HEALTH CARE CONSUMER

September, 1984 Newsletter of the Champaign County Health Care Consumers Vol. 8 Issue 2

MEDICARE TASK FORCE BRINGS AFFORDABLE HEALTH CARE TO AREA SENIORS !

CCHCC's Medicare Task Force has won an important victory for the 10,000 senior citizens and disabled persons on Medicare in Champaign County. Over one year of organizing by the Medicare Task Force was rewarded on April 5th when the Task Force and Burnham City Hospital jointly announced the creation of two new health care plans - Medicare 100 and Medicare Plus. These two unique health care plans offer substantially reduced out-of-pocket health care expenses for area Medicare recipients. Designed specifically for people on the federal Medicare Program, CCHCC's Medicare 100 and Medicare Plus plans cover from 25 % to 100 % of the medical expenses not covered by Medicare. The Task Force estimates that individuals enrolled in the Medicare 100 program will save, on the average, $1000 per year in health care expenses.

The Medicare Task Force and these progams grew out of the tremendous burden medical costs place on senior citizens. As Lillian Cotter, Chair of CCHCC's Medicare Task Force, told the press on April 5th, the Federal Medicare program covers on the average only $38 of every $100 that senior citizens spend on health care costs. Citing politicians who continuously vote to shift Medicare's cost to the beneficiaries rather than build some cost-containment into the system, Lililan said, "They seem to forget that Medicare was originally designed to protect senior citizens from the ravages of health care cost inflation." Faced with such a dire situation, the Medicare Task Force began to organize locally, Lillian explained, "By organizing a large enough group of us on Medicare -- who are the largest group of health care consumers -- we started to look for health providers who would be willing to offer us a reduced rate."

Lillian Cotter, Chair of CCHCC's Medicare Task Force, looks victorious after cutting the symbolic hospital bill in half at the April 5th press conference.

With competition among local health care providers more intense than ever before, the Task Force found a willing audience with health care providers. The Task Force first

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CRANE BLASTS HEALTH COST CONTROL BILL

The Kennedy/Gephardt "Medi-Care Solvency and Health Care Cost Control Act" (H.C.C., March '84, p. 5) has prompted the wrath of Congressman Dan Crane.

"I will oppose this bill with all resources available to me," Crane declares in a letter sent to selected constituents in early June.

Crane's objections focus on Kennedy and Gephardt's effort to bring governmental influence to bear on the spiralling cost of health care. He opposes such intervention because he says it "could lead to full-blown 'National Health Insurance' of socialized medicine".

Mr. Crane's opposition appears to arise from his fear of "direct federal and/or state control of all hospital fees". However, the bill, while clearly sympathetic to price controls, does not mandate them. Rather, it encourages states to devise their own programs. A state could choose to set prices, suggest guidelines, impose greater competition among providers, encourage alternative systems, or create any combination of the above methods. Any system is acceptable as long as it attains the price restraint required by the federal government.

The Kennedy/Gephardt bill is more focused on ends than on means. Mr. Crane does not seem to perceive this. Thus he claims the bill seeks "the imposition of the public utility model on the health care system."

It is important to ask what disturbs Mr. Crane so intensely. Who are the potential victims he is so concerned

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Health Care Consumer is the quarterly newletter of the Champaign County Health Care Consumers.

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, 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.

We focus on consumer participation, education, and action. Our public forums educate the general public on consumer health issues. 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, women, and senior citizens. We have established a Consumer Health Hotline for resident who have questions, concerns or complaints about the local health care system. Finally, we publish The Doctors Directory for Champaign County.

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.

IN THIS ISSUE

Staff Updates

Medicare Task Force

In August, CCHCC bid a fond farewell to staff member, Bob Gern. Bob started working with CCHCC in January of 1983 as organizer for CCHCC's Medicare Task Force. It was with his support that the Task Force successfully negotiated a contract with Burnham City Hospital for the Medicare 100 and Medicare Plus programs.

We wish Bob the best of luck in his on-going work for social change and congratulations on his marriage to Laurie!

Robert West, long-time Champaign resident, has returned to work after a "premature retirement", joining CCHCC's staff as organizer for the Medicare Task Force. Bob who has worked as a Respiratory Therapist brings a first-hand knowledge of the health care field to the job as well as extensive knowledge of individuals and organizations in the community.

Health Hotline:

Cheri Sullivan, CCHCC's Health Hotline Coordinator has taken a maternity leave from August 1 to January 1, 1985. Going to press Cheri's child had yet to appear, but was expected soon (on Labor Day). Congratulations to Cheri, from us all!

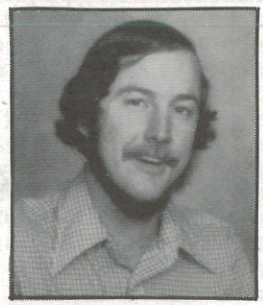
Tess Hall will be working on the Hotline in Cheri's absence. Tess, a part-time student in Community Health Education at the University of Illinois was a volunteer with the Health Hotline before joining CCHCC's staff.

Health Coalition:

We advertised for one organizer... but we got two! Clayton Daughenbaugh and John Lee Johnson joined CCHCC's staff in May as half-time organizers for CCHCC's new tri-county health coalition. Both bring years of organizing experience and community work to the job. Clayton has been involved in political campaign; in the formation of a food bank, a nuclear freeze group and several other church-sponsored social action organizations in the Charleston area. John Lee has been and continues to be a central figure in Champaign-Urbana's social action and political community.

CCHCC welcomes Clayton, John Lee, Tess and Robert to our staff!

Robert



Clayton

Tess

Articles, letters and comments for print in *Health Care Consumer* are welcomed. While we reserve the right to edit submitted material, we request that you include name, address, and phone number so that we may consult with you during the editing process. Material for print should be directed to the above address.

Medicare

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approached Burnham City Hospital in a public meeting held in August of last year. At this meeting, and in subsequent negotiating sessions, the Task Force impressed upon Burnham Hospital's administration their mutual need. It was pointed out that Burnham, with their occupany rates falling 7 % points in two years to 66 %, needed more patients or they would be facing a severe financial shortfall; at the same time, the Task Force argued, many of Champaign County's senior citizens in need of health care could not afford it.

Given that each empty bed to Burnham costs them an estimated $45,000 annually, the Task Force asked Burnham to consider discounting services for individuals on Medicare so that they would get needed medical care - and Burnham would get its beds filled. For six months CCHCC's Medicare Task Force and Burnham's administration faced each other at the bargaining table, negotiating for a program that would benefit both area seniors and Burnham Hospital. The final result: the Medicare 100 and Medicare Plus programs.

The two programs were officially announced by CCHCC's Medicare Task Force, Burnham City Hospital, and representatives of its affiliated physicians at the April 5th press conference. Peter Coshy, Chief Executive Officer of Burnham City Hospital, attended the event and signed the official statement of understanding between the two organizations, launching the Medicare 100 and Medicare Plus programs. In his statement to the press, Goshy said that it was the unique combination of a consumer group's presentation of their needs and Burnham Hospital's ability to respond to those needs which resulted in the Medicare 100 and Medicare Plus programs.

