HEALTH CARE CONSUMER

NEWSLETTER of the Champaign County Health Care Consumers 2 Summer 1983

Medicare Task Force to Negotiate with Burnham

Under the banner "Fair Share of Medicare", nearly 100 senior citizens packed the parlor of the First United Methodist Church of Champaign on August 4th to explain to Burnham Hospital representatives the inadequacy of Medicare coverage. At the public meeting, organized by the Medicare Task

Force, seniors gave testimony about Medicare and about their related high medical bills. Among the points raised were the facts that most doctors charge far more than Medicare will pay and that area seniors want more doctors to accept Medicare Assignment as payment-in-full for their services.

A concrete victory was achieved when the Burnham Hospital representatives signed a statement which says: "We recognize that Medicare coverage is not adequate . . . [and] we agree to meet with representatives from the CCHCC Medicare Task Force to discuss local solutions to these problems." This is the first time that any local health-care-provider-institution has agreed to negotiate with area senior citizens regarding Medicare.

Lucille Thompson of the Medicare Task Force chaired the meeting, which was initially delayed by the late arrival of the hospital administrators. Another Task Force member, Mary Evans, gave the introductory remarks, followed by the presentation of a petition by Clara Clark. After testimony was

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Under the Fair Share of Medicare sign, CCHCC Medicare Task Force members, Lucille Thompson, Mary Evans, Lillian Cotter and Clara Clark were panelists at the meeting with Burnham.

Nurse-Midwives: Is Champaign County Ready?

Less than a year after its formation, members of CCHCC's Midwifery Task Force think they see the light at the end of the tunnel. "For the first time, we are receiving concrete indications that the medical community in Champaign-Urbana is beginning to reconsider its long-standing exclusion of nurse-midwives," explained Task Force Chairperson Loretta Morales.

The optimism stems from the response to a recent Task Force letter sent to local OB/GYN, General and Family Practitioners, and all four local hospitals urging the addition of nurse midwifery services locally. Within a week, CCHCC was contacted by Doctors at two local clinics expressing an interest in adding a nurse midwife. Although no commitments have been made, there is clearly a new receptiveness to midwifery in the local medical community.

"For many women in the Task Force, the issue is largely one of choice," explained Morales. Dissatisfied with physicians emphasis on medical intervention in the birth process, women across the country are increasingly choosing midwives to deliver their babies. However, Illinois law requires nurse midwives to practice under the supervision of a physician. Although there are nearly 100 midwives practicing in Illinois, local physicians have been resisting this growing trend. As a result, women in our community are denied their right to choose.

At the same time, many low-income women in the area are denied access to prenatal care because of economic barriers.

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Health Advocate Reports....

IMPORTANT POINTS ABOUT MEDICAL MALPRACTICE

The stakes are high in malpractice suits. Individuals who win malpractice suits are often awarded huge sums of money for compensation. However, for individuals who lose malpractice suits, the loss can be both financially and psychologically devastating.

Contrary to what is believed by many consumers, only a small number of complaints about health care services can be successfully resolved through malpractice suits. This is not because the other complaints are not true, or have not resulted in obvious and grave consequences; rather, it is because malpractice falls under Tort law, and therefore, in order to prove a case in court, four specific conditions must be met:

1. There must be a "recognizable duty of care" for the type of medical service you received. That is, a proper standard of care must be defined and widely accepted in the field.
2. There must be a breech of that "recognizable duty" on the part of the medical provider.
3. There must be a resultant injury directly related to the medical provider's practice.
4. There must be "real damage" to you as a result of the injury.

If these four criteria are not met, a case may not qualify as a malpractice case. In order to determine if it would be wise to go ahead with a malpractice case, it is best to discuss the case with a lawyer. Fortunately, there are some lawyers in town who will not charge for the initial consultation. And if your complaint does not qualify as a malpractice suit, don't despair. There are other means of seeking resolution: through regulatory agencies, through the court, and through negotiations. Unfortunately, the rewards from these alternative means are often not as great as from malpractice suits, but then, neither are the potential losses.

If you are considering a malpractice suit and would like help with contacting a lawyer or if you would like to discuss alternative complaint procedures, call the CCHCC Consumer Health Hotline at 352-6533.

CONCERN ABOUT AIDS

To date, no cases of Acquired Immune Deficiency Syndrome (AIDS) have been diagnosed in the Champaign County area. However, due to the national coverage the disease has received, the severity of the illness, and the recognition that the group afflicted with AIDS is expanding geographically and demographically, AIDS is a concern of many Champaign County residents. Several callers to the CCHCC's Consumer Health Hotline in recent weeks have requested information about AIDS.

As with Toxic-Shock-Syndrome and Herpes, AIDS' rapid escalation as a national public health issue has led to the spread of misinformation on the subject. To get accurate, up-to-date information on AIDS, we are suggesting that individuals call a toll-free hotline set up by the U.S. Public Health Service. The AIDS Hotline number is (800) 352-AIDS, and it is open from 8:30 am to 5:30 pm EST. If your questions on AIDS are less pressing, CCHCC's Fall Newsletter will include a feature article outlining the medical facts and the political implications of AIDS.

IN THIS ISSUE

CCHCC Board Nominations

CCHCC's annual election for our Board of Directors is coming up later this fall. All CCHCC members are invited to nominate themselves or another CCHCC member for a slot on the Board. CCHCC has a *working* Board of Directors: Board members are some of the organization's most active volunteers. The CCHCC Board of Directors is responsible for: determining the over-all programs, policies and plans of CCHCC; approving the formation of task forces; giving final approval of the organization's fiscal budget; and planning and participating in fundraising activities. But don't let this list of activities intimidate you. The most important qualities for Board Members are their commitment to CCHCC's ideals, their interest in seeing these ideals actualized, and their time. Carrying out these responsibilities requires a commitment from Board Members of about six hours per month.

Nominations for the Board election close on Friday, October 19th. You can submit nominations by calling or writing the CCHCC office. Once nominated, individuals will be contacted to confirm that they are interested in being on the Board, and then their name will be placed on the ballot. Ballots will be mailed by October 26th to all dues-paying members and must be returned by Friday, November 23rd. The new Board members will be seated at the December board meeting.

In September, 1982, CCHCC's by-laws were amended by the Board so that at-large positions on the CCHCC Board are held for a two-year term. This amendment was enacted to provide continuity to the Board from year-to-year. The at-large Board slots are staggered, however, so that six slots will be open each year. Board members who are completing their second year on the CCHCC Board and who may be seeking re-election to the Board include: Loraine Cowart, James Culp, Debbie Doyle, and Louise White. Board members beginning their second year on the CCHCC Board are: Mike Doyle, Susan McGrath, Madeline Mockabee, Ray Murphy, Diane Sauer, and Mamie Smith.

If you'd like more information about CCHCC's Board, call the CCHCC office (days: 352-6533) or CCHCC's Board chairperson, Debbie Doyle (evenings: 344-0300).

