PDR	Physicians' Desk Reference.
	PF	Physicians' Forum.
	PHP	prepaid health plan.
	PHS	U.S. Public Health Service.

	PHS Act	Public Health Service Act.
	PMA	Pharmaceutical Manufacturers Association.
	PNHA	Physicians' National Housestaff Association.
	POMR	problem oriented medical record.
	PSRO	professional standards review organization.
	PT	physical therapy or therapist.
Q	QAP	Quality Assurance Program.
R	RCC	ratio of costs to charges.
	RCT	random controlled trial.
	RFP	request for proposal.
	RMP	regional medical program.
	RN	registered nurse.
	RVS	relative value scale or schedule.
S	SC	service connected.
	SHCC	Statewide health coordinating council.
	SHPDA	State health planning and development agency.
	SMI	Supplementary Insurance Program of Medicare.
	SMSA	standard metropolitan statistical area.
	SNF	skilled nursing facility.
	SRS	Social and Rehabilitation Service.
	SSA	Social Security Administration.
	SSI	supplemental security income.
T	Title XVIII	Medicare.
	Title XIX	Medicaid.
U	UCR	usual, customary and reasonable.
	UHDDS	Uniform Hospital Discharge Data Set.
	UR	utilization review.
	USAN	United States Adopted Names Council.
	USP	United States Pharmacopeia.
	USPHS	United States Public Health Service.
V	VNA	visiting nurse association.
W	WBGH	Washington Business Group on Health.
	WHO	World Health Organization.
	WRMH	Washington Report on Medicine and Health.
	314(a) agency	State CHP agency.
	314(b) agency	Areawide CHP agency.

SUGGESTIONS

The preceding dictionary is, at best, an initial exploration of the language of health care. The professional staff would greatly appreciate receiving suggested additional terms with definitions, corrections, comments, and other forms of feedback. When suggestions occur to the reader, they should be sent, before forgotten, to:

Thank you.

LEE HYDE,

*Professional Staff Member, House Committee on Interstate and
Foreign Commerce, Rayburn House Office Building, Wash-
ington, D.C.*



ANDREAS VESALIUS OF BRUSSELS

Andreas Vesalius of Brussels was a wonderful man. His greatest works, the *De Humani Corporis Fabrica*, and its companion, the *Epitome*, were published in 1543. These works revolutionized anatomy, marked the beginning of modern observational science and research, and remain to this day among the finest volumes in the history of printing. The illustrations in this dictionary are taken from them and suggest both the scientific quality and artistic power of Vesalius' masterpieces.

Vesalius was born in Brussels in 1514 to a family in which he was to be the fifth generation of physicians. He was educated in Paris and Padua, lived and worked, first as an anatomist and then as physician to Emperors Charles V and Philip II, in Italy, Belgium, France and Spain, and died in 1564 on a small Greek island during a pilgrimage to the Holy Land. His greatest work was done while professor of surgery at the University of Padua in the 1530's. In this work he was assisted by the great Italian artist, Titian, and the staff of Titian's studio. The illustrations in the *Fabrica* are apparently a mixture of work by Vesalius, Titian, and others in Titian's school. The illustrations were made from woodblocks which survived a tortuous history for over 400 years before being destroyed in the bombing of Munich in the Second World War. They are taken in this work from prints made from the blocks in the 1930's, and reproduced in *The Illustrations from the Works of Andreas Vesalius of Brussels* (with text by J. B. deC. M. Saunders and Charles D. O'Malley. 1950. Cleveland, Ohio: World Publishing Company).

Vesalius lived and worked at the beginning of the Renaissance, a time when medicine had not yet developed a philosophy of progress but looked upon the present as inferior in knowledge and achievement to the ancient Greeks, particularly Galen and Hippocrates. Anatomy, and most other science, until Vesalius was not done by observing nature but by recreating the writings and knowledge of Galen and his contemporaries. Anatomy texts until Vesalius were not in fact illustrated except for artistic purposes. Vesalius began modern science by basing his work upon the careful observation of nature and for this was frequently criticized because he corrected errors in the work of Galen.

After finishing the *Fabrica* in 1543 Vesalius left the practice of anatomy to take up what he apparently felt was the higher calling of the practice of medicine. While he never returned to the anatomist's life, despite a desire to do so, his stunning use of the observation of nature carried over into his practice of medicine where he introduced for the first time a variety of new methods and treatments based on his knowledge of the human body, and reintroduced the classic Hippocratic operation for the drainage of the chest in empyema.

It is hard today to appreciate Vesalius' contributions to the beginning of science. Always a man of controversy, his new truths tore the old with great violence. He is, however, now ranked with *Hippocrates*, *Galen*, *Harvey*, *Lister*, and *Osler* among the great physicians of history.

KEY TO THE ILLUSTRATIONS

A. Delineation of the bones, an articulated skeleton. This, like the other illustrations, is closely keyed to the original text, the first time in history that text and illustrations were thus closely related.

B. The first three cervical vertebrae from the front and back.

C. The anatomist's tools for an "administration", or dissection.

D. The brain and cerebellum from the right side with seven of the cranial nerves.

E. The heart with its principal vessels and nerves.

F. The palm and back of the bones of the hand.

G. The muscles of the front of the body. The backgrounds for the plates of the muscles, placed side by side, form a continuous landscape around Abano Terme near Padua in Italy. They were apparently done by Domenico Compagnola, a draftsman employed by Titian.

H. The intestines. This figure was one of a series intended to be cut out and laid upon each other in order to show the relationships of the various parts of the body at different depths. It was the first use in the history of anatomy of the overlay technique.

I. The skull. It rests on a dog's skull both to lift it at an appropriate angle and because Vesalius' work had revealed to him that much of Galen's description of the human skull was actually based on the study of dog rather than human skulls.

J. The entire venous system with the major arteries. Of particular importance because of the widespread use at the time of venesection, or "bleeding", for treating numerous diseases.

K. Three thoracic vertebrae with one rib.

L. The deep anatomy of the female torso.

M. The scapula, or shoulder blade.

N. Delineation of the bones from the back.

O. Cut-away view of the brain below the cerebral hemispheres.

P. The top and bottom of the bones of the feet.

Q. The muscles of the back of the body, some of which have been freed at one end and turned down to show those beneath.

R. Several views of the muscles of the larynx.

S. The front and back of the sacrum, the base of the spine.

T. Andreas Vesalius of Brussels.

BIBLIOGRAPHY

The following references were consulted in the preparation of the dictionary. Where a single term received different definitions in more than one source, the several definitions were synthesized into the one given. Many terms defined in the various references are not included in the dictionary because they were judged too technical, obscure, obvious, or unlikely to occur during the consideration of national health insurance. Thus the interested reader should consult the longer or more specialized references for additional assistance.

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