Also speaking at the event, which drew over 100 area Medicare recipients, was Clara Clark, Medicare Task Force member. She emphasized the sense of accomplishment which she and other members of the Medicare Task Force have gained from their efforts. "We're proud of ourselves -- the senior citizen members of the Medicare Task Force -- for proving that we really can improve our lives if we work together." Doris Arnold, an active member of the Medicare Task Force's negotiating team picked up on Clara's theme of pride-in-accomplishment by saying, "Medicare 100 and Medicare Plus prove that ordinary people like ourselves can actually work to change some of the most important factors affecting our lives."

Following the press statements, area Medicare recipients had the first opportunity to sign up for the Medicare 100 and Medicare Plus programs - and in the short space of an hour, over 40 did. To date, over 400 seniors and disabled persons from around the county have enrolled in the programs. Encouraged by the tremendous success of the program, the Medicare Task Force is currently negotiating with a local pharmacy to offer a similar discount of prescription drugs. Anyone interested in learning more about the Medicare 100 and Medicare Plus programs or in becoming involved in the Medicare Task Force should call the Health Care Consumers at 352-6533.

MEDICARE 100 MEDICARE PLUS

Medicare 100 and Medicare PIUS are two distinct programs developed by CCHCC's Medicare Task Force in cooperation with Burnham Hospital and its medical staff. Currently, 25 different specialties are represented by 84 particiapting phsicians who practice in Chamapign-Urbana and in various communities throughout Chamapign County. While not health insurance policies or prepaid health plans, these programs are specifically designed to reduce out of pocket expenses for people on Medicare. Eligibility for these programs is determined on the basis of specific financiasl guidelines. Persons who exceed the financial gudelines for Medicare 100 will be eligible for Medicare PIUS. The only overall requirement is enrollment in Medicare Part A(Hospitalization) and Part B(Medical) Insurance. The only restriction is that a person cannot simultaneously use a Public Aid Medical Card. No questions are asked about pre-existing health conditions and the total cost for membership is $5 per person per year.

Medicare 100 is avaialable for individuals with an annual income of no more than $10,000 and for married couples with a combined annual income of no more than 13,500. Whether single or married, total assets cannot exceed $25,000(excluding personal housing)

Medicare 100 benefits include--

- Burnham Hospital will waive the $356 Medicare deductible for each benefit period.

- *Burnham Hospital will waive the $89 and $178 daily copayments normally due after 60 and 90 days, respectively, of hospitalization in a given benefit period.*
- All 84 particiapting physicians will accept Medicare Assignment as payment in full for all in patient and out patient services that are approved by Medicare.

- All 84 participating physicians will waive the 20%Medicare Part B co-payment.

For Medicare PLUS eligibility--

Thsoe applicants who exceed the finacial guidelines for Medicare 100 will be eligible for Medicare PLUS. Specifically, Medicare PLUS is available for individuals with an annual income in excess of 13,500. Or, whether single or married, total (excluding personal housing) must exceed $25,000.

The benefits of Medicare PLUS--

- Members will receive a 30% discount on on all out-of-pocket expenses(including deductibles and co-payments) for Medicare approved services provided at Burnham Hospital.
- Members will receive a 25% discount on all out-of-pocket expenses (including deductibles and co-payments) for Medicare approved services provided by the 84 participating physicians.

The only part of Medicare not covered by these two programs is the $75 annual deductible for medical expenses (Part B). Any portion of this which has not yet been made this year will be payable to Burnham and will be billed along with a $5 application fee.

To enroll, cotact CCHCC's Medicare Task Force(124 N. Neil, Chamapign, 352-6533) to receive a brochure, a list of participating physicians, an application form, and a pre-paid envelope to return the applicationto CCHCC. Approximately 1-2 weeks after returning the form, the applicant will receive a membership card from Burnham Hospital, along with a bill for the $5 enrollment fee and any unmet portion of the $75 annual Medicare Part B deductible.

The membership card is to be shown whenever visiting Burnham Hospital or any of the 84 participating physicians. There will be an annual re-enrollment every year starting on January 1.

CCHCC Launches Coalition Effort for Health Care Cost Control

With $12,000 in funding from the Villers Foundation, the Health Care Consumers have launched a new campaign -- the formation of a tri-county coalition to work on state and national legislative health issues.

Spiraling health care costs created the impetus for this project by making health care issues a top priority for many low- and moderate-income organizations. Labor unions are being forced to make concessions in other contract areas to maintain adequate health insurance coverage for their members. Senior citizens, once assured access to medical care through the Medicare program, now find it unaffordable, with Medicare paying less than 60% of their total medical costs. Cuts in Medicare programs have left almost 50% of poverty-level families without any health care coverage. Members of each of these constituency groups are demanding that some solution be found to the growing crisis in health care.

This public outcry has generated a variety of solutions to spiraling health care costs. Some of these solutions attack the growing inflationary rate in health care is its roots; others take the task of balancing more costs on the backs of the consumers who can least afford them: the poor, the working poor and senior citizens. CCHCC's health coalition will mobilize low- and moderate-income organizations to guarantee that our voices are heard in the debate on health care cost-control, and that our interests are represented in any solutions adopted.

Coles, Vermilion and Champaign Counties will be included in CCHCC's coalition project, expanding CCHCC's geographic area. Two half-time staff people have been hired to work on the project: Clayton Daughenbaugh, based in Coles County, and John Lee Johnson, covering Champaign and Vermilion Counties. Each county-wide coalition will address health care issues in their area and in addition, will coordinate support for the Medicare Solvency and Health Care Cost Control Act of 1984 -- national legislation which would institute statewide cost containment measures for hospitals and doctors.

'OH SURE, WE CAN STILL AFFORD TO GET SICK... IT'S GETTING WELL THAT'S OUT OF THE QUESTION...'

CCHCC's project will join a newly-found network of state and national organizations working on the issue of health care cost-control. This network includes the Illinois Public Action Council, the National Council of Senior Citizens, National People's Action and Citizen Action. Each of these organizations has been working on health care issues independently, with little or no coordination of their respective efforts. The Villers Foundation is spearheading an effort to formalize this network and, in doing so, will create a stronger, more effective lobbying force on state and national health care issues.

The coalition got off to a rousing start on July 11th, as 40 statewide organizations, headed by the Illinois Public Action Council, sponsored a day-long conference on the status of health in America.

Twenty-two senior citizens from the CCHCC Task Force on Health Care Cost Containment traveled to Chicago, carrying with them over 100 signed testimonies from senior citizens throughout Champaign, Vermilion and Coles Counties. These testimonies documented the crippling effect spiraling health care costs have on consumers in our area. Seniors testified to the loss of their homes due to unpaid medical bills, and to delaying needed medical care due to their inability to pay for hospital costs or doctors' visits. The burdensome cost of prescription medication -- a cost frequently not covered by state or federal programs -- was another prevalent concern.

The Chammpaign group heard similar stories from numerous speakers at the conference, as well as a firm desire by all present to speak to the issue of health care costs and to unite for the fall campaign, so that the concept of health-care-for-all may become a political reality.