Medicare: Reagan Pushes to Cut and "Reform"

Although the budget cutting rhetoric is the same, President Reagan's proposed $1.7 billion in Medicare cuts aren't merely "fiscally conservative" cuts in outlays—they reflect ideological reforms aimed at undoing the entire system of federally-funded health insurance for the elderly and disabled.

Predictably, Reagan wants to shift the burden of medical costs even further away from the government and onto the beneficiary. This will mean an increase in deductibles for both Medicare Part A and Part B. For Part A (hospital insurance), the projected deductible is $350 per year up from the current $304. (It was $204 when Reagan took office.) For Part B (doctors' fees and out-patient services), the deductible will increase from $75 to $80 per year. On top of this, the premium for Part B, currently set at 23% of the average cost, or $146 per year, will increase to a whooping 35% in 1988 if Reagan has his way, or nearly $400 per year.

Unfortunately, even these adjustments aren't enough to satisfy Reagan's ideological opposition to federal funding for health. The President has made two major proposals for Fiscal Year '84 which, if passed into law, may undermine Medicare itself. The first is the highly-touted "Catastrophic Coverage." Presently, there are no beneficiary co-payments for the first 60 days of hospitalization once the $304 deductible is paid under Medicare Part A. After that, senior patients must pay $76 to $152 per day until 60 lifetime "reserve days" are used, after which the patient is responsible for the full payment. The Reagan proposal would shift beneficiary cost to the front end of hospitalization periods so that people with short stays would pay far more. For days 2-15, the co-payment would be $28 per day (in addition to a $350 deductible) followed by $17.50 per day for days 16-60. No co-payments would be required after the 60th day—thus the "catastrophic coverage."

As noted by the National Council of Senior Citizens, however, only 0.6% of the 29 million Medicare beneficiaries would benefit from such a plan. For the remaining 99.4%, it would be financially devastating. For example, a hospital stay of 60 days under current law costs the Medicare patient $304, but under Reagan's proposed plan this would sky-rocket to $1530! Even the average hospital stay of about eleven days would consume one-and-a-half months' worth of a widow's average Social Security benefit of $375 or a retired worker's average benefit of $406. This proposed reform is expected to save $1.1 billion per year. In other words, senior citizens will pay $1.1 billion more each year for their health care.

The Reagan Administration claims these co-payments will reduce unnecessary hospital use. However, people do not enter hospitals at will, but on doctors' orders. The proposals will discourage many elderly and disabled people from receiving necessary medical care or will impoverish them further when they need hospitalization. In addition, hospitals may turn away low-income elderly and disabled patients who cannot afford to pay their bills.

The second "reform" proposed by President Reagan involves something called "Medichoice." Beneficiaries would be given a choice between a voucher with which they could purchase private insurance or continued Medicare coverage. If they purchase a policy cheaper than the face value of the voucher, they could pocket the money. This is called "competition in health care", based on the theory that consumers could find cheaper coverage elsewhere. But, as the Gray Panthers point out, "It is preposterous to think that individuals can purchase more cost-effective insurance than the Federal Government can provide for a group of 29 million."

Again, this "competition" theory assumes that consumers decide on medical care when it is usually the doctors who determine how much care is needed. The obvious danger is that lower-income beneficiaries could be lured into purchasing "cheap" private insurance which may, in fact, end up costing them more because of poor coverage. Or, if most of the beneficiaries who choose a voucher over Medicare are low health-care utilizers, the cost of health care to the federal government could actually increase because the chronically ill would keep Medicare coverage. Another potential problem with the "Medichoice" proposal concerns the suggestion that vouchers become mandatory once a certain percentage of Medicare beneficiaries become voucher recipients, which could spell the beginning of the end for Medicare.

The pattern is clear: faced with growing budget deficits and shortfalls in the Medicare Fund, Mr. Reagan calls for drastic cuts in Medicare expenditures by the federal government. Not surprisingly, Mr. Reagan's reforms place the burden of absorbing the loss of federal funding directly on senior citizens. At the same time, these reforms further erode the long-term stability of Medicare by discouraging participation by healthy and financially-secure older Americans.

But who is to blame for Medicare's financial crisis? The Congressional Budget Office estimates that 50% of the problem is due to inflated prices of medical services. Since 1966, when Medicare began, doctors' fees and medical costs in general have gone up *three times* as fast as the overall rate of inflation. The average salary of a physician today is well over $100,000, compared to less than $30,000 in 1965. Medicare's reimbursement rate (called Medicare Assignment) is tied to what doctors actually charge. It's a complicated formula based on "customary, prevailing, and actual" prices, but the point is that it keeps going up. Doctors know that if they charge more one year, Medicare's index will go up the next. Medicare in its present state allows medical providers to constantly inflate prices and be guaranteed of payment. Rather than being a form of medical insurance for senior citizens, it has become a form of medical payment *assurance* for medical providers. Medicare is going broke not because America can't afford to help its 26 million senior citizens, but because we can't afford to subsidize the six-digit salaries of 450,000 doctors and the overexpansion of hospitals.

What is needed is an aggressive program aimed at containing the sky-rocketing cost of medical care. One proposal in this area is a plan based on Diagnostic Related Groupings (DRG's). Medicare would pay hospitals one fixed sum according to the primary diagnosis of the patient's injury or illness, rather than the current payment according to services used and length of hospital stay. For example, hospitals would be paid the same rate (with adjustments for local wages) for treating a patient with a broken hip requiring surgery, regardless of length of hospital stay or number of services used. This method of prospective payment is expected to force hospitals to operate more economically and efficiently. As true as this proposal is, it will fail unless it is applied across-the-board to all insurers and all providers and not just to those under Medicare. If it is not, hospitals may discriminate against Medicare patients and may shift costs to privately insured patients. As with Medicare as a whole, a good idea could backfire if not implemented broadly enough.

The Well-Kept Secret of P.S.R.O.'s

by Bob Gern

Have you ever heard of PSRO? Neither had I, until recently. Have you ever heard the expression, "The fox guarding the henhouse"? Well, that is what PSRO is.

PSRO stads for Professional Standards and Review Organization. By reviewing doctors' payment requests under Medicare and Medicaid, it is supposed to protect the health care consumer from improper medical practice or billing. But, in fact, it is thoroughly controlled by the very people it is supposed to monitor—the doctors.

The reason that most health care consumers haven't heard of PSRO is because most doctors prefer it that way. Actually, most doctors would prefer that there were no such thing as PSRO. In 1972, when PSRO's were created by a Congressional amendment to the Social Security Act, the AMA fought vehemently against it. When that didn't work, the AMA did the next best thing—it coopted the entire PSRO system.

The job of a PSRO is to "establish acceptable standards of care for treatment in a community." Then, according to these standards, the PSRO is supposed to review all Medicare and Medicaid claims submitted by doctors in the area and "recommend appropriate action against the doctors responsible for overutilization or unnecessary hospitalization and procedures." In addition, they conduct periodic Medical Care Evaluation (MCE) studies to assess the quality of care and to identify changes or improvements that are needed.

