active. Many HSAs have discouraged poor quality SNFs in their application for new beds. There is a significant amount of material in the state licensure files which gives information on the quality of SNF. PSROs are also a source. In the Northeast, the role of public nursing homes in the care of severely disabled elderly has been documented.[4, 5]

We have consistently advocated that HSAs have a major role to play in long-term care planning. Moreover, we suggest that it is a leadership stance—one that includes positive and optimistic approaches while realistically recognizing barriers to be overcome, and constraints to which to adjust. Equally important is the capacity of HSAs to convene and coordinate related agencies and researchers. This was the essence of our commentary, and we are pleased that Mr. Katz agrees.

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On 'Who Shall Deliver Primary Care?'

In Dr. Yankauer's editorial "Who Shall Deliver Primary Care?"[1] he comments that in the New Mexico study[2] which demonstrates decreased hospital utilization after the arrival of pediatricians in the study area, the type of training of the previously practicing family physicians is unknown. However, the fact that these practitioners were practicing in 1970 guarantees that they were *not* residency trained family physicians, as residency training in this field did not begin until that year.

Having practiced in a rural community briefly myself during the study period (1974-75), I was intrigued by the finding that pediatric hospital utilization had fallen more than 25 per cent before the arrival of the pediatricians. In the community where I practiced, admissions experienced a similar decline because a strong utilization review committee, headed by a General Practitioner, put heavy pressure on a few marginal practitioners to admit more prudently. A careful informal review of the records of these practitioners left an impression that they were using the hospital more to generate income for their practices than to care for their patients.

Current third party reimbursement of physicians rewards hospital care significantly more than office care. The overcautious or semi-scrupulous physician has every financial incentive to admit at the drop of a hat. While hospital admission rates may in part relate to the competencies of the differently trained practitioners, I suspect they are much more heavily influenced by reimbursement systems, as the literature comparing health maintenance organizations and fee-for-service hospitalization rates amply demonstrates.

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Variance and Reliability in Estimates of OC Use

In a recent article, Hartz and others[1] presented estimates of the per cent of women who had recently used oral contraceptives (OCs), based on interviews with a sample of hospital patients 18-69 years of age. The estimates were presented according to various sociodemographic and health characteristics of the patients. The authors commented that "certain features of the data suggest that these findings can be generalized." Without examining the merits of that claim, we invite the reader's attention to another source of statistics on use of oral contraceptives—National Survey of Family Growth (NSFG)—which was specifically designed to produce reliable estimates for the U.S. population and its major sociodemographic subgroups.

The National Survey of Family Growth is a periodic sample survey of reproductive age women in the household population of the conterminous U.S. It is conducted by the National Center for Health Statistics to obtain basic national data on childbearing, contraception, and related aspects of maternal and child health. Among the many published reports from the NSFG, several have included estimates of oral contraceptive use by age, race, religion, income, and other characteristics.[2-6]

The estimates of OC use from the NSFG appear to be systematically higher than those reported in Hartz and others (although comparisons of the published data cannot be exact). For instance, we estimate from the NSFG that about 23 per cent of currently married women 15-44 years of age were using oral contraceptives in 1976, while Hartz and others estimate that only 13 per cent of married premenopausal women were using OCs. The most likely reason that the hospital patient sample produced lower estimates was its older age composition—33 per cent were over 40 years of age, compared to only 6 per cent in the population represented by the NSFG. Many women over 40, although premenopausal, are sterile or married to sterile husbands, so that their inclusion in the population "at risk" of OC use is problematic.