At the conclusion of the conference Mamie Smith of the CCHCC Board expressed her personal appreciation for the seniors who made the trip to Chicago. In the words of one Task Force member, the conference was "one small step of participation, but a gigantic step for seniors."

Individuals interested in learning more about the coalition health projects should contact John Lee Johnson in Champaign at (217)352-6533, or Clayton Daughenbaugh in Charleston at (217)345-7203.

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about? Nowhere in his letter does Crane mention the difficulties patients have with the present system. He expresses no concern about the doubling of Medicare's deductible, the reduction in reimburseable services by Medicaid, or corporate efforts to gain health benefit "give-backs" from their employees. He is worried, however, that we might not want "health care professionals regulated like the electric company is regulated".

Mr. Crane seems most anxious about the difficulties the Kennedy/Gephardt legislation might cause health care professionals. He identifies himself as one of the club by putting D.D.S. (Doctor of Dental Science) below his signature, something his letters normally don't carry. Indeed, he even assumes we share this anxiety over regulation of the health care industry. That is the only instance in which his letter considers the feelings of consumers.

It is certainly true the opinions and needs of our health care professionals are deserving of respect and consideration. However, they are the priviledged and prosperous in the industry. The average net income for a physician is now over $100,000 a year. One can be certain the average net income of health care consumers is well below that. So far below, that few of us can afford to be sick or injured.

In his letter opposing the Kennedy/Gephardt bill, Crane does not offer, or even allude to, an alternative method for slowing health care's cost spiral. It would appear he prefers the system as is. Is Crane protecting the priviledge and prosperity of the health care providers while consumers are forced to mortgage their lives to regain their health? With such a status quo the hospital begins to look more and more like a company store.

Our last issue of the Health Care Consumer featured a detailed description of the Kennedy Gephart legislation and a postcard statement of support we asked readers to sign and send in. Cards supporting the bill have also been distributed to individuals and organizations participating in CCHCC's new tri-county health coalition. To date, we have collected over 300 cards. If you'd like to participate in our card campaign or would like more information about our other activities on health care cost containment, please call our office.

CCHCC Moves to Protect Carle

Soon after Carle purchased Savoy Terrace Nursing Home, Charles Van Vorst, President of Carle Foundation stated that Carle would improve the reputation of the nursing home by "managing it differently". On March 7th members of the Health Care Consumers publicly denounced one feature of the nursing home's "new management style" at a demonstration held at Carle Clinic's University Ave. entrance. At issue was Carle's attempt to evict 80 Public Aid residents from the newly named Carle Arbours facility. In addition to demanding an immediate halt to all discharges from the facility, the Health Care Consumers criticized the intentions and integrity of the Carle Administration. In a statement delivered to the press at the demonstration, Mary Evans said, we are here "to express our sense of outrage at the intolerable behavior of the Carle Foundation toward Public Aid residents at the Carle Arbours Nursing Home. Carle's disregard for the rights of these residents is nothing but pure hypocrisy when it comes from an institution which spends so much on advertising aimed at convincing this community of it's desire to serve."

The actions of the Carle Administration that led to the CCHCC protest occured in the preceding three weeks. A letter was sent by the Carle Administrators on Februray 17th to 80 Public Aid residents at Carle Arbours. The letter stated that as of March 18th, they would no longer be offered a Medicaid-certified bed at the Carle Arbours facility: that on or before that date they would have to find somewhere else to go. On February 27th, Richard Grabher of the Illinois Department of Public Health notified Carle that their action was in violation of the 1979 Il. Nursing Home Reform Act and that they could not ask the residents to leave the facility for the reasons they had given. Instead of notifying residents that they were not obligated to leave the facility, the Carle Administration continued to "assist" the residents in transfering to other facilities.

Despite broad knowledge of the transfers throughout the medical, regulatory, and social service community, little or no action was taken to force Carle to stop the illegal transfers. With Carle controlling a majority of medical resources in the community, many institutions, agencies, and organizations appeared simply unwilling to challenge their actions - even though Carle was violating the law; the rights of the nursing home residents; and throwing the residents lives into turmoil.

What these organizations knew, and what Carle knew, but was not telling the Carle Arbours residents, was that the law provides only three reasons for involuntary transfers from a nursing home. These are: medical reasons (i.e. an individual has to go to the hospital); resident safety; or non-payment. The law further states that if a facility wishes to reduce the number of Public Aid residents at a facility they may do so, but that it must be accomplished by attrition, they cannot force residents already at the facility to leave.

On March 2nd, Cynthia Ward, Executive Director of the Health Care Consumers, and Patrick Harvey of Illinois Public Action Council's Senior Citizen Task Force visited several residents at Carle Arbours. "They were utterly amazed when we told them Carle could not force them to move out," says Ward. "We knew that at least twelve residents had already been transferred. When we visited the residents and learned that most still thought they had to leave - that many wanted to stay - and that more residents were being moved each day, we knew we had to act quickly."

The following Wednesday, over 30 individuals from the Health Care Consumers, Seniors Organizing Seniors (SOS) and Illinois Public Action Council (IPAC), battled the cold spring wind to picket Carle Clinic. Chanting the slogan of, "1, 2, 3, 4, If you're poor, you're out the door" the picketline was joined by several Clinic patients and encouraged by the honking of passing cars. Even some of Carle's employees observing from the windows seemed to offer at least tacit support to the action.

Reading from a letter to Charles Van Vorst, Clara Greenblau of CCHCC delivered seven demands to the Carle Administration. CCHCC demanded that Carle: immediately halt all transfers; notify residents who had already been transferred that they could return; meet regularly with the Carle Arbours Resident Council; place a resident on the Carle Arbours Board of Directors; maintain at least 50 % of Carle Arbours bed space for Public Aid residents; and abandon plans to develop a seperate wing and dining room for private pay residents. The letter closed by stating that Mr. Van Vorst should respond to the demands in a statement to the press

