HEALTH CARE CONSUMER

Winter | Newsletter of the Champaign County Health Care Consumers | 1989-90

Covenant Chief Promises Continuation of Medicare 100/Plus

On November 16, nearly 100 senior citizens braved the winter's first snow and single digit temperatures to attend a CCHCC sponsored forum featuring Mr. Joseph Beard, the first Chief Executive Officer of the new Covenant Medical Center. The purpose of the meeting was to open a dialogue with the new administration concerning the future of the Medicare 100 and Medicare Plus programs.

Right from the start, those in attendance wanted to hear what Mr. Beard had to say about these valuable programs. Established in 1984 by CCHCC and Burnham Hospital, both programs help eliminate or greatly reduce out-of-pocket medical expenses for senior citizens. When the City of Champaign initially proposed a merger between Burnham City Hospital and Mercy Hospital, it was unclear what commitment would be made for the continuation of Medicare 100 and Medicare Plus. And although the final merger agreement included specific language assuring these programs would continue through 1992, many wanted to know how aggressive the new administration would be in supporting these commitments.

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Coming Next Issue

- **CCHCC Challenges Patient Dumping at Christie Clinic**
- **Public Action Unveils Universal Health Care Plan for Illinois**

Governor Thompson was greeted by CCHCC members urging him to sign legislation aimed at helping community health centers. Thompson dodged the issue by signing "I'm thinking it over." He later vetoed the legislation for the second time (see story page 6). Photo by Lloyd Young, Daily Illini

Public Health Board Approves Changes in Dental Program

As part of its effort to increase local access to dental care for the poor, CCHCC's Low-Income Task Force targeted the Champaign-Urbana Public Health District (PHD). On November 29, those efforts paid off when the PHD board approved several new policies which should greatly expand access to dental care.

The PHD board first voted to study its dental care program on September 13, in response to concerns raised by the Task Force. At that meeting, Task Force member Debbie Doyle noted that the PHD's annual report for 1988 indicated that, on average, only 4 dental patients were being served each day by the PHD's full time dentist. The hygienist treated an average of 6 to 7 children a day.

"It is troublesome that, although there are 24 appointment openings available each day (12 each for the hygienist and dentist), this publicly financed agency is seeing less than half that number of people," explained Doyle. "At a time when dental care is so inaccessible for so many low-income families, it is unacceptable that this situation exists."

Leading the charge for an investigation, PHD Board Chair Ken Zeigler stated his support for taking a closer look at the program. "We need to get some idea of what the need is,"

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Consumer Backlash Grows as HMO Rates Climb

Consumer outrage at local HMOs picked up steam this fall as more rate increases were announced. A flood of calls came into CCHCC's offices from angry consumers last October, when individual rates were announced by PersonalCare HMO. One of the hardest hit groups was those aged 55 to 64, who saw their rates jump from $276/quarter to over $493/quarter. These same HMO members must now pay a 20% coinsurance on the first $3,000 for hospital visits, and a $10 copayment for each physician visit. In addition, these members and many others saw a drop in benefits, including the elimination of prescription drug coverage.

CCHCC Board member Judy Checker (left) announces that CCHCC and local unions will survey U of I employees about local HMOs.

The anti-HMO sentiments haven't surfaced only in calls to the office. A joint initiative of CCHCC and three unions based at the University of Illinois has received tremendous response from university employees, who saw their rates skyrocket and benefits shrink last spring. In an effort to solicit feedback from university employees about their HMO coverage, CCHCC, AFSCME Local 698, SEIU Local 119, and the Union of Professional Employees mailed out over 6,000 consumer surveys to university personnel.

"People feel very strongly about this issue," explained CCHCC board member Judy Checker at a news conference announcing the survey. "This survey will provide people with a chance to give their side of the HMO problem. Up till now, it's been the HMOs saying we need to change this, or adjust that. It's our hope that this survey will provide a foundation for what consumers want from their HMOs."

The response was incredible. Within days, over 2,500 surveys poured into our offices. Hundreds of employees not only filled out the survey, but took time to write out extended comments about their experiences.

The surveys are currently being tabulated, and the findings are expected to be released as the third in a series of HMO reports being put together by CCHCC. The first HMO study, released last September, challenged HMO industry claims that higher utilization by patients was the cause of skyrocketing rates and the introduction of physician copayments. That study found that utilization had dropped over the past five years, raising serious questions about the need for copayments and rate increases.

