tions. These standards for health and safety will be a significant addition to the efforts of State licensing agencies to improve quality;

(*d*) Pay for the cost of quality care beyond minimum standards. The program offers a financial incentive for high quality care by operating under the principle of reasonable cost reimbursement for service provided;

(*e*) Pay for certification, consultation, and coordination services: certification to assure that standards are met, consultation to assist providers in meeting the standards, and coordination to integrate the health insurance program with ongoing or new health and medical care activities in each State.

Utilization of hospitals and related medical facilities.—An increase in days of hospital care for the aged resulting from the program has been estimated as 20 percent nationally, over and above the increases that would simultaneously occur through expansion of the population age 65 and over. Spread across all ages, the impact is expected to produce a national increase of 5 percent in bed occupancy.

The expansion in bed requirements will be uneven, community by community and hospital by hospital, affecting some more than others. There will be some shifting of geriatric patients, since the program will not finance care in nonaccredited hospitals. There may be shifts from public to voluntary hospitals resulting from the new resource for financing care privately. A variety of factors may be expected to alter the current patterns of care and increase the effective demand of the aged for hospital and nursing home care, including the requirement that there be effective utilization review committees functioning for each hospital and extended care facility.

When examining the impact of the program on utilization, there is a tendency to overlook the fact that a large proportion of the aged have had some kind or amount of voluntary hospital insurance and another segment has been eligible for care at public expense. While not all of those with voluntary insurance were adequately protected for the costs of care, it is probably true that the inadequacy of their coverage was not brought home to them until they had received hospital care. Effective demand could be said to have existed, then, for most of them. The same might be said of those whose care was publicly financed. Of the remainder some would have received all the care they required, in some cases at a sacrifice. Others would have had unmet needs.

Summing up, utilization of hospital care by geriatric patients is expected to rise, but is unlikely to expand markedly unless there is sudden expansion in the number of hospital beds. Dislocation in beds will undoubtedly occur, but the requirements for beds for acutely ill, younger patients will remain as a strong deterrent to unsound hospitalization of the elderly. Expansion of beds should not be undertaken without areawide planning to see if dislocations can be corrected through upgrading existing facilities, etc.

Extended care facilities.—Beginning in January 1967, there will be an increased demand for nursing home beds, since a means of financing will be available to many aged for the first time.

The shortage of nursing home beds will be a major problem, and the supply varies greatly from one part of the country to another.