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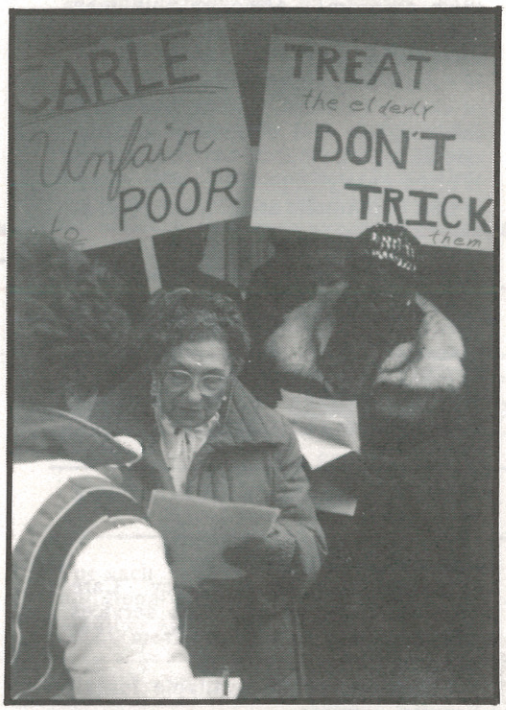
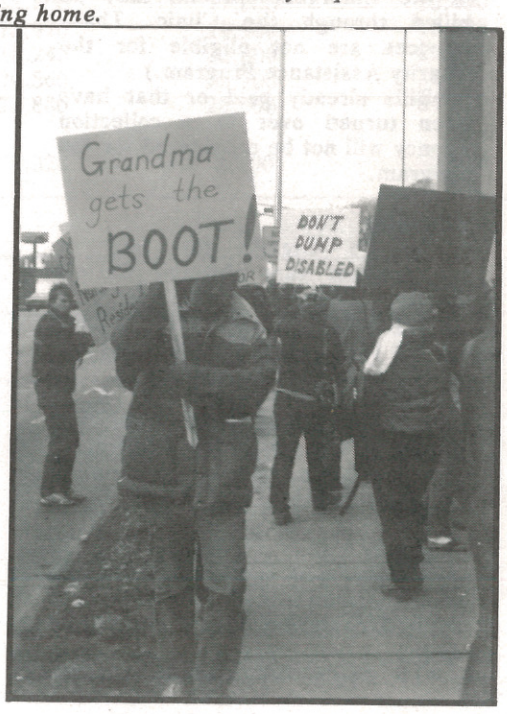


Clara Greenblau reads CCHCC's seven demands on Carle Arbours nursing home residents' rights before delivering them to Mr. Charles VanVorst at Carle Hospital.

Nursing Home Residents Rights

CCHCC members turned out in force to protest Carle's treatment of residents at their newly aquired Carle Arbours nursing home.



Free And Low-Cost Hospital

In January, the last of Champaign/Urbana's three Hill-Burton hospitals, Mercy Hospital, completed its federal requirement to provide free and low-cost care to individuals unable to afford hospital care. Like the other two area Hill-Burton hospitals, Burnham City Hospital and Carle Hospital, Mercy established its own free-care program to replace the federaly-mandated Hill-Burton program. As we have reported in earlier editions of Health Care Consumer, CCHCC's Hill-Burton Task Force was instrumental in raising the issue of, and generating public pressure demanding the establishment of, post-Hill-Burton free-care services.

Pressure from the Hill-Burton Task Force led each of the hospitals to adopt written eligibility guidelines for their programs. Although this may seem only logical, it is in fact a major accomplishment, for while many hospitals may claim to have free-care or charity services, finding out about the program and obtaining information about whether or not you qualify is often nearly impossible. The result is that individuals are often subject to the whims and prejudice of the hospital staff who determine eligibility for free care.

In addition to reducing discriminatory distribution of free-care funds, published guidelines allow individuals to determine whether they will qualify for free-care services before they receive medical care. With many individuals delaying seeking treatment because they don't have money to pay for the services, published guidelines help ensure that those in need of medical care receive care.

With three of Champaign-Urbana's

CARLE HOSPITAL'S CHARITY ASSISTANCE PROGRAM

Note: Since we have yet to meet with Carle concerning their Charity Assistance program, we have the least information about this program. The information contained below was compiled from a Carle advertisement that appeared in the News Gazette and from phone calls to Carle's Business office.

Program Description

•Carle's Charity Assistance Program includes free-care services and discounts on services from 75% to 25%.

•If you are eligible for discount services, and you make regular payments on the remainder of your bill, no finance charges will be added to your account.

•The program is available for all services provided at the hospital and billed by the hospital. (If is important to note that some services you receive at the hospital, such as some tests run in the Emergency Room, may be billed through the Clinic. These services are not eligible for the Charity Assistance Program.)

•Bills already paid or that have been turned over to a collection agency will not be considered for the program.

Eligibility

•To be eligible for free or reduced-cost care through Carle's Charity Assistance program, your gross (including taxes) family income for the past twelve months must fall below the income guidelines (see Chart A).

•Although Carle had not published guidelines for assets, the Carle Billing office states that they "take savings into consideration."

To Apply

•Before you apply for Carle's Charity Care Program, you must first apply for, and be denied by, Public Aid.

•To apply for Carle's Charity Assistance Program, call or visit Carle Hospital's Business Office and ask to speak to the Accounts Receivable Manager. (the phone number is 337-3030) Carle will let you know if you are eligible for the program within five working days.

MERCY HOSPITAL'S MERCY CARE PROGRAM

Program Description

Mercy Hospital's Mercy Care program includes free care services and discounts on services from 75% to 25%.

•The program is available for all hospital services

•Bills already paid or that have been turned over to a collection agency will not be considered for financial assistance.

•Spend-downs for Public Aid and deductibles for Medicare will be considered for financial assistance.

Eligibility:

•To be eligible for free or reduced-cost care through the Mercy Care program, your gross family income for the past twelve months must fall below the income guidelines, and the total value of your families assets must be below the asset guidelines. Assets include: property, cars, savings, stocks, bonds, etc. Although Mercy includes the value of a family's home and car in with assets, we have been assured that some flexibility exists in the guidelines, and that in some cases they will be exempted. For income guidelines, see chart B: for Mercy's asset guidelines, see Chart C.

To Apply:

•You may apply for the Mercy Care program any time before or after you receive services at Mercy.

• Before you apply for the Mercy Cares Program you must first apply for, and be denyed by Public Aid.

•To apply for the Mercy Care program contact Mercy at 337-2233.

BURNHAM CITY HOSPITAL'S FINANCIAL ASSISTANCE AND CHARITY CARE (FACS) PROGRAM:

Program Description:

•Burnham's Financial Assistance and Charity Care (FACS) program includes free care services and a low-cost interest-free payment plan.

•Under the payment plan, individuals pay monthly installments of from $10 to $30 for a maximum of 60 months or until the bill is paid. No finance charges are added to these accounts. (For example: If you have a bill for $2500 and you qualify for the $10/month payment plan, you would pay $10 for 60 months, or a total of $600)

•The FACS program is available for all hospital services.

•Bills already paid or that have been turned over to a collection agency will not be considered for financial assistance.

Eligibility

•To be eligible for the FACS program, your gross family income must fall below the income guidelines; and, your families assets must be below the asset limits. Burnham does not include a families home or car in the asset limit.

•If you are eligible for the payment plan of the FACS program, your incme will be reviewed yearly; adjustments in your payment plan will be made if your income or asset level has changed. If your income changes before the annual review date, you may request that your payment level be changed.

•For income guidelines, see Chart D: for asset guidelines, see chart E.

To Apply:

•You may apply for the FACS program any time before or after you receive services at Burnham Hospital

•Although Burnham may require you to apply for Public Aid before giving you financial assistance, they will take your application at any time and will inform you within seven working days if you will be

Care In Champaign-Urbana

four hospitals publishing guidelines for their free-care services (Cole Hospital has not), local consumers have an additional benefit: not only can individuals determine whether they will be eligible for free or reduced-cost care before receiving services, individuals can determine which hospital's free-care program best meets their financial needs. Included below are summaries of the free-care programs available at Burnham, Mercy, and Carle Hospital. When reviewing the summaries, keep in mind that the following factors may influence which hospital's program will best meet your financial needs: anticipated cost of hospital care; level of your families assets; and, type of your families assets. If you'd like more detailed information about any of the programs or would like assistance in determining which program best meets your financial needs, please call the Health Care Consumers at 352-6533.