The second report will focus on where the money from higher premiums is going if it's not being used to pay for additional services. Theoretically, HMOs are designed to lower utilization, and thus hold down costs. Unfortunately, they seem to be doing only the first half of their job, by lowering utilization with no corresponding drop in rates.

CCHCC staff members are putting the finishing touches on this second HMO report after encountering serious difficulties in gathering the necessary data. Specifically, CCHCC found that CarleCare HMO contracts were not on file for public inspection as required by law, and that PersonalCare HMO had not filed required HMO utilization data. After numerous calls, letters, meetings, and some help from State Representative Helen Satterthwaite, the Department of Insurance eventually agreed to go back and get much of the missing information. The second report is expected to be released in January of 1990.

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agreed Zeigler. "We need to get some idea of to what extent the need is being met."

PHD Director Gale Fella had a number of excuses for the low numbers. One was that they closed the doors whenever the dentist was out of town on National Guard duty. Another was that there was a large number of no-shows for appointments. Both were quickly addressed by Task Force members who argued that the PHD should hire another dentist to fill in instead of closing the clinic. This suggestion was taken into immediate consideration and approved. As for no-shows, Task Force members pointed out that the PHD no-show rate was only about 10%, far below the 50% of dental appointments that were vacant.

"Many agencies experience some no-shows," explained Doyle. "The key is to determine what type of no-show rate you have and then overbook by that amount."

After completing its three month investigation, the PHD adopted several changes in its dental program which were recommended in a report prepared and submitted by Zeigler. In that report, Zeigler noted that "a major reason for the fact that the District's dental program is providing too little service is the appointment scheduling system ... that creates a lot of 'down time' in the dental department."

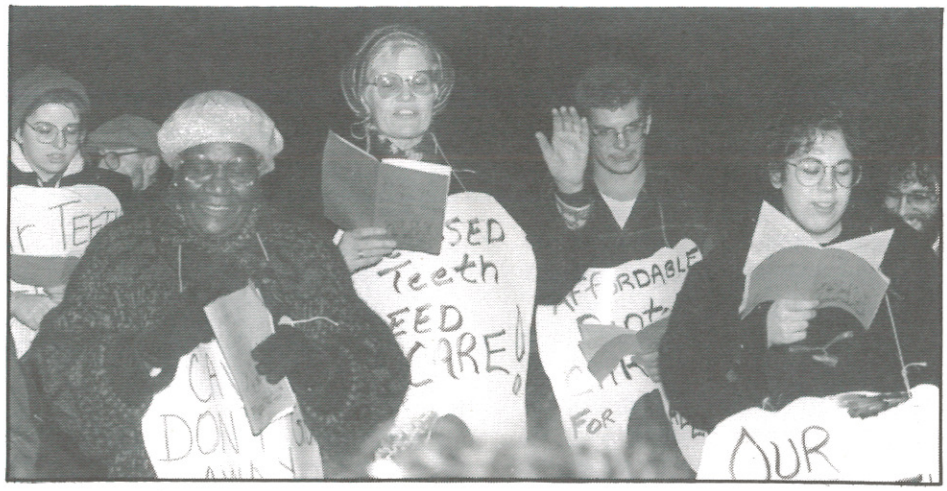
However, Zeigler noted that "when the dentist was absent and a substitute dentist took his place, the statistics for that month showed more than the ususal level of activity in the dental department."

Based on his findings, Zeigler recommended, and the board unanimously approved, the following changes:

1) Dental appointments should be made every day, rather than only on one day of the month.

2) Walk-ins should be seen for dental cleaning and exams.

3) Evaluations and complaints should be solicited from the Dental Department's clients and forwarded to the Board of Health.



CCHCC Low-Income Task Force members sing carols to local Dental Society members. Photo by Scott Vesecky, Daily Illini

Carolers Provide "Season's Greetings" at Illini Dental Society Gathering

IF YOU HAVE A TOOTHACHE
(sing to "Away in a Manger")
'If you have a toothache, need care right away
And you call a dentist, they'll ask how you pay.
If you say 'Public Aid' with green card in hand,
Then outside the front door is right where you'll stand...'

Over 40 people braved the cold winds on Friday evening, December 1, to sing unique renditions of popular Christmas carols to local dentists as they arrived at the Champaign Country Club for their Christmas Party. The demonstrators carried teeth shaped signs with messages to the dentists such as "We need Teeth Service, not Lip Service" and "Fix Cavities, not Cocktails." Overall, the protest sent a clear message to the dentists that the community is not going to let up the pressure on the urgent issue of access to dental care.