In theory, this is all a good idea. The problem is that—thanks to the AMA—it is now a "peer review" system. Local Medical Societies have complete control over the local PSRO. PSRO boards are composed of a rotating panel of local doctors. This means that a doctor who is called on the carpet one month may later be in a position to call his or her colleagues on the carpet the next month. This, in effect, assures that any patient complaint about a physician will be kept "in the family."

There are about 200 PSRO's in the country, including eleven in Illinois. In east central Illinois, our PSRO is located in the Blood Bank building on University Avenue in Champaign. Not so coincidently, the door next to the one marked "PSRO" is marked "Medical Society." This is indicative of the fact that PSRO's are run by the doctors, of the doctors, and for the doctors.

There is no consumer involvement whatsoever on the local level. That is, consumers cannot sit on the local PSRO board, they cannot vote for board members, they cannot effect policy decisions, and they cannot have any input into a case involving a patient's claim.

That brings us to another problem: very few claims are ever filed. This is due to the fact that, as mentioned earlier, doctors prefer to keep PSROs a secret. According to Tom O'Neil, the director of the East Central Illinois PSRO—which serves the surrounding 16 counties—only three cases have been brought before our PSRO in the past five years! Considering that there have been at least 50,000 federaly funded medical claims in that time period, this represents approximately 0.01% of the total. Further, out of those three complaints, none were decided in the patient's favor.

Theoretically, if a case were to be filed, it would first go to the local office. A panel of six doctors would review the case. Theoretically, if the patient weren't satisfied with the result, she could appeal it to a state-wide PSRO. The Illinois State PSRO is located in Peoria. By law, State PSRO Councils are composed of "four persons knowledgeable in health care" in addition to the physicians. These people are recommended by the governor and are selected by the Secretary of HHS. Since consumer groups can submit names of people for nomination to the council, this is the only area of consumer input into the entire physician-review process. Consumer groups may also recommend names for the National PSRO, but all names must be physicians!

In short, PSROs are set up for consumer protection in health care delivery, but are virtually inaccessible to the health care consumer. This is true not only in terms of consumer representation and input, but also in terms of consumer access to the enormous amount of data collected by the PSRO regarding each local doctor's practice and the practice of the local hospitals and clinics.

Increased Interest in Nursing Home Care

A week-long series of articles on nursing home care that appeared in the News-Gazette in early summer has prompted the formation of a local independent task-force on nursing homes. The series of articles, entitled "Broken Promises" focused on the failure of nursing homes to improve service following the passage of the Illinois Nursing Home Care Reform Act in 1979. The issue of nursing home care is not new to Champaign County. The Citizens For Community Involvement in Nursing Homes and the Nursing Home Resident Council Association, organizations devoted specifically to this issue, have been active in our community for close to five years. However, the article that appeared in the News-Gazette and the resulting increase in public awareness on the issue provided an opportunity for local nursing-home activists to broaden local involvement.

Immediately following the series, a public meeting was called to discuss the problems raised in the articles and the possibility of increased community participation in nursing homes. Well over 60 persons attended, including nursing home residents and administrators, social service workers and local consumers. After discussing the issue, participants showed interest in forming a task-force focusing on community involvement in nursing homes. In the ensuing weeks, the group has met regularly to define the task force goals and to form a plan of action. At the most recent meeting, a four-pronged approach was outlined by the task force members:

•Community Volunteer Involvement

Currently nursing home residents have little opportunity for one-on-one contact with community residents. Although local programs do place volunteers in local nursing homes, the programs are not coordinated, as they vary in the amount of training and support provided to volunteers and do not reach all local nursing homes on a regular basis. The focus of this task force committee will be to coordinate existing nursing home volunteer programs and to expand volunteer involvement in nursing homes.

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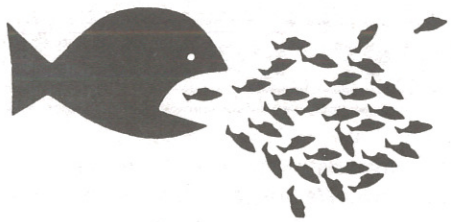
National Peoples Action Tackles the AMA



On June 23, over 500 people gathered in Chicago to attend a Health Action Conference sponsored by the National People's Action (NPA) organization. NPA is an umbrella coalition of some 300 neighborhood, church and senior citizen groups from 38 states. The NPA conference coincided with another conference in Chicago — that of the American Medical Association. Among those attending NPA's health conference were several CCHCC staff and Board members. The conference featured six workshops on topics ranging from the cost of prescription drugs, to alternative health care, to Medicare and Medicaid cutbacks. Most of the conference participants, and many of the conference workshops, were geared towards senior citizens.

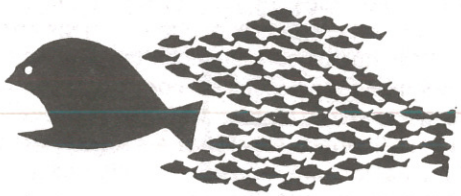
A number of representatives from the health care industry were invited to attend NPA's conference, but most declined the offer. At several points during the conference speakers attacked these representatives for being too busy across the street at the AMA conference to come and hear the people's opinions on health care in America. One industry representative who did accept NPA's invitation was Dr. William Rial, out-going President of the AMA. However, Dr. Rial was less than happy with the treatment he received at the conference and stomped out before the conference was over.

The cause of Dr. Rial's consternation was NPA's People's Prescription, and the conference participants' demands that he respond. In each of the conference workshops participants approved a demand, specific to their area of concern, to be made to the AMA. Together, these demands formed NPA's People's Prescription. It reads as follows:

- That the AMA lobby for national legislation requiring all doctors to accept Medicare Assignment, to accept all Medicare patients and not to require senior citizens to pre-pay for reimbursible third-party billing.
- That the AMA lobby against the Reagan administration's proposed cuts in the Medicare and Medicaid programs.
- That the AMA create a $2 million pool for pilot projects in selected cities leading to the establishment of senior citizen designed and run health centers.
- That the AMA invite the top 10 drug companies to a series of regional hearings to discuss exorbitantly high drug costs.
- That the AMA co-sponsor with NPA 10 regional hearings with the AMA's Task Force on a health policy agenda for the American people, and that the NPA have continued input into the task force's decisions.

In the closing session of the conference, Dr. Rial was asked for his support in securing these demands from the AMA. Instead of voicing support, Dr. Rial criticized several of the demands and refused to be held accountable on the others. The moderator, NPA Chairperson Gale Cincotta, and the conference participants became angry with his side-stepping maneuvers. In the end, Dr. Rial agreed to take the demands back to the AMA house of delegates, but no more. NPA is currently awaiting a response from the AMA.