In addition, if you have any comments, concerns or observations about these programs, please let us know. Over the past year, members of the Health Care Consumes have met with representatives from Mercy and Burnham Hospitals, at their request, to discuss the hospital's free-care programs. Many suggestions by CCHCC have been, or are in the process of being, incorporated into Burnham and Mercy Hospital's free-care programs. Carle has, as of yet, declined our invitation for input. We will, however, be contacting them again in the near future to repeat our request to discuss their free-care programs.

eligible for the FACS program if you are denied by Public Aid.

•To apply for the FACS program, call Burnham at 337-2500 and ask to speak to your Business Office Account Representative.

Chart A

Carle Hospital
Income Guidelines

Size of Family	No Charge	75 % Discount	50 % Discount	25 % Discount
1	4,800	5,800	6,900	9,000
2	6,300	7,000	9,100	11,600
3	7,800	9,400	11,300	14,200
4	9,300	11,200	13,500	16,800
For each additional family member add:	1,500	1,800	2,200	2,600

Chart B

Mercy Hospital
Income Guidelines

Size of family	No charge	75 % discount	50 % discount	25 % discount
1	4,980	6,640	8,300	9,960
2	6,720	8,960	11,200	13,440
3	8,460	11,280	14,100	16,920
4	10,200	13,600	17,000	20,400
5	11,940	15,920	19,900	23,880
6	13,680	18,240	22,800	27,360
7	15,420	20,560	25,700	30,840
8	17,160	22,880	28,600	34.320
For each add'l family member	1,740	2,320	2,900	3,480

Chart C

Mercy Hospital
Asset Guidelines

Size of Family	Asset Level
1	$1,500
2	2,250
3	2,300
4	2,350
5	2,400
6	2,450
7	2,500
8	2,550
For Each Add'l Family Member	Add $50

Chart D

Burnham Hospital
Income Guidelines

Size of Family	Patient Payment	$ -0-	$ 10 per month	$ 20 per month	$ 30 per month
1		5,000	6,700	8,350	10,000
2		6,750	9,000	11,250	13,500
3		8,500	11,350	14,200	17,000
4		10,200	13,600	17,000	20,400
5		11,950	15,950	19,950	23,900
6		13,700	18,300	22,850	27,400
7		15,450	20,600	25,750	30,900
8		17,200	22,950	28,700	34,400
Each additional person add:		1,680	2,880	2,240	3,360

Chart E

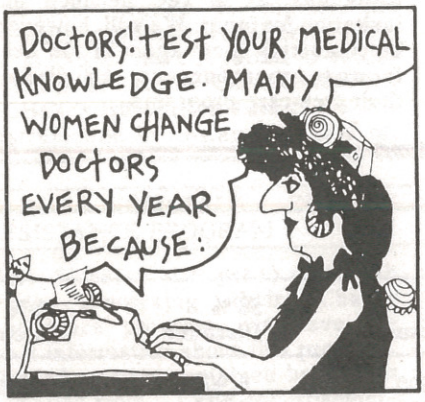
Burnham Hospital
Asset Guidelines

$1500	1 person family unit
$2200	2 person family unit
$2240	3 person family unit
$2300	4 person family unit
$2350	5 person family unit

Add $50 for each additional person.

Nurse-midwife to Practice

After close to two years of organizing, CCHCC's Midwifery Task Force has realized their first goal: nurse-midwifery services in Champaign County! Barbara McFarlin, a nurse-midwife from Chicago, will be joining the practice of Dr. Suzanne Trupin in October. A flurry of



activities by CCHCC's Midwifery Task Force, starting with National Nurse-Midwifery week in March, led up to this announcement.

During the National Nurse-Midwifery Week, the Task Force launched an all-out effort to bring the Champaign County Medical Society (CCMS) to the meeting table. Since last October, the Task Force had made several requests to meet the medical society - all of which were ignored. Believing that this cold-shoulder treatment resulted from the local physician's assumption that there isn't a need or demand for nurse-midwifery services, the Task Force set out to prove that such isn't the case.

During the week, the Task Force collected over 200 postcards written by local consumers detailing their support for nurse-midwifery. The postcards, which were addressed to the medical society, contained a wide range of viewpoints and messages. Many, such as Linda Flotow, wrote that if nurse-midwifery services were available in this community, they would use them. "Many women in this area, including myself, are looking for the type of care that nurse-midwives provide. Their attitude that birth is a normal, although special physical process, rather than a state of ill-health, is a much more positive approach. Perhaps the medical community does not realize that a doctor who adds a midwife to his team will increase his number of patients. I, for one, will switch to whichever doctor provides midwifery care," Flowton stated. Another wrote, "I urge you to reconsider your present stand on nurse-midwifery. All local citizens deserve a choice of types of medical treatment. My family would use this form of non-interventionist care, if it were available in Champaign County."

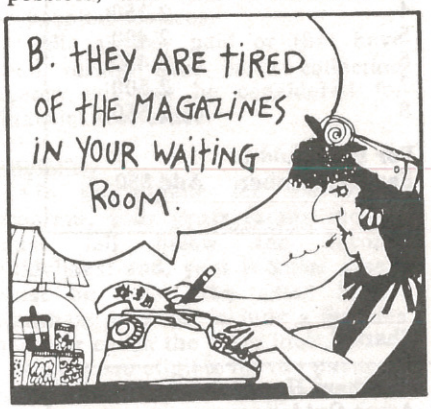
Others told of the lack of prenatal care they experienced due to low-incomes and of their hope that nurse-midwifery services would help meet this need. One woman wrote,

"As a mother and a medical customer, I am strongly in favor of your allowing and encouraging the practice of nurse-midwifery in Champaign County. Because of economic hardship, I didn't seek prenatal care 'til six months into my pregnancy. I wonder how many women get no prenatal care because of money?"

Several individuals criticized the medical society for their unwillingness to meet with the Midwifery Task Force. One individual, who said that while she was not sure of her position on nurse-midwifery, "I do feel that the Champaign County Medical Society should have the courtesy to meet with the Health Care Consumers to discuss the issue. Too often professional groups seem to lose sight of the fact that their reason for existence is to regulate professionals and protect the public, not to promote a monopoly."

In a press conference held on March 8th, Task Force member Nora Harvey announced the results of the postcard campaign. "We knew that there was support for nurse-midwifery in this community, but even we were surprised by the extent and diversity of support that was shown by the postcards! It is our hope that the medical society will be equally impressed." The following Monday, postcards were sent to every physician in Champaign County along with a letter asking them to support the Task Force's request to attend a CCMS meeting.