The action was initiated when the Illini Dental Society refused to support any of the proposals developed to address problems low-income residents encounter when seeking dental care. The proposals were developed by CCHCC's Low-Income Task Force at a community meeting last October aimed at increasing access to dental care. The three main proposals which came out of the meeting included:

1) Establishing a centralized billing and claims office to ease the paperwork burden on local dentists who accept Medicaid recipients;

2) Developing a rotating referral system in cooperation with local social service and government agencies to assure that Medicaid recipients get needed care; or

3) Encouraging local dentists to volunteer time at local agencies to assist in providing dental care to the poor.

The Dental Society later refused to consider any of the proposals. Dr. Vohs, president of the Illini Dental Society, stated that local dentists "feel like we have contributed far more than our share already...It is no longer a question of if a low-income person can have dental work done, it is just a matter of when."

"This response from the Dental Society is outrageous and unacceptable. Conditions in Champaign County are so bad that a public aid recipient can't find a dentist in the phone book who will accept the green card," asserted Low-Income Task Force member Amber Adams at the caroling protest. "Everyone in town acknowledges that there is a problem. They're just sticking their heads in the sand."

The Task Force is determined to see that the Dental Society helps make changes in the dental care system. "We need to know that there is a structure in place that provides access to dental care regardless of how much money we have or if we use the medical card," emphasized Task Force member Debbie Doyle.

CCHCC Briefs

Board Nominations

Our next issue of Health Care Consumer will include a ballot for the annual election of at-large board members. Each spring, half of CCHCC's 12 at-large seats are determined by ballots sent out to members through our newsletter. At-large members are elected for a two year term, and are joined by two representatives elected by each CCHCC task force.

CCHCC's Personnel/Membership Committee is currently soliciting potential nominees. If you are interested, or know of someone you wish to nominate, please contact Dave Rein or Mike Doyle at 352-6533. The Personnel/Membership Committee is developing a short job description for board members that will be available upon request to potential nominees.

Membership Dues To Increase

At its December meeting, CCHCC's Board of Directors voted to increase membership dues for the first time in ten years. "Although we dislike increasing any cost to our members, if we are to remain effective in our work, we need the resources to do the job," explained CCHCC Executive Director Mike Doyle.

Regular membership dues will increase from $15 per year to $25 annually, while fixed income and senior citizen members (including those enrolled in Medicare 100 and Medicare Plus) will see only a $5 increase, from $10 to $15 per year. Family membership, which had been $25, will increase to $36.

New Staff Welcomed

We want to welcome several new staff employees who have joined CCHCC since our last newsletter. Joining us are Eugenia Hilligoss, Jason Gascoyne, and Nancy Greenwalt. Eugenia and Jason have been busy with our work on the HMO issue, while Nancy will become our new Canvass Director.

Canadian Health Care System Seen As Alternative

In contrast to the way Americans feel about their health care system, the vast majority of Canadians are very pleased with theirs. A recent survey found that 67% of Canadians were "very satisfied" with their health care service, as opposed to 35% of Americans (see accompanying article). A recent article in Business and Health emphasizes this point:

"When Canadians talk about their health care system, it's like Americans discussing their Constitution. Canadians consider their health care program to be the finest thing their government -- and maybe any government -- has ever created."

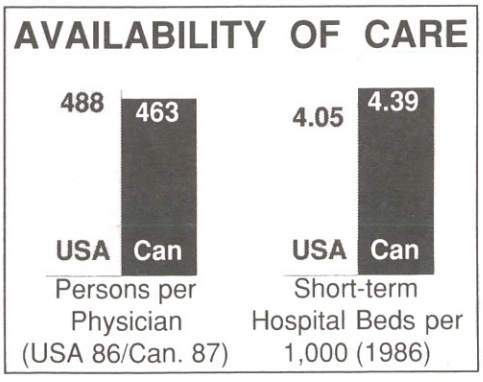
Canada's unique national health care program is a health insurance plan (as opposed to a health care delivery system) that includes long term care, acute care, and primary medical care. Canadian patients choose their own doctors, whose bills are then paid by the provincial government. Canadian doctors are not employed by the state (as they are under Britain's National Health Plan), and Canadian patients are able to seek medical care from any health professional willing to treat them. Freedom of choice, and freedom from worry about paying medical bills, have made Canada's national health insurance plan overwhelmingly popular, as measured by public opinion polls.