The Health Action conference was part of a national health action campaign NPA is sponsoring. During the conference, steps were also outlined for direct action projects that the participants could carry out at the local level. Some of these include: • Contact the U.S. Senator in your state and ask them to request that Senator Heinz's Special Committee on Aging hold field hearings in your city. • Set up a public meeting with your local medical society and demand that they publish a list of doctors who will accept Medicare Assignment. • Compare drug prices by survey in your neighborhood drug stores. NPA is also planning a similar health action conference in Washington, D.C. in late September. For more information about the trip or NPA's other activities, write or call NPA/954 W. Washington Blvd., Chicago, IL 60607 (312) 243-3038.



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• Community Education

Nursing homes tend to be institutions that aren't thought about by the general public until a family member needs to enter one. The result is that individuals often make decisions about nursing homes in a crisis situation and with too little information. This committee will work to remedy this situation by providing information to the general public about nursing homes. Committee members are planning to develop a speakers' bureau and a resource center.

• Nursing Home Resident Involvement

Most nursing home residents do not have family or friends living nearby. Once in a nursing home, they are likely never to leave the grounds of the facility. Since, as mentioned earlier, few community residents visit nursing homes, nursing home residents are effectively cut off from the community. It is hoped that through the activities of this committee this circumstance will change. The committee plans to sponsor and coordinate activities that will allow nursing home residents to leave the facility and that will encourage the community to visit individuals in nursing homes.

• Issues and Advocacy

Many factors besides the degree of community involvement influence the quality of care provided by nursing homes. Some of these factors can be influenced at the local level, such as increasing enforcement of the 1979 Illinois Nursing Home Care Reform Act. Other factors, such as government reimbursement levels for nursing home care must be addressed at the state and national level. The issues and advocacy committee will investigate these other avenues for increasing quality of care in nursing homes.

Anyone interested in becoming involved with the Nursing Home Task Force should contact the Task Force co-chairs: Connie Eaton-Cheren (359-9560) and Cathy Moses (367-1191).

The Business of Health Care - A Consumer Perspective

In the last several months numerous articles about health care have appeared in business sections of mass-market magazines and newspapers. The articles report on, analyze, and speculate about the growing share for-profit corporations are taking of the medical marketplace. The articles focus almost entirely on the potential profits and possible losses within the for-profit health care industry. In and of itself, this viewpoint is fascinating: what do the investors and financial analysists think about our health care system. But the articles also raise an issue that they do not address.

This article, the first of a two-part series, will highlight the perspectives outlined in the business section articles. In addition, the series will address what the business community doesn't care to report: the profits and losses that health care consumers will realize from the growing influence of for-profit corporations in the health care field.

Since their inception, certain areas of health care have been dominated by for-profit companies—most notably the drug industry. Other areas, such as hospitals, remained almost entirely the domain of non-profits. But this pattern is changing. For-profit corporations are rapidly emerging in all areas of the health care field. In addition, whole new allied health care fields (i.e. hospital management firms and computer companies specializing in health care industry needs) are developing on a for-profit model. Within the business community, speculations about the impact of this trend vary quite a bit. One point financial analysists seem to agree on is that the increasing numbers of for-profit health care providers, along with the excess of doctors and hospital beds in certain areas, and the impending change in government reimbursement for health care services towards cost containment are combining to accelerate competition within the health care field. However, beyond this point, opinions vary.

Certainly, some financial anaylsists are estatic about the prospects of the health care industry, as reflected in several recent articles that appeared in newspaper business sections. On June 28, Andrew A. Lecky reminded Sun-Times readers that, "health care stocks have been among the most hospitable choices for investors . . . offering growth and predictibility as their primary strengths." And on July 11th, an article entitled, "Birth of a Health Care Concern" in the New York Times Business section led off with, "The formula for striking it rich used to involve oil wells. Then it was computers. Now the key phrase is health care." The article continues, "Michael L. Coney, a health care analysist at Merrill-Lynth, figures that there is no easier way to earn money than to start a health care company." A representative from another reputable brokerage firm, New York's E.F. Hutton, is quoted in the Sun Times article as saying, "Health care companies have been able to increase their earnings at a 25% annual rate and they should be able with some predictability to do the same or even better in the future."

But, the cover story in the July 25 issue of Business Week entitled, "The Upheaval in Health Care - Government Cost Controls will soon have Hospitals under the Knife," painted a less rosy picture. The general tone of the article was capsulized in the following quote, "'The whole industry may well suffer a decline in margins,' predicts W. Robert Freidman, Jr. a health care analysist for San Francisco based Montgomery Securities. 'We are going into an environment where so many changes are going to take place that you have to question long-range forecasts of growth or profitability.'" The article argues that upcoming reforms in Medicare reimbursement will leave hospitals "exposed to the full risks and rewards of the competitive market for the first time."

Not surprisingly, the articles from these various newspaper business sections and business magazines give little mention to how this 'upheaval in health care' will affect the health care consumer. Consumers are referred to in these articles mainly in terms of their buying power and consequent impact on the industry's profit margins. Andrew Leckey's article was perhaps coldest in its analysis: throughout the article he discusses congressional legislation providing health care insurance benefits for the unemployed; the aging population of the United States; and the decreased "risk" of national health insurance all in terms of increased profit margins for providers. By an ever-increasing portion of the health care system, we are being viewed solely in terms of our buying capacity. So, we too, will be exposed to the full risks and rewards of the competitive market.

For consumers, the effect of this trend will be to sharpen the distinction that already exists in our two-class health care system: as for-profits skim more of the well-financed patients from the market, services provided to the rest of us will continue to decrease in quality and availability.

The real losers in this trend are, as always, the poor and working poor. As actively as the for-profits woo the well-insured, they resist placing themselves in positions where they may have to provide services to the non-insured. For-profits tend to locate in affluent suburbs; few are to be found in rural areas or in the inner cities. Some areas, such as Champaign-Urbana, where poor and affluent neighborhoods fall within a single institution's service area, pose a more difficult problem. The industry's solution seems to be to locate in the area but then to develop methods of "discouraging the poor" from seeking services while promoting the image of being a "caring, community institution" to the rest of the community.

It appears that not just the poor will be impacted by the risks of this increased competition; consumers with the money to pay, will receive services—but pay for them, they will. A study published recently in the New England Journal of Medicine shows that total inpatient charges were 24% higher in investor-owned hospitals than comparable community hospitals. So, unlike, in the neat supply-demand curves drawn by economists, the "competition" created by for-profits entering the health care market will not decrease, but increase health care costs.

So far, the impact of this trend on consumers appears quite bleak. A few hopeful notes will be explored in the second article in this series. Unfortunately, these short-term rewards will likely result in long-term losses for health care consumers. These potential losses will also be explored when the second article appears in the Fall edition of Health Care Consumer.