The Task Force's postcard campaign was successful, and on July 14th three Task Force members addressed the Champaign County Medical Society at their monthly meeting. Task Force member Nora Harvey set the tone for the evening, telling the medical society members, "We know that someday Champaign-Urbana will have Certified Nurse-Midwives. Our efforts are aimed at seeing that they come as soon as possible, and with a minimum of



agitation on anyone's part. We have communicated with you in the past, and are here this evening in the hopes that you will tell us your concerns so

Carle con't from pg. 5

within four days.

One immediate result from the demonstration was that the press, who for the previous week had been stonewalled by the Carle Administration, were granted an interview. Carle's spokesperson, Cathy Emanual told the press an interesting story. She said the residents had not been forced to leave, but that they had voluntarily made the decision to leave when Carle told them the nursing home was changing the focus of the facility to geratric sub-acute care. Furthermore, Emanual said she was not aware of the "alleged" February 17th letter. If, before responding to the press, Emanual had read this "alleged" letter that was sent by the Carle Administration to the 80 Public Aid resident, she would have been aware that it says, "It is the decision of this facility to discharge you. After the date of the discharge (March 18th) you will be responsible for securing shelter and health care for yourself outside the facility."

"Carle may have been calling the transfers voluntary - but we knew they were not. Carle was coercing residents to leave by keeping them under the false assumption that they had legal grounds to do so," states Patrick Harvey. Following the demonstration at Carle, eight of the protesters continued out to the Carle Arbours facility. "We want out to Carle Arbours to talk to the residents - to make sure that they all knew that Carle couldn't force them to leave. We had demanded that Carle do this - but given their previous actions - we didn't think we could

that we may have the opportunity to address them."

Nora then reviewed a fact sheet prepared by the task force outlining common concerns about nurse-midwifery. (SEE SIDEBAR.) Rounding out the presentation, the physicians were asked to fill out a questionaire on their support for and/or concerns about nurse-midwifery. Although only 10 questionaires were returned, 6 said that they supported nurse-midwifery; and only 1 said he did not support nurse-midwifery.

In addition to the unexpected physician support for nurse-midwifery shown in the questionaires, Dr. Suzanne Trupin announced at the meeting that she was in the process of interviewing nurse-midwives. It was late July when the Task Force received a call from Dr. Trupin indicating that she had hired a nurse-midwife who will begin practice in October.

"We are overjoyed that we have finally reached our goal of nurse-midwifery services in Champaign County", Loretta Morales, Chair of the Midwifery Task Force recently said. "I've been involved with the Task Force from the start and I must admit that there were times when I thought we'd never reach this point. But also after being involved for this long I realize that this is just the first hurdle in the long road towards getting the type of birthing options women need and want. I think the first reaction of the task force was to say, "We finally got here," but their second reaction was to say, "Now lets get back to work."

Fulfilling that statement, the Task Force has been busy meeting with representatives from local hospitals, developing a position paper, and arranging to meet with Dr. Suzanne Trupin and the new midwife. Anyone interested in becoming involved in the Task Force or in receiving monthly mailing about the Task Force activities should call CCHCC.

trust them to comply," says Harvey. This assumption proved to be correct. The Carle Arbours staff did inform the residents that they did not have to leave the facility by March 18th - but then told the residents that they mighthave to leave before April 18th. Members of CCHCC IPAC, and SOS told the residents that this was again not true and assisted residents in securing legal representation.

In the days following the demonstration, the Illinois Departments of Public Aid, Public Health and the Attorney General's Office began investigations into the case. On March 12th, Mr. Van Vorst notified CCHCC that he had complied with CCHCC's first demand: an immediate halt to all transfers. No mention of CCHCC's other demands were in the letter. However, the department of Public Health has since forced Carle to comply with CCHCC's second demand. Carle sent letters to all the residents who had been transferred from the facility informing them that if they wished, they could return to the Carle Arbours facility.

With the involvement of the Health Care Consumers, SOS, and IPAC, the immediate concerns for the nursing home residents have been resolved - they can remain at, or return to the Carle Arbours facility. However, the long-term issues in this case have yet to be resolved. "What concerns me most is that Carle almost got away with it!" states Cynthia Ward. "We caught them this time - but given Carle's actions in this and other cases, it wouldn't surprise me if they take other actions that ignore the legal rights of the residents and their moral obligation to serve. We need stronger and swifter enforcement mechanisms to assure that all nursing home administrations - even ones as powerful as Carle - cannot willingly violate the rights of nursing home residents."

Answers to Common Questions about Nurse-Midwifery

What is the legal status of Certified Nurse-Midwives (CNM) in Illinois?
Despite a common myth that nurse-midwives are illegal, over 125 CNM's are legally practicing in Illinois. CNM's in Illinois are regulated by the Department of Registration and Education and practice under the Nurse Practice Act. State regulations define midwifery practice as "the observation, care, counsel and management of the uncomplicated patient throughout the reproductive cycle, within the framework of a health care team organized to provide maternity care and directed by a qualified obstetrician-gynecologist."

Does a nurse-midwife attended birth mean a home birth?
No, not necessarly. The 125 CNM's practicing in Illinois do so in a variety of settings: as part of hospital services, hospital-based alternative birth centers, health maintenance organizations (HMO's), state or local public health departments, private practice with obstetricians and nursing or nurse-midwifery educational programs. CNM's have practiced within hospital maternity settings in the U.S. since 1959. According to a 1977 survey by the American College of Nurse-Midwives, 45.6 % of the CNM's practicing in the U.S. were in hospital settings.

Why would consumers choose CNM's when physicians are available?
Ten to twelve years ago, childbearing couples were demanding a more home-like environment as opposed to a typical delivery room setting in which to give birth. Although birthing rooms met tremendous opposition from many physicians and hospitals, it is now clear the demand has outlived these unfounded fears. Similarly, the demand for nurse-midwifery services is on the rise. A number of authors have found that in addition to a more economical alternative, women are also looking for more personalized care than what is offered through conventional obstetrical care. Although many physicians argue that their services are no different from those of nurse-midwives, the increased use of midwives is a good indicator that some women still prefer to make their own choice.

Are CNM's qualified to deliver care safely and economically?
CNM's are highly trained professionals. A CNM is educated in two disciplines: nursing and midwifery. CNM's are registered nurses who have graduated from an accredited school of nurse-midwifery and who have passed the national certifying examination administered by the American College of Nurse Midwives.

Here in Illinois, the University of Illinois at Chicago (since 1973) and Rush Presbyterian St. Luke's Medical Center (since 1983) offer graduate programs in nurse-midwifery. CNM's are educated to provide prenatal care, manage labor and delivery, care for the newborn, and provide post-partum care, including family planning.

One study examining the issues of safety and cost before and after the implementation of a nurse-midwifery program reported a decrease in expenditures for perinatal care with a concomitant decrease in infant mortality.

With the health care community focusing on cost containment and consumers looking for lower charges and more personalized care, CNM services become a logical and necessary option.