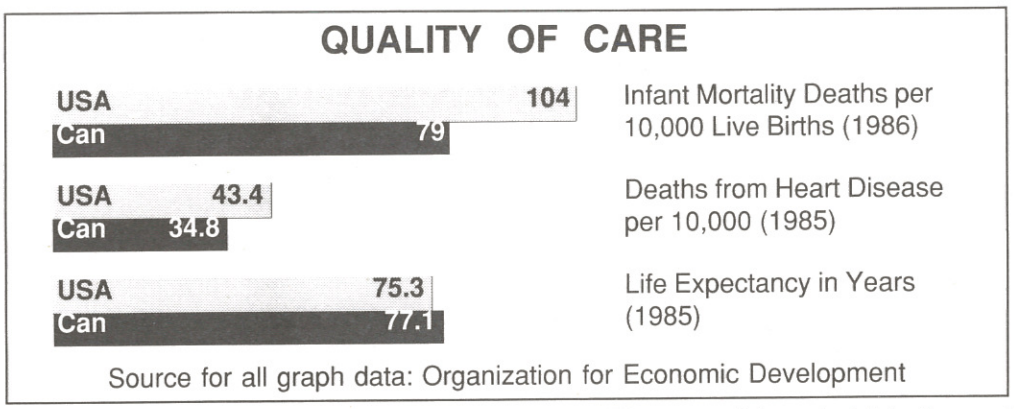
Although it is thought of as a national program, Canada's health care system is actually ten different programs that vary from province to province. The differences between programs relate to the size and range of physician's fees, and whether the plan's financing is shared by the public in the form of insurance premiums, as well as general taxes.

Canada's federal health care program requires that each province's system meet five criteria:

- it must cover the entire resident population;
- benefits must be portable between provinces;
- benefits must be comprehensive, covering all medically necessary hospital, physician, and surgical dental procedures;
- it must provide health care without any extra billing, deductibles, or coinsurance; and
- the plan must be publicly administered on a nonprofit basis.

This means that, in Canada, it is normal to receive medical care and never even see a hospital bill.



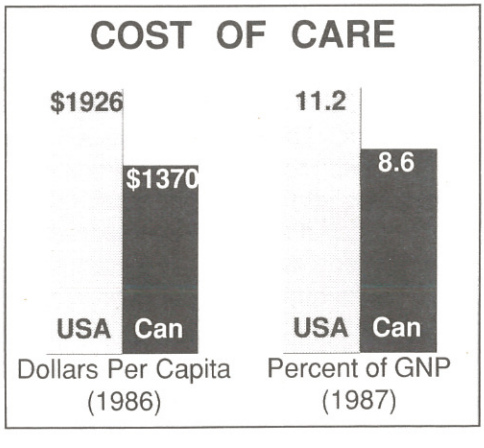


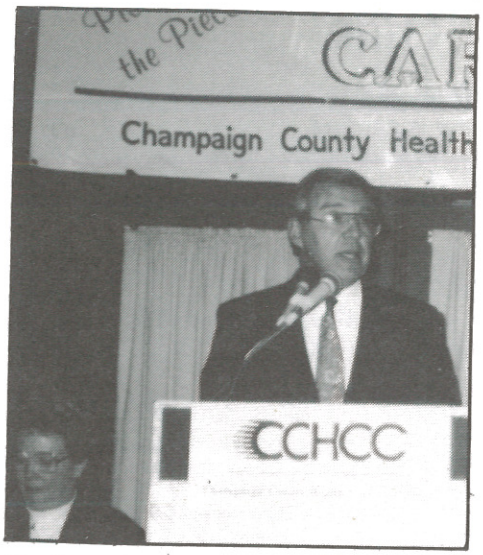
Canadian Medicare pays for health care beginning with the first dollar spent, and there is no limit on what the system will pay for a Canadian's health care during their lifetime.

The cost to Canada for this coverage is an average of $1500 (U.S.) annually per citizen, for a total of $39 billion. Since 1978, the percentage of Canada's GNP spent on health care has leveled out at 8.5%, as compared with 11.1% in the U.S.