Burnham Keeps an Open Door to the Poor

On July 31, 1983 Burnham Hospital closed its books on its free care obligation under the federal Hill-Burton program. But fortunately for hundreds of low-income residents in East-Central Illinois, Burnham will not close its doors to the poor. Instead, Burnham Hospital has implemented its own free care program, initiating a commitment Burnham officials made last summer after months of negotiations with CCHCC's Hill-Burton Task Force.

"It's rather a historic moment" explained Task Force member Susan McGrath. "There is no legal obligation involved. Burnham agreed to develop this program as a means of demonstrating their commitment to the poor in response to community concerns centering around Hill-Burton. We commend Burnham for their leadership on this issue and will continue to work to insure that the other local institutions follow in their footsteps."

Community concerns about Hill-Burton peaked in 1981 when local and federal investigations found widespread non-compliance with regulations governing the Hill-Burton program. Under the Hill-Burton program local hospitals (Burnham, Carle and Mercy) received federal dollars for expansion of their facility. In return, the hospitals agreed to provide free and low-cost care to persons unable to pay. Charges by CCHCC that local hospitals were not informing patients about the Hill-Burton program, and that individuals were therefore not receiving the assistance to which they were entitled, were confirmed by the investigations of local and federal agencies.

In addition to confirming non-compliance, the local investigation, conducted by members of the Health Systems Agency (HSA), concluded by issuing a set of recommendations to local Hill-Burton hospitals. One of the recommendations was that local hospitals develop their own free care programs once their legal obligation to provide free care under the Hill-Burton program expired. Mike Doyle, a member of the Hill-Burton Task Force explained, "By the time the HSA completed its investigation, the hospitals had pretty much cleaned up their act and eliminated many of their past abuses. All of a sudden everyone seemed to know about Hill-Burton. The hospitals quadrupled the amount of free care they were providing. However, a real issue that concerned us was what would happen to the poor when these institutions no longer had a legal obligation to provide free care. We also felt that because of their past abuses, these institutions owed the community. Therefore, we were very pleased when the HSA recommended that hospitals develop their own free care programs after their Hill-Burton obligations expired."

When the HSA did not pressure local hospitals to implement their recommendations, the CCHCC Hill-Burton Task Force approached local hospital with the report in hand. Of the three area Hill-Burton hospitals Burnham was the only one that committed to setting up their own free care program similar to the federal Hill-Burton program.

Since early summer the CCHCC Hill-Burton Task Force has been negotiating with Burnham Hospital administrators about the format of their free care program. Although the basic structure of the free care program has been approved by the Burnham Board of Directors many details of the program are yet to be finalized. An overview of Burnham Hospital's free care program will be included in the fall issue of *Health Care Consumer.*

In Response to Consumer Demand....

CCHCC Introduces the Consumer Report on Health Care Services

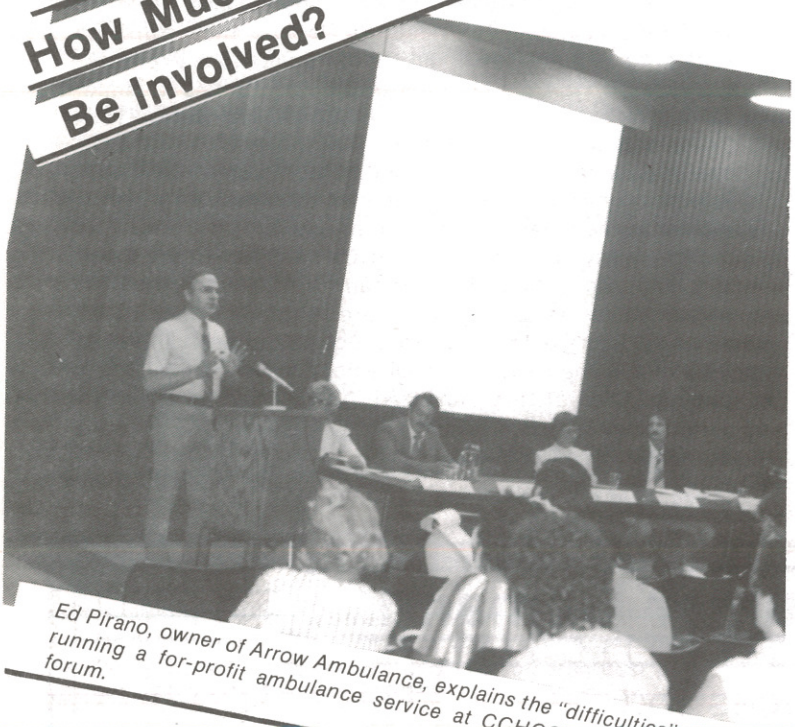
Since we got our first telephone, CCHCC has received calls from consumers asking for assistance selecting physicians. Questions have ranged from: "Who's a good internist?"; to "What do you know about Dr. X?"; to "How is the pediatrics department at X clinic?" In some ways, these consumers were lucky. We could refer them to the *Dr's Directory* — a resource most communities don't have. The *Dr's Directory* is an excellent source of information about local clinic's and physician's policies, practices and fees. However, as it is compiled from questionnaires sent to the health care providers it only includes information from their perspective. The calls we receive are from consumers who want to know what other *consumers* have to say about locl physicians health care facilities.

To meet this demand, CCHCC is setting up a Consumer Report on Health Care Services. Once operational, the Consumer Report will provide Champaign County residents with qualitative information from a consumer's perspective about local health care providers. Whereas the *Dr's Directory* tells consumers how providers say they practice, the Consumer Report will tell what consumers think about the services they receive.

In order to provide this service, *we need your help.* We need to know what you think about your physician or health care facility. On the Consumer Report form you will have a chance to rate your health care provider on such factors as accessibility, cost-consciousness, personality, and medical quality. Please take the time to fill out the enclosed Consumer Report form and send it back to us. If you need additional forms or have friends who would like to evaluate their health care providers, either Xerox a copy or contact the CCHCC office to have us send you more.

Please help us make this needed service available to area consumers!

Ambulance Services - How Much Should the Government Be Involved?



Ed Pirano, owner of Arrow Ambulance, explains the "difficulties" of running a for-profit ambulance service at CCHCC's community forum.

Ambulance service has been a controversial issue in Champaign-Urbana over the last three years, with frequent complaints about the billing practices and quality of service. Those concerns surfaced again at a CCHCC forum entitled, "Ambulance Service: How Much Should the Government Be Involved?"

Over 50 persons attended the July 26th forum at the Champaign Public Library to hear four panelists offer differing perspectives on the topic. Tony Marquez, Chief of Program Operations, for the state agency responsible for emergency medical services, spoke first about state regulations which govern ambulance service and the limits of those regulations. Mr. Marquez emphasized the lack of resources to adequately monitor ambulance services around the state. He noted that improvements and changes are usually the result of a scandal which highlights the deficiencies and forces public officials to committ more resources to the problem. Mr. Marquez noted that the recent upgrading of state regulations came after a Chicago Tribune expose on private ambulance service in the Chicago area.