Collective Bargaining - Effects on Patient Care

With the 1969 legislation granting the right to health care workers to participate in collective bargaining, unionization in the health care field has become a topical issue among health care consumers. Recent nurses strikes in Minneapolis and New York have further highlighted the issue, raising questions about the effect unionization has on the cost and quality of patient care. So as not to neglect this important development in the health care system, CCHCC sponsored a community forum entitled: "Collective Bargaining in Health Care: Effects on Patient Care" on May 14th at the Champaign Library.

In planning the forum, we originally planned to have panelists who represented both union and management perspectives. Unfortunately, none of the numerous health care administrators or Illinois Hospital Association representatives we contacted accepted our invitation to speak. Rather than cancel the forum, we asked the panelists, all of whom support the right to collective bargaining for health care workers, to also address what they knew of management perspectives on this issue.

The first panelist to address the 50 consumers and health providers at the forum was Professor Ronald Peters, of the University of Illinois' Institute of Labor and Industrial Relations. Ron began by summarizing the Supreme Court decisions which established the legal right of health care workers to organize and bargain collectively. He described the 1935 Wagner Act, landmark legislation in protecting the rights of workers to organize, which specifically excluded health care workers. It was not until 1969, with the passage of an amendment to the National Labor Relations Act that health care workers were extended similar protection under the law. Peters also noted that since 93.7% of health care workers are women, the Women's Movement in the '70's had a significant impact on the rise of union activities in the health care field. A few of the anti-union strategies employed by health care administrators were also reviewed by Ron. One recent and very important development he described is the hiring of management firms specializing in advertising and sophisticated management techniques to prevent unionization.

Pat Barnett, an organizer employed with the Chicago office of the Illinois Nurses Association, was the second panelist. Pat highlighted some of the developments in the overall health car system which directly affect health care workers. One development she described is the increasing demands high technology place on the skills of

health care workers: demands which affect not only health care workers but health care consumers. Many hospitals meet changing personnel needs by assigning nurses to departments outside their speciality - often with little or no training. Bargaining for adequate training and reduced "cross-departmental shifts" have been key issues in several nurses union contract negotiations. Increased unionization among health care workers will improve patient care, according to Pat, by ensuring that hospitals and nursing homes hire an adequate number of qualified staff and provide adequate training to meet the needs of patients.

The final panelist of the evening, Peter Powell, of the International Brotherhood of Electrical Workers described his recent work organizing health care workers in a nursing home in Vermilion County. He told the audience that the workers at the nursing home want a union so that they can bargain for increased pay, a 40-hour work week, increased medical insurance coverage, and a standardized policy for sick days, days off, and vacation time. While some of these demands may seem to raise the cost of health care for consumers, they in fact may not. The majority of jobs in the health care field are poorly paid and have a very high turn-over in employees. If conditions were such that health care workers were more satisfied with their work, they would stay longer, gain more skills, and the costs of training new staff would decrease. Increased salaries, and better working conditions may in the end result in over-all cost savings to the consumers and a higher quality of care.

Following the forum, we asked the audience to fill out questionaires about what they did and didn't like about the forum. Several of the respondents complained that we did not present a "balanced picture" on the issue. All we can say is, we tried.

Fluoridation

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found that fluoridation is a health risk and he declared the law unconstitutional. Incredibly, the defendants have appealed the case to the Illinois Supreme Court.

We who oppose fluoridation do not seek to prevent others from taking fluoride. It may be purchased in tablet form at minimal cost. Used in this manner, it is prescribed in precise dosage and may be discontinued if ill effects occur. (See U.S. Pharmacopeia for possible side effects.) Our objection is to the use of the public water supply to dispense a prescription drug to everyone en-masse.

No one is infallible. A true scientist does not claim to be. Along with the many great triumphs in medical history, there have been tragic mistakes, i.e. in recent years the swine flu vaccine, thalidomide, DES, etc., but these were acknowledged and the products withdrawn when the awful effects became known. What is absolutely intolerable is to deny the error and compound the tragedy.

Why are the advocates so tenacious in their defense of fluoridation in view of the enormous body of evidence against it? That is a question which they should be called upon to answer.

1. National Fluoridation News, Nov./Dec. 1981 contains a list of 13 fluoride spills which occured in the U.S. between 1972 and 1981.
2. National Fluoridation News, Route 1, Box 139, Gravette, Arkansas 72736. Subscription rate: $2.50 year.
3. G.W. Waldbott, A.W. Burgstahler, and H. L. McKinney, Fluoridation: the Great Dilemma, Coronado Press.

J. A. Yiamouyiannis, Fluoride, the Aging Factor, Health Action Press, 1983. Anne-Lise Gotzsche, The Fluoride Question, Stein and Day, Publishers, 1975.

Viewpoints

The Fluoridation Controversy

by Mrs. Allen Sapora

You can't taste it or smell it. In fact many people don't know it is there, but everyone who uses a public water supply in the state of Illinois is getting an indiscriminate dose of fluoride every day. State law requires that this prescription drug be added at the rate of approximately 1 part per million. Why worry? Isn't that just "a drop in the bucket?" Yes, but two drops in that bucket is illegal and officially recognized as unsafe! In warmer climates only 0.6 part per million is allowed to be added because presumably people drink more water there. This seems to indicate a very small margin of safety. Actually, the safety factor is zero because some people are suffering ill effects at the prescribed dosage. Fluoride is similar to arsenic or lead in its ability to cause chronic poisoning from the ingestion of minute amounts over a period of time. It accumulates not only in the teeth but in the soft tissues as well.

Fluoride is one of the most corrosive substances known. It is a waste product of fertilizer, aluminum, and other manufacturing processes and formerly constituted an enormous disposal problem. Since fluoridation began, it is delivered over our highways in rubber-lined tank trucks to be metered into water supplies all across the nation. Chemical Week, n 1951, noted that "the market potential has fluoride producers goggle-eyed." A problem encountered very early was severe corrosion of water pipes and mains, especially where the water is soft--low in minerals such as calcium. This problem was only partially solved by the addition of lime or sodium hydroxide. Each week in cities large and small, tons of fluoride, a non-biodegradable poison, are added in an effort to reduce tooth decay in children. This shot-gun approach is adding further contamination to our already polluted lakes, rivers, and coastal waters.

Fluoridation was introduced in 1945 by dental and Public Health officials and soon was hailed as the greatest health program in dental history. In all good faith, they thought they had finally discovered an easy and effective way to improve dental health. Since then they have been zealously promoting it, using government appropriations of many millions of dollars each year--despite the increasing opposition of scientists and laymen. Our tax dollars were also used for many years throughout the world to trump up support for this "boon to mankind", but very few other countries adopted it because their professional people had free and open discussions of both sides of the issue and have advised against it.

In contrast, in the United States the advocates of fluoridation, from the very beginning, declared the issue closed and non-debatable. Anyone openly opposing it has risked ridicule or even slander. (A flagrant example is the editorial, American Dental Ass'n Journal, Nov. 1962) This has effectively silenced all but the most intrepid opponents. Certainly the way to resolve conflicting viewpoints is through open and unrestricted evaluation of all available data on the subject. This has not been allowed to take place in regard to fluoridation. A Canadian researcher has called this a "tragedy in the life of science."