Comparative studies of the Canadian and U.S. systems suggest at least six differences which explain why the Canadian health care system is so much less expensive:

- In Canada, the government exercises tough central control over capital expenditures.
- Hospital patients in Canada undergo fewer tests and procedures, use fewer nurses, fewer drugs, and less complex technology.
- Physician fees have grown much faster in the U.S. than in Canada, where provincial governments negotiate provider fees and set expenditure caps.
- There is much more marginal or inappropriate care in the U.S. In particular, the number of inappropriate surgical procedures -- from c-sections, carotid endarectomies, and hysterectomies to appendectomies, by-pass surgery, and the use of pacemakers -- is much higher here.
- Expenditures on heroic medicine and very expensive care delivered to people in the last months of their lives is much higher here.
- The cost of the administrative and bureaucratic support system is much higher in the U.S. Ours is a very complex and expensive system to administer. One study shows that 23% of U.S. health care spending (over $130 billion) goes to managers, administrators, insurers, lawyers, and other paper pushers, compared to only 13% in Canada. A typical U.S. hospital apparently has about 50 billing clerks sending and tracking bills. The equivalent Canadian hospital apparently has three such clerks, and they are mainly concerned with billing American visitors.





Mr. Beard addresses CCHCC's Senior Task Force members at November forum.

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British said they failed to get needed care. But in the U.S., fully 13% said they failed to get needed care. If 13% sounds small, remember that this represents almost 24 million people. As for the causes, 7.5% of Americans said they had failed to get care for financial reasons, but in Canada and the U.K., less than 1% gave this reply.

In discussing how Americans feel about the costs of care, Taylor said:

"On *cost* the news is worse. While many people -- if not as many as you might think -- are at least dissatisfied with the cost of their health care services, the vast majority believes that the total cost of care in this country is *excessive*. Indeed, there is a virtual consensus on this point -- the excessive cost of care -- from corporate CEOs to legislators to the general public."

Unfortunately, there is much resistance among the American medical industry to adopting cost containment measures, for the simple reason that effective cost containment means that someone gets less, such as the doctors, hospitals, drug companies, or medical device and equipment people.

(The preceding article was compiled from remarks by Mr. Humphrey Taylor which appeared in the Public Citizen Health Research Group's "Health Letter.")

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"We understand just how important it is that the administration believes in these programs and supports them 100 percent," explained Task Force Chair Clara Clark. "There is much that needs to be done, and we wanted to see how the man at the top felt."

One of the most frequently asked questions was the most obvious: would Covenant drop the Medicare 100 and Medicare Plus programs? In response, Mr. Beard repeatedly assured those in attendance that Covenant was committed to continuing Medicare 100 and Medicare Plus.

"We have a contractual obligation to continue the programs, so even if we wanted to drop it, legally we couldn't," Beard said. "Are we going to do it 15 years from now? I don't think I can say that far down the road."

Another topic of great interest among the seniors was physician participation in the programs. Task Force member Clara Greenblau spoke right to the heart of the matter: "Although nearly 80 doctors participate in the program, there are more than 40 doctors on Covenant's medical staff who don't participate. What plans does Covenant have to encourage more of your doctors to participate?"

On this issue, Mr. Beard seemed a bit more elusive, saying "They are independent practitioners; we can't force them to do anything."

There were also several questions about what plans Covenant had for improving or strengthening other aspects of the programs. Many felt that the whole merger process left many unanswered questions about specific aspects of the programs. Would Mercy's VIP program, which offered some basic amenities but no savings on medical bills, be merged into the Medicare 100 and Medicare Plus programs? Would there be a new brochure? Who would be in charge of the Medicare 100 and Medicare Plus programs at Covenant? Would Mercy staff members receive training about how the programs work?

In most cases, Beard indicated that Covenant was just beginning to take a closer look at these questions, but hadn't made any decisions yet. When asked about CCHCC's Senior Task Force's participation in these decisions, Mr. Beard indicated a desire to work with the Task Force and develop a mutually agreeable plan of action.

Mr. Beard has agreed to a follow-up meeting on January 9 with CCHCC's Monitoring Committee, which oversees the Medicare 100 and Medicare Plus programs. If you would like to be kept abreast of these discussions, call Amber Adams at CCHCC's office (352-6533). For those members who have specific problems or questions about their Medicare 100 or Medicare Plus coverage or billing, please call Covenant at 337-2923.

The Catastrophic Debate and National Health Care: Fundamental reform or piecemeal change?

During debate on the Medicare Catastrophic Coverage Act, the following were among dozens of representatives who came out for national health care.

Bruce Morrison (D-CT): "Universal health insurance should be the goal we seek., rather than continuing a piecemeal approach that is doomed to failure."

Marty Russo (D-IL): "Until we make universal health care a national priority, we will continue to have a health care system that the young cannot afford, that the old cannot afford, and that the poor cannot afford."