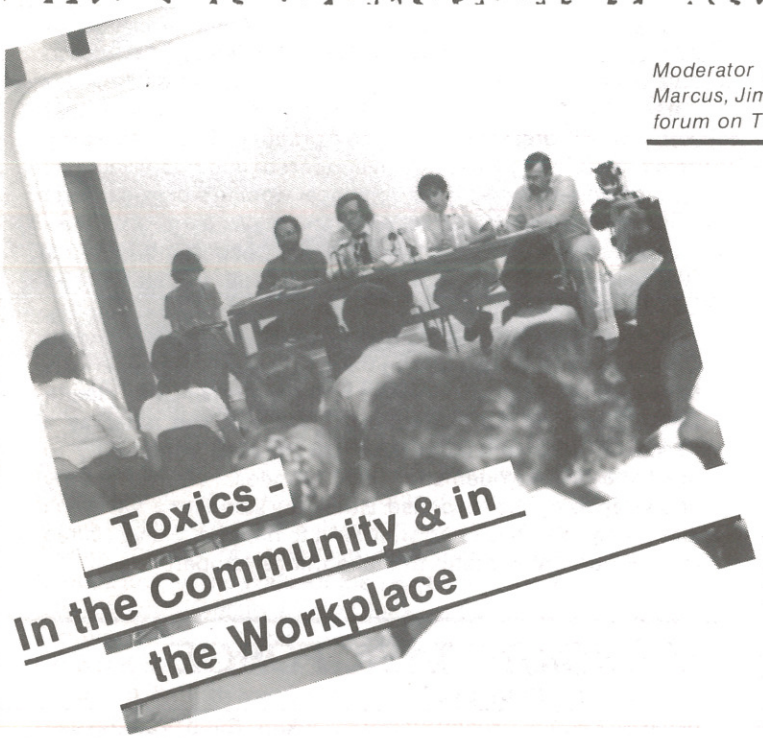
Joyce Lee, Administrator of the Farmer City Ambulance Service gave a short presentation on the largely volunteer services offered in Farmer City. Ms. Lee explained that as a volunteer operation, those who provided the services are committed to the concept of quality services, but struggle with the problem of burnout among volunteers.

Ed Pirano, owner of Arrow Ambulance in Champaign, spoke next and focused on the difficulties of operating a private ambulance company. In his presentation, Mr. Pirano defended high charges for ambulance services by listing the high cost of purchasing and operating sophisticated equipment. He addressed the compalints about poor treatment of patients saying, "Our business isn't to be nice to a patient, but to save their lives."

Mike Doyle, Regional Director of the Illinois Public Action Council, gave the final presentation calling for local ordinances to regulate ambulance service. "The issue is not whether or not to regulate, there seems to be little disagreement that such a critical life and death service ought to be regulated," explained Doyle. "The real issue is how much regulation is needed." He argued for local ordinances that would allow for resolution of consumer complaints, expand monitoring and inspections, and review rate structures when there is no competition to keep rates down.

During the question and answer session following the panelists, members of the audience seemed particularly unhappy with Mr. Pirano. When asked about complaints, Mr. Pirano stated he had a clean slate. However, later he acknowledged that he served on the one committee charged with hearing consumer complaints about his service. No consumers served on this committee. Another audience member questioned his collection practices on unpaid bills. At one point in response to the audience, Mr. Pirano stated his support for a local ambulance ordinance, even one that regulated rates. By the end of the evening, Mr. Pirano agreed to meet with community representatives to discuss problems and complaints about Arrow's service. Representatives of several community groups, including Senior Organizing Services which unsuccessfully worked for passage of a local ordinance in 1982, stated they will take Mr. Pirano up on his offer.

Forums



Moderator Ellen Heine and panelists (from left to right) Philip Marcus, Jim Yoho, Paul Blanc and Don Hank at CCHCC's June 16th forum on Toxics.

Toxics - In the Community & in the Workplace

Illinois is the second largest producer of toxic wastes in the United States—and the message from the panelists of CCHCC's June 16th Community Forum on Toxics was loud and clear: industry and the state legislature are not doing enough to clean up and contain this hazard.

Paul Blanc, M.D., PhD, author of *Stop Environmental Cancer, A Citizen's Guide to Organizing,* was the first panelist to speak and ended his presentation by listing the seven warning signs of Corporate Cancer: (1) corporations won't tell what chemicals they are using; (2) increasing numbers of birth defects or miscarriages; (3) open dump sites; (4) public officials unresponsive to residents; (5) increased occurrence of chronic diseases; (6) the use, production, transport, and disposal of toxic substances; and (7) contamination of ground or surface water. Throughout the forum, he admonished industry for its lackadaisical efforts to contain toxics. However, he cautioned the audience that we can probably never expect industry to lead the way in identifying and cleaning up toxics. He felt that citizens would always be the first to sound the alarm against toxics in their communities and workplaces, citing the Love Canal and Agent Orange issues as examples.

The next panelist, Don Hank from the Chicago Area Committee on Occupational Health and Safety, reiterated this last point. He gave the example of asbestos—which was known to cause cancer in 1910, but which companies continued to use without providing proper protection for workers until 1970. Hank identified the passage of Right-To-Know legislation as a cornerstone of protection for workers from the hazards of toxics. He mentioned one piece of Right-to-Know legislation, II HB 741, which has since passed out of the House and Senate and is currently awaiting the Governor's signature. This bill will require labeling of the most toxic workplace chemicals and will require employers to disclose health hazard information to workers and union representatives.

Philip Marcus, Executive Director of the Illinois Environmental Consensus Forum, also felt that industry should be more accountable on the issue of toxics. However, he argued that control needed to be strengthened primarily at the local level. He proposed, among other things: negotiated and monitored site locations for toxic dump sites; reimbursement to the local community from the developer of toxic dump sites; and provisions for individual disabilities resulting from toxics.

The final panelist, Jim Yoho, did not focus on industry as the cause of the problem. Instead, Yoho, a Champaign attorney, said that each of us should look into the toxics that are produced as a result of our lifestyles. He pointed to PBCs produced by fluorescent lights, to food additivies, and to formaldahyde in housing foam-insulation. He proposed that, to a large extent, toxics are the result of the lifestyles consumers have chosen, and that individuals should consider eliminating products from their households that directly or indirectly (through by-products) result in the production of toxic substances.

Contrasting views on this last point dominated the questions and discussion that followed the panelists presentation. Several members of the audience agreed with Yoho, and proposed that the problem of, and solution to, toxics lay primarily within consumers' product choices. An equally vocal segment of the audience disagreed and argued that the primary responsibility and cause lay with industry. By the end of the discussion, neither side appeared to have won over any supporters from the other side. It was, however, an exciting end to an informative evening.