Adverse evidence has been coming in from scientists in various fields throughout the world for over thirty years. Clinical, laboratory, and epidemiological research has shown that the cumulative effect of even 1 ppm of fluoride added to drinking water is harmful to at least a part of the population. The symptoms of chronic fluoride poisoning are many and varied because of fluoride's well-known inhibiting effect on enzymes, which are involved in all body functions. They include headache, gastro-intestinal disturbances, urinary tract irritation, arthritis, skin rash, etc. Fluoride has also been associated with an increase in cancer, birth defects, and premature aging.

We are approaching a "critical mass" of fluoride in the environment caused by water fluoridation, foods processed in fluoridated water, fluoride supplements, mouth rinses, toothpastes, certain anesthetics and medications, pesticides, fertilizers, air pollution, etc. This may be aptly described as fluoride 'overkill'.

The advocates of water fluoridation never use the term "artificial". It is called "controlled fluoridation", obviously a misnomer because the dose depends on the amount of water consumed. Even control at the water plant may be erratic. There have been numerous fluoride spills and overfeeds due to mechanical or human error, resulting in widespread illness and at least one death.1 Litigation is in progress. Several deaths have resulted from the use of fluoridated water in hemodialysis. Such tragic accidents would be expected to make headlines across the nation but few people have heard about them. National Fluoridation News, a quarterly, non-profit newspaper, is published to disseminate general and scientific information not readily accessible to the public.2 Fluoridation has not received the serious scrutiny it deserves in major U.S. professional journals or in the public press.

Many scientists feel compelled to speak out against what their research has shown to be a serious medical-dental blunder. A number of books have been written on the subject; several are in our local libraries.3 A classic in the field is Fluoridation: the Great Dilemma, by Drs. Waldbott, Burgstahler, and McKinney. It contains a voluminous bibliography for further investigation. Cancer Research, March 1984, noted some recent and disturbing research on the subject. Environmental Action, July/August 1984, contains a five page critique of fluoridation and the methods used to promote it.

Scientific expertise is not required to recognize the following facts: A competent doctor would never prescribe a medication without prior examination of the person involved; he would never tell the patient to take as much or as little of the prescription as he chooses; he would never prescribe the same dosage for infants, the aged, the sick and the well. And of course he would not and could not force a patient to take a medication against his will. Fluoridation does all of the above. It is compulsory mass medication for a non-contagious disease--an alarming departure from accepted medical ethics and practice.

From Maine to California there has been continuing controversy on this issue, with bitter arguments, lawsuits, and referendums taking place. Some cities have defeated it many times but the promotion continues. A lawsuit was filed in Illinois in 1968 against statewide mandatory fluoridation. After 14 years of evasive action and postponements by the defendants (the Dept. of Public Health and the EPA) the case was finally heard in Circuit Court. After 10 weeks of testimony, Judge Ronald Niemann

continued on page 10

Health Advocate Reports.....

Trouble with a Collection Agency?

If you have any unpaid medical bills, you may suddenly find yourself confronted with a barrage of letters and phone calls from a collection agency. Intimidating as this may be, there is a limit to what the agency may say and do in trying to collect from you. You **do** have rights.

•A collector may not contact you at a time or place that is inconvenient for you (such as at work, or before 8:00 a.m.).

•You may stop a debt collector from contacting you by sending him a letter asking him to stop. He may notify you again only to tell you of a specific action that may be taken -- but only if it's an action that the collector usually takes.

•The collector must not announce to anyone (except you and your attorney) the purpose of is trying to contact you. He may not send a postcard or put anything on an envelope to indicate that he is a debt collector.

•Within five days of first contacting you, the collector must send you a written notice stating how much money you owe, who the creditor is, and what to do if you think you don't owe the money.

•A creditor may **not**: threaten you with violence; swear at you; advertise your debt; or make any false claims about you, himself, forms being used or action being taken.

If you feel that the debt collector has acted illegally, you may sue within one year. Any questions or complaints should be directed to the Chicago Regional Office, Suite 1437, 55 E. Monroe St., Chicago, IL 60603.

Overcharged on Your Hospital Bill?

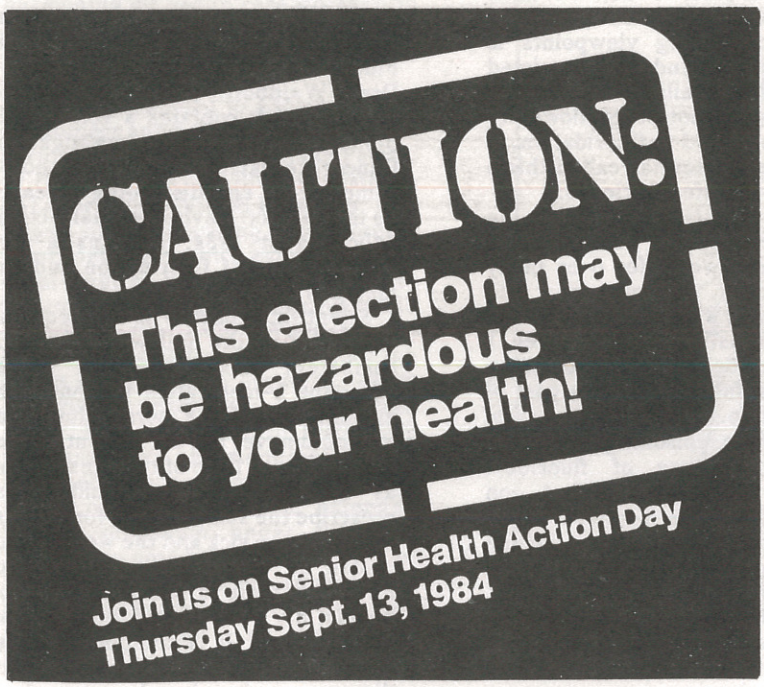
Equifax of Atlanta recently conducted a national survey and found that 93% of hospital bills contain errors -- and that 85% of these errors favor the hospital. From the calls we receive at the Hotline, we know the problem exists on the local level, too. One person found that every time he'd gone to a local hospital he's been overcharged! Many consumers who call us about other matters discover that, in addition, their hospital bill is inaccurate. What can you do to protect yourself from hospital overcharges?

First, demand an itemized bill. If you don't understand the bill, ask for an explanation.

Second, ask about costs before you receive a service, and then check your bill to see that the charges agree with the ones you were informed of earlier. It is not always easy to get a doctor or member of the medical staff to tell you what charges will be -- but it is worth your while to be persistent and find out at least a reasonable estimate in advance.

Third, if you find an error in your bill, notify the hospital in writing. Keep a copy of the letter you send.

Finally, during your hospital stay you might want to keep a list of the names of doctors who saw you, lab tests and drugs you were given, etc., as well as the dates and times services were rendered. This will help you check over your hospital bill when you receive it.



Health Care Consumers:

REGISTER AND VOTE!

Your vote can make the difference and that difference may affect: Medicare, Medicaid, and Health Care Costs. If you need to register (the deadline in Illinois is October 9th) or want to help register other voters, call us at 352-6533!

A vote is a terrible thing to waste.

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