Joseph Brennan (D-ME): "I feel strongly about ... establishing a health care system in this nation which provides everyone with accessible and affordable care, including long-term care for our nation's increasing population of senior citizens."

Major Owens (D-NY): "People in Brooklyn simply do not understand how it can be that the governments of Lybia and Luxembourg and dozens of other nations can provide more generous health care coverage to their people than the government of a wealthy and powerful nation like the United States ... They want action now."

Thompson Vetoes Health Bill for Second Time

In a callous move, Governor Thompson vetoed for the second time this year an emergency appropriation for the state's sixty community health centers (CHCs). Governor Thompson's action comes at a time when the health care crisis in Illinois is growing out of control. CHCs have become the only link to health care services for many residents in rural and urban communities whose hospitals have closed.

A week before Thompson's second veto, over 20 members of the Champaign County Health Care Consumers braved frigid temperatures by picketing Thompson before he met with the local newspaper's editorial board. Thompson was asked by the health care activists to sign a pledge card indicting that he would support the appropriation. Dodging the issue, Thompson wrote on the pledge card "I'm thinking about it." Dissatisfied with his answer, the protestors pressed Thompson even further. As the debate got more specific and heated, Thompson was unable to refute the cost effectiveness of CHCs, and kept searching for additional excuses. Out of excuses and looking dumbfounded, Thompson abruptly ended the discussion and proceeded inside the building.

Last spring a bi-partisan coalition of rural and urban legislators succeeded in passing several bills contained in the Campaign for Better Health Care's "Rural & Urban Health Initiatives." A key aspect was the allocation of $8 million for CHCs to: 1) bolster their ability to handle the growing demand for their services; and 2) expand their outreach into other areas of the state. In September, Thompson issued the first of his two vetoes.

...the Chicago Tribune [urged] the governor to sign the legislation.

Supporters regrouped and pressed forward in the fall veto session. Initially seeking a $4 million appropriation (as an allocation for the remainder of the year), a last minute compromise of $2 million was included in the budget supplemental bill that passed overwhelmingly. Support grew, with the Chicago Tribune urging the governor to sign the legislation.

"Although the $2 million is far from what is needed, it is a step in the right direction to begin helping the rural and urban medically underserved areas of Illinois," commented Lon Berkley, Executive Director of the Primary Health Care Association.

Meanwhile, as the debate continued, CHCs throughout the state were feeling the financial squeeze even more. In fact, Miles Square Health Center in Chicago was to close, and the Frances Nelson Health Center in Champaign struggled to recruit new doctors.

A report prepared by the Coalition for Consumer Rights on the cost effectiveness of CHCs was released in October in conjunction with the Campaign. The report substantiated the fact that CHCs are the most cost effective way to provide primary health care to people. Specifically, for every $1 dollar spent on health centers, it saves the state $1.61 on reduced Medicaid costs, and for every $1 spent on prenatal care, it saves the state $3.38 by avoiding the high costs of neonatal intensive care.

Unfortunately, on December 5, Thompson vetoed the $2 million appropriation.

Nursing Conference Addresses Access to Care

CCHCC board member Kathleen Jones was one of several local nurses and health education employees to present data at a conference titled: **Ambulatory Care Nursing -- Accepting the Mandate to Improve Access to Care**. Over 150 nurses from many fields were represented, enabling data sharing and networking among peers. Speakers addressed a wide range of topics such as AIDS, pharmacology, child health, Alzheimer's, domestic violence, triage telephone nursing, teenage psychiatric nursing, and infection control.

In a publication distributed at the conference titled: "The Nation's Nurses -- A Credible Profession Doing an Incredible Job," one national health care leader summed matters up well by saying, "There is strong evidence that nurses and nursing care can affect patient outcomes positively, both in and out of hospitals...A research team at George Washington University, examining all of the factors involved in determining the result of a patient's stay in a surgical ICU, concluded that nursing care was by far the most important influence." Surveys also indicate that public confidence in nurses is very high. Because of their cost effectiveness, nurses increase the access of underserved populations to health care services.

The keynote speaker, Dr. Lillie M. Shortridge, RN, Associate Dean and Professor of Nursing at Pace University, Pleasantville, NY, spoke of the 37 million uninsured persons in the U.S.; of the dramatic rise in the number of elderly persons (who will have 3 to 5 times more need for use of health care facilities); and of the change in payment systems. Dr. Shortridge sees changes fast approaching, such as nurses being reimbursed directly for procedures that they alone perform.