NURSE-MIDWIFERY *con't from pg.1*

For example, the coordinated Interagency Prenatal Program (CIPP)established in 1979 to provide prenatal care to low-income women, is overwhelmed and patients are turned away on a regular basis. In pushing for midwifery services, the Task Force also hopes to improve the accessibility of prenatal care for low-income women. "Midwives have traditionally served the underserved; particularly in rural and low-income communities," Morales emphasized. "We believe that the introduction of nurse midwives cannot only broaden the choices available to women, but will help meet a critical need in our community. Our strategy is to coalesce these different but complimentary self-interests in demanding midwifery services."

The Task Force is an outgrowth of the Women's Health Task Force which successfully fought to save the DES Act in Illinois in 1981 and joined with the Illinois Nurses Association in 1982 in an unsuccessful effort to clarify the legality of nurse midwives under state statutes. "Through our past work on women's health issues, there has always been a core of CCHCC members concerned about birth alternatives locally," noted CCHCC Executive Director Cynthia Ward. "We held a forum on midwifery last summer that seemed to bring people together with a renewed commitment to change things locally."

In an effort to assess local physicians' feelings about midwives and to communicate the growing desire for midwives among consumers, Task Force members set up meetings with physicians in late 1982. "We found out that individually doctors were not necessarily opposed to the idea of nurse midwives, some even had worked with nurse midwives elsewhere," explained Morales. From these meetings, it became clear that doctors balked at hiring a nurse midwife for one of two reasons. The first was an unwillingness to rock the boat. No one wanted to be the first out of fear of disapproval from their peers. The second was economic. Nurse midwives were seen as a threat to their patient load.

With this in mind, the Task Force set out to create an atmosphere of acceptance of midwives. The objective was to communicate to the physicians that 1) there is a demand for nurse midwifery services and 2) the providers meeting that demand will greatly expand their practice. The Task Force began circulating a petition in support of midwifery services and seeking endorsements from local women's organizations such as the National Organization for Women, etc. "The response has been pretty phenomenal," according to Ward. "We've already collected several hundred signatures and people keep calling us for more petition sheets."

In August of this year, the Task Force sent its letter to local Doctors and Hospitals asking them to "assist us in our efforts to add certified nurse-midwives to the Maternal Child Health Care Teams in our community." We saw the letter as a necessary step of asking the local medical community to meet the growing demand," said Morales. "We are greatly encouraged by the response. But at the same time, we aren't just going to sit back and wait for it to happen. We've waited long enough. We intend to make things happen."

Staff & Board Changes

The summer of 1983 brought both staff and Board changes for CCHCC. At the July Board meeting, Board and staff members bid a fond farewell to long-time CCHCC and CCHCC Board member, Carol Hollowell. Expecting their first child this fall, Carol and her husband Jeff left Champaign-Urbana in early August moving to Milwaukee, WI. Carol, who grew up in Danville, first became aware of the Health Care Consumers in 1979 but didn't become active until the formation the CCHCC's Hill-Burton Task Force. Carol joined the Board in November of 1981. During her involvement with CCHCC Carol consistently contributed thoughtful input and willing assistance on numerous CCHCC projects. We wish Carol and Jeff the best of luck in their new home.

A second farewell was given at the July Board meeting to CCHCC staff fundraiser, Pam Fox. In recognition of her eight months as a CCHCC staff member, Pam was presented a Mickey Mouse wristwatch by the Board. In January of 1983, Pam resigned from the CCHCC Board to become CCHCC's staff fundraiser. In accepting the position, Pam informed the Board she was considering returning to school for a graduate degree in English in the fall. In her short time on staff, Pam provided staff support for the 1983 Membership Drive, the Walk-For-Change, and our recent forum on Ambulance Services. Not wanting to see Pam leave CCHCC altogether, the Board nominated her for an open position on the Board of Directors at their August meeting.

Replacing Pam as CCHCC's staff fundraiser is Roxanne Cardona-Rodriquez. Although not a C-U native, Roxanne has lived in Champaign-Urbana for several years as a health education student at the U of I and later as an employee at the Frances Nelson Health Center and Family Service of Champaign County. Roxanne brings to CCHCC an extensive background of organizing and advocacy on health issues. Roxanne's first project with CCHCC will be to plan CCHCC's fall fundraiser.

MEDICARE TASK FORCE *con't from pg.1*

given by Marilyn Brown, Maurice Jenkins, Billie Fruhling and many others, a summary of concerns was read by Lillian Cotter. Clara Greenblau then formally requested a commitment from the Burnham Hospital representatives to agree to negotiate with the Medicare Task Force.

Representing Burnham were Jim Neuses, Chief Financial Officer, and Sandi Kauffmann, Director of Marketing and Development, both of whom signed the written agreement to negotiate. Afterward, Ms. Kauffmann described Burnham Hospital's position, stating that "since approximately 30% of Burnham's caseload is from the Medicare population, we are vitally interested in what any group has to say regarding the program and related issues."

The next step for the Medicare Task Force is to prepare for the up-coming negotiations with Burnham. Eventually, we will be approaching the other health care providers in town with similar proposals. Leading up to our victory with Burnham was months of meeting, planning, and educating ourselves about Medicare and the local health care business. Task Force members had been circulating petitions stating that we want more doctors to accept Medicare Assignment as their full payment. In addition, meetings have been held at all of the local Senior housing complexes, Peace Meal sites, Senior Citizen Centers, and various church groups in Champaing-Urbana, as well as in towns such as Rantoul, St. Joseph, Savoy, and Seymour.

Our next meeting will be held on Wed., Sept. 21 at 10:00am at the Champaign Public Library. We will discuss the negotiations and take nominations for officers of the Task Force. Also, we will be joined by members of Older Americans for Elderly Rights, a group in Rock Island which is also fighting for improved Medicare reimbursement in their area.

1983 Walk-For-Change

"Rain? What rain?" Defying pessimistic weather forecasters and ominous greying skies, forty-eight walkers gathered faithfully at Champaign's West Side Park the last weekend in April to kick off the 1983 Walk-For-Change. Although many rushed along the 10-kilometer route in order to beat the rain, spirits remained high as walkers crossed the twin cities to raise money for any of seventeen participating organizations. Groups joining the Walk for the first time this year included: Coalition of University Women, Labor Roundtable of Vermilion County, North Urbana Concerned Citizens Development Corporation, and Prairie Center for Substance Abuse.

Now in its fifth year, the walk-a-thon has met with few structural changes since its conversion from a 10 K.-run to a walk-a-thon format in 1979. "Change-oriented" community groups are invited to participate in the event, and walkers, as is customary in most "thons," solicit pledges for each kilometer they intend to walk, channeling the money to the organization of their choice. Along the way, alterations here and there have been made to diversity and expand the Walk.