The conference also featured a poster presentation session, in which several nurses presented researched data from various studies, including "No Access to Health Care for 15% of Illinoisians" by Ms. Jones.

Kathleen based her presentation on data from the Illinois Public Action Council's study, released in 1988. It found that over 14.6% of the nonelderly (largely young, white, employed) population of Illinois are without any health insurance.

Jones' poster concluded with a quote from IPAC Director Robert Creamer: "We need a new approach to health care, both in Illinois and across the nation. Americans deserve a health system that is just as effective, just as affordable, and just as efficient as the rest of the industrialized world. The time has come for our nation to guarantee access to health care for all, while providing that care at an affordable cost to our society."

UPDATE: Campaign for Self-Sufficiency

Phone-A-Thon Big Success, University Opposes United Way's Donor Option Program

Membership support has jumped dramatically under CCHCC's Campaign for Self-Sufficiency, despite a ruling by the University of Illinois which prohibited University employees from contributing to CCHCC through payroll deductions. A major source of increased support came from our first annual Phone-A-Thon, which generated more than $10,000 in pledges from CCHCC members.

Committed to broadening support for our work throughout the community, CCHCC decided late last summer to participate in the United Way's Donor Option Program, which allows contributors to give their donations to qualified non-United Way agencies, such as CCHCC. Special instructions on how to donate to CCHCC through the Donor Option Program were included in our last newsletter, and instructions were distributed among several employers in the county.

However, in early September, we began receiving calls from CCHCC members at the University, who indicated that the instructions provided by the United Way were different from the procedures used at the U of I. After confirming the special procedure used at the U of I, CCHCC printed a special brochure for University employees, explaining the procedures they needed to use to support CCHCC through the Donor Option Program. Consumer advocate Ralph Nader agreed to write a cover letter, and the Student Coalition for Health Care agreed to mail the brochure to all 11,000 employees.

But suddenly, a new problem arose. Just days after CCHCC brochures were received by University employees, Dr. Zimmerman, Chairperson of the University Campus Charitable Drive, sent a memo stating that contributions could not be forwarded to CCHCC through the Donor Option Program. After dozens of phone calls, several meetings, and even a formal hearing before the University Campus Charitable Drive Committee, the University administration ruled that it would not allow employees to give payroll deduction contributions through the United Way's Donor Option Program, although single one-time gifts would be forwarded.

"We were really disappointed in the University's decision," explained CCHCC Fundraising Director Elizabeth Hamlin. "They seemed to feel that our mailing was unfair to other groups, and that it came after the United Way campaign was already underway. We were just trying to get the information out to employees who were never told how the system worked. It was frustrating for everyone involved, including many U of I employees who called to complain that they wanted to support CCHCC through their payroll deductions."

It is hoped that the confusion surrounding this year's effort can be avoided next year. The University has agreed to reconsider its decision to not make the Donor Option available to University employees. CCHCC has expressed a desire to work with the University in developing a fair and manageable system, whereby CCHCC and other qualified local charities can participate in the University Campus Charitable Drive.

"We hope to sit down with the University after the first of the year and see what can be done," explained Hamlin.

However, on another front, CCHCC has been far more successful. For nine nights in early October, over 100 volunteer phone callers, operating out of a phone bank at the American Heart Association, called several hundred CCHCC members, encouraging them to take action on one of three important health care issues, and support CCHCC with a financial pledge.

When all was said and done, more than 330 members pledged $10,363, while another 192 members pledged their financial support at an unspecified amount. In addition to the financial support, many members took time to write the new CEO of Covenant Hospital, encouraging him to take a leadership role in addressing some key post-merger policies, while others collected hundreds of signatures on petitions calling for a rollback of HMO premiums, or wrote Congress about strengthening laws governing the use of pesticides on our food.

A special thanks goes to the American Heart Association for allowing CCHCC to use their phone bank facilities. Each evening for nine nights, volunteers would meet, have a short training session, and a light meal donated by a local restaurant before calling CCHCC members. Many restaurants also provided gift certificates, so that volunteers could leave with a little thanks for their time.

October was also a big month for raffle ticket sales, as CCHCC volunteers sold more than $1500 worth of tickets to help support CCHCC's Consumer Health Hotline. The lucky grand prize winner was James Harris of Urbana, who won two season tickets to Illini basketball games. The second prize of two tickets to the Illinois vs. Michigan football game went to Molly French from Decatur.

CCHCC would like to thank all of the members that made a pledge. All the volunteers and businesses who provided support will be listed in a special section in the next issue of the HEALTH CARE CONSUMER.

CCHCC 1990 MEMBERSHIP RENEWAL FORM

(Please clip out and return with your membership dues.)

[ ] Enclosed is my check for $_____.
[ ] Please bill my credit card.

Membership levels:
$36 - Family Membership
$25 - Individual Membership
$15 - Senior Citizens/Students/Fixed Income

Check one: _____VISA _____MasterCard Expiration Date:____/____
Account number: __|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__

Contributions to CCHCC are tax deductible.

Please return to: CCHCC, 44 E. Main, Suite 208, Champaign, IL 61820

Survey of Seniors Suggests Medicare Changes Needed

This summer hundreds of CCHCC supporters sent postcards to Congress urging action to reform the way physicians charge Medicare beneficiaries, as well as the way Medicare reimburses physicians. This effort was in response to recommendations by the Physician Payment Review Commission (PPRC), which was established by Congress to study Medicare and recommend some reforms. As part of its work, the PPRC conducted a national survey of Medicare beneficiaries. The recently released survey findings strongly support CCHCC's stand that both mandatory assignment and paperwork reduction for beneficiaries are essential.

According to survey findings, nearly one half of all Medicare beneficiaries were charged in excess of the Medicare rate for their last physician visit.

The standard argument physicians use against mandatory Medicare assignment is that they claim they consider a person's income when deciding to bill in excess of the assigned rate. Contrary to these claims, the survey found no statistically significant relationship between assignment and beneficiary income.

Another reason mandatory Medicare assignment is necessary is that the high cost of health care prevents many seniors from getting the care that they need. The PPRC survey found that seven percent of survey respondents (representative of over 2 million beneficiaries) reported that they had put off seeking care in the past year because of cost.

Finally, the survey results indicate the need for physicians to submit claims, rather than the beneficiaries, who often have difficulty understanding the process. Nine percent of survey respondents reported that they had paid at least one medical bill in the last year rather than file a Medicare claim. The most commonly cited reason for not filing was that filing claims is too complicated.

Based on the survey findings, the PPRC's preliminary recommendations include limiting physician overcharges and requiring physicians to submit all claims directly to Medicare.

Renew Your 1990 Membership Dues Today -- See page 7

Americans Express Dissatisfaction with U.S. Health Care System

A recent survey of American, Canadian, and British attitudes concerning health care found that, quite frankly, most Americans are fed up with our current system, and would welcome major changes to improve it.

The survey, conducted by Louis Harris and Associates, asked respondents to choose between three alternative statements about the health care system. When asked the most positive statement, ("On the whole, the health care system works pretty well and only minor changes are necessary to make it work better.") a majority (56%) of Canadians agreed. In Britain, just over a quarter (27%) did so. But in the U.S., only one person in 10 agreed. Most Americans (60%) picked the second alternative ("There are some good things in our health care system, but fundamental changes are needed to make it work better.") Even worse, almost one person in three (29%) agreed with the statement that "Our health care system has so much wrong with it that we need to completely rebuild it." This response was shared by only 5% of Canadians and 17% of the British.

Furthermore, only 35% of Americans are very satisfied with our system, as compared to the much higher 67% of people in Canada and 39% in Britain.

As Arnold Relman, Editor of the New England Journal of Medicine, concludes, "There is now a growing sense that the time has come for a more basic and systematic realignment of our health system."

According to Mr. Humphrey Taylor, President of Louis Harris and Associates, there are several reasons for this growing discontent over the American health system.

*The U.S. system is by any measure (percent of GNP or dollars) the most expensive in the world.

*The cost of the U.S. health care system is growing faster than the much lower cost of health care in most other democratic, developed nations.

*The cost per capita, in dollars, or as a percent of all health care dollars, going to the bureaucracy -- to marketers, administrators, managers, and other paper pushers not delivering care -- is much higher in the U.S. than in most other developed nations.

*The amounts of unnecessary, inappropriate, or merely marginal care and testing delivered to or performed on patients is much higher here than in most other nations.

*The U.S. health care system is far and away the most inequitable and highly-tiered system among all the democratic, developed nations.

The Harris survey also asked about access to care. When asked if they had at any time in the preceeding 12 months failed to get the health care which they thought they needed, only 4% of the Canadians and 5% of the

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