This year walk-a-thon participants were offered the unique opportunity to link up with the C—U Nuclear Freeze Committee's "Legs Against Arms" Freeze March midway along the walk-a-thon route. The March, a dramatic climax to Ground Zero month, enjoyed widespread community support. Not surprisingly, its ranks were bolstered further by most of the Walk-For-Change walkers. Walk-a-thon volunteers staffing the checkpoint tables at West Side Park and selling food at CCHCC's 'concession stand' were thus greeted by an unusually large entourage, made up of returning walkers and 250 other singing, chanting marchers. A rally following the Freeze March and walk-a-thon, which featured speakers and music, rounded out the day's events (and managed to ward off the rain for a little while longer). Pam Fox, CCHCC staffperson and coordinator of the 1983 Walk, commented that "While the walk-a-thon/march merger may not have been ideal for everyone involved, a large number of our walkers chose to participate in both events; for many, I think, the Freeze march lent special significance to the 'walk for change' concept, and they took advantage of the chance to demonstrate their support for this issue."

CCHCC would like to thank all who came out for the Walk, as well as those CCHCC members who donated pledge money to the event. Over $3500 was raised by the walk-a-thon this time around. SPECIAL APPRECIATION goes out to CCHCC member and walker MARQUITA SYKES, who, for the second year in a row, raised the most money for the Health Care Consumers!!

A report on this year's Walk would not be altogether complete, however, without a frank assessment of the fundraiser's results. After the "hoopla" died down—and after thank you notes were written, T-shirts were given away—it became clear to those who worked extensively on the event that the '83 Walk had not come close to meeting its fundraising expectations. Riding on the success of previous Walks, staff and volunteers had set a lofty financial goal for the walk-a-thon; both the number of participants and the total pledge amount were much lower than anticipated. Poor weather, competing events, and waning interest in "thon" fundraisers have all been discussed as possible reasons for the day's low turn-out. Our purpose in mentioning this matter is not to devalue the efforts of participants and volunteers in any way, but to open the issue up to our membership. We invite your comments and suggestions about the Walk so that we can begin planning the upcoming fiscal-year's fundraising schedule. Please drop us a note or call the office if you have an opinion you'd like to share.

Door-Knocking for Support

"The response from people has just been fantastic — even from people who had never heard about the Health Care Consumers before," exclaims Suzanne Feldman, Director of CCHCC's summer fundraising and educational canvass. "People who have heard about CCHCC almost uniformily support us because of our programs. People who haven't heard about CCHCC, support the group because they believe in the need for an organization like ours."

Since July 11th, CCHCC's canvassers have been going door-to-door in Champaign County telling people about CCHCC's activities and asking them to support our work by signing petition sheets, volunteering, and making financial contributions. Like the postal workers motto, the canvassers brave rain, hail and heat to carry our message to the doors of Champaign County. The canvassers work five or six days a week putting in an average of fifty hours per week. CCHCC canvassers are paid for their work, but the $160/week salary alone would not provide sufficient incentive for them to go out each night. "In addition to it being my job, I feel like I'm contributing to social change," states CCHCC canvasser Laury Mantel. "I believe that the canvass can greatly enhance grassroots organizing. We hear about different problems at the door and can plug residents into different campaigns, not to mention the educational aspects of the canvass."

Door-to-door issue canvassing of this style is a relatively new phenomenon. It was first developed in the early 70's by organizer and fundraiser, Mark Anderson, for the Citizens for a Better Environment (CBE). The success of CBE's canvass led to the rapid adoption of their canvassing model by change-oriented organizations. In this community, people are most familiar with the Illinois Public Action Council (IPAC) canvass, which knocks on over 3,000 doors each night in Illinois. CCHCC's projections are more modest, but are impressive for an organization of our size. By the end of the eight week canvass, over 8,000 Champaign County residents will have been contacted and over $14,000 raised for CCHCC. We've already added 257 new members through the canvass and identified 25 new volunteers.

We'd like to extend a special welcome to all our new members and convey our thanks to the canvass staff.

Volunteers Needed.....

Since CCHCC began in 1977, most of the work accomplished by the organization has been done through volunteer efforts. In addition to our task forces, CCHCC has a number of other projects that are dependent upon volunteer input. A sample of our volunteer projects are listed below. If you're interested in one of these or would like to discuss other ways you can work with CCHCC, call us at 352-6533.

- **Investigative Researcher**

Volunteer needed to uncover hidden facts about the U.S. Health Care System and local medical institutions. Project will include investigating public records and researching relevant articles. The results will be used in developing new CCHCC campaigns. Requirements for the position are: a commitment to social change, basic research skills, patience for tedious work, and at least 40 hours of time in the next three months.

- **Dr's Directory Editorial Assistant**

CCHCC is beginning work on our third edition of the *Dr's Directory for Champaign County.* The Dr's Directory includes information on local physicians' fees, practices and philosophy as well as features on consumer health topics. In the third edition we hope to expand the types of providers listed and the topics of consumer health covered. Volunteers are needed to assist with: developing questionnaire; gathering lists of physicians by specialty; researching and writing consumer health sections; and collating, mailing and following up on surveys. Requirements for volunteers - none, except a commitment to volunteer at least four hours per month.

- **Health Hotline Advocates**

Help! We are being swamped with calls and our Health Hotline has a backlog of cases. Attend our upcoming Health Hotline Training Session on Sat., Oct. 1 from 10:30-3:30 and Tues., Oct. 4 from 7 to 9 pm. Once a trained advocate, you can help local consumers resolve complaints with physicians, insurance companies and clinic billing offices. In the process, you'll learn a lot about the local and national health care system. Advocates need to have a home phone and be good at working with people. Time required is about 2 to 4 hours a week.

Donation Needed.....

As CCHCC expands in staff size, we find ourselves outgrowing our office furniture. Our file drawers are overflowing and we're using boards and boxes for desks. Anyone with old lamps, typewriter tables, desks or tables that would like to donate them to a worthy (and tax deductible) cause - give us a call. We'd love to hear from you.

CHAMPAIGN COUNTY HEALTH CARE CONSUMERS

WHO WE ARE.....

Champaign County Health Care Consumers is an organization of local citizens concerned with improving health care delivery to all residents of our area. We are community-based and include representatives of women and minority groups, religious bodies and local elected officials, local businesses, labor unions and progressive provider organizations. We believe that health care is too important a matter of public concern to be left solely to those who provide it, and that major improvements will come only with the real involvement of consumers. Champaign County Health Care Consumers is funded largely through tax-deductible contributions of members and other local community residents. It is a not-for-profit, tax-exempt organization. For more information on becoming a member write CCHCC, 124 N. Neil, Champaign, IL 61820 or call (217) 352-6533.

WHAT WE DO.....

We focus on consumer participation, education, and action. Our public forums educate the general public on consumer health issues. Our leadership training workshops provide consumer leaders with knowledge and skills to carry out their responsibilities. Our newsletter helps keep consumers abreast of health care problems and emerging solutions. We work for responsible health planning and administration in accordance with federal regulations. We form Consumer Task Forces to address community health problems, currently emphasizing the problems facing low-income consumers and women. We have established a Consumer Health Hotline for residents who have questions, concerns or complaints about the local health care system. Finally, we publish The Doctors Directory for Champaign County.

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