HEALTH CARE CONSUMER

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City to Investigate Discrimination at Christie Clinic

On April 2, Champaign's Human Relations Commission (HRC) voted to investigate Christie Clinic for human rights violations, after hearing testimony from former Christie patients. The testimony was brought before the Commission by CCHCC's Low Income Task Force, which worked with the patients to file formal complaints after Christie Clinic denied them health care when they became eligible for Medicaid.

Last summer, CCHCC learned that physicians at Christie Clinic were dumping pregnant Ob/Gyn patients when they applied for Public Aid. CCHCC wrote the clinic in August, 1989 to ask for clarification of their Medicaid policy. Robert Thompson, the Executive Director of Christie, dismissed our concerns, stating that "If a person's financial class changes from non-Medicaid to Medicaid status, there is no denial of services." However, over the following weeks, more than half a dozen names of patients dumped at Christie Clinic were passed on to CCHCC by another physician in town. In response to the continued complaints, the Low Income Task Force held a news conference calling for: an end to Medicaid discrimination at Christie; an investigation into patient dumping; disciplinary action against doctors found to be in violation of clinic policy; and a written statement of patient rights. However, when attempts were made to meet with the clinic's executive director, he refused.

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Executive Director Mike Doyle announces the winner of CCHCC's Golden Bedpan Award (story on p. 4)

Coming Next Issue

- 6,892 Questionable Doctors
- Medigap Insurance: Fighting Back
- The Politics of National Health Care, Part II

Physician Refuses Care

Clinic Retaliates Against Medicaid Patient

Just one month after participating in a CCHCC news conference about patient dumping at Christie Clinic, Amber Adams, a Low Income Task Force member and CCHCC volunteer, was denied urgent health care by her Christie Ob/Gyn physician. The physician had been treating her for a number of months for a chronic problem, but suddenly refused care to Amber when her condition took a turn for the worse. The physician, Dr. Mildred Nelson, told Amber that she would no longer serve her because she was affiliated with CCHCC and spoke out at the news conference.

To Amber, the denial of care had grave implications. "I was shocked when this happened," she explained. "Not only did I have urgent health care needs myself, but as a mother of three, I was worried about where my children would receive care, since they also saw physicians at Christie."

In what might prove to be a strategic mistake, the physician added insult to injury by sending a registered letter, restating her refusal of care. In the letter she stated that "I am severing our patient/physician relationship. As per our discussion, I am uncomfortable continuing care to persons involved with the Champaign County Consumer Organization [sic] who allows themselves to be interviewed on local news suggesting that Christie Clinic does not take care of patients on Public Aid."

The denial of services is prohibited by Champaign's Human Rights Code. Amber has since filed a complaint with the Human Relations Commission.

New Rate Increases Spawn HMO Task Force

With local HMOs announcing another round of premium rate hikes on the heels of last year's huge premium and co-payment increases, CCHCC is beginning to dig in for the long haul. Many frustrated HMO members have joined with CCHCC in an effort to address these policies and formulate changes in the local HMOs, leading to the formation of a new CCHCC Task Force on HMOs.

Last year, the local HMOs announced premium increases as high as 71%, and new $10 co-payments for each physician visit. This set off a furor in the community. In response, CCHCC issued a series of investigative reports, which raised serious doubts about the need for higher costs when fewer services were being provided by local HMOs.

The premium increases which state employees face this year were not introduced with the same fanfare which accompanied last year's rate hike and co-payments. But with state employees receiving, at most, a 3% salary increase, the new premium rates mean less take home pay for many state employees, such as those at the University of Illinois. CarleCare HMO, which covers the most state employees in Illinois, is raising the rate each employee must pay by more than 34% this year. PersonalCare HMO, which received the highest average premium increase in the state, raised the premium each employee pays by more than 100%. State employees are also face premium increases for dependent coverage of as much as 49%.

Many HMO members have said enough is enough. Together with CCHCC, local HMO members are beginning to develop a strategy to make the HMOs live up to their early promises of cost containment through preventive care.

On another front, legislation drafted by CCHCC, and introduced by Rep. Helen Satterthwaite, was defeated during the spring session in the Illinois House of Representatives. The legislation: required HMOs to have a substantial number of consumers on their Boards of Directors; prohibited individuals with a conflict of interest from serving on these boards; and closed loopholes which allow HMOs owned by insurance companies to avoid filing HMO reports. Unfortunately, the bill was defeated in the House Insurance Committee due to intense pressure from the HMO industry, led by CarleCare's lobbyist.

For the Task Force to be successful, we need your input. If you have any comments or suggestions, or you want to be involved with the HMO Task Force, please contact Jason Gascoyne at the CCHCC office (352-6533).

Commissioners Criticize Delta Dental Contract

On April 23, representatives of CCHCC's Low Income Task Force testified in Springfield at a Legislative Audit Commission (LAC) hearing, and urged the termination of the contract between the Illinois Department of Public Aid (IDPA) and Delta Dental. The Task Force urged the commission to end the contract because of the lack of dental care for Medicaid recipients, as well as the corruption surrounding the Delta Dental/IDPA relationship.

In response to the audit, Legislative Commission members harshly criticized Kathleen Kustra, the Director of IDPA, on the continuation and expansion of the Delta Dental contract. Rep. McGann (D-Chicago) introduced a motion to recommend the termination of the Delta contract after stating, "Let's do the job right, no matter what it takes. Get rid of them! ... We have an obligation to the constituency... I think the direction should be coming from this Commission to recommend to them to drop this contract as quickly as possible and proceed."

"Let's do the job right, no matter what it takes. Get rid of them! ...drop this contract as quickly as possible and proceed."

The hearing focused on the results of a 21-month Auditor General investigation, which found massive fraud and mismanagement of state funds under IDPA's $23 million annual contract. The initial investigation had been triggered by a CCHCC report, released in 1987, about the failures of the IDPA/Delta contract.

Rep. Tim Johson (R-Champaign) also supported the termination of the contract, and seconded McGann's motion. Rep. Johnson explained his support on the basis of the overwhelming consumer and dental provider dissatisfaction with Delta Dental's management of the program. He provided statements from dentists dissatisfied with Delta, such as: "Delta's system is a disgrace to the state. Horrible, shameful, disgusting. Grossly inefficient. Deliberately difficult. An affront to dentistry."

The Commission also asked Auditor General Al Cronson whether the Auditor's office would recomend that the contract with Delta should be terminated. Cronson replied, "We would have unhesitatingly said yes."

However, after a last minute phone call from the governor's office, the Commission tabled the motion to recommend termination of the contract, but refused to close the audit until the issue is addressed at the next Commission meeting. "We have been fighting for dental care for years, because people need their teeth, and this Delta contract has prevented people from getting the care they need," explained CCHCC Low Income Task Force member and CCHCC Board member Mamie Smith after testifying at the Audit Commission hearing. "We will not let this issue drop until all of us get the care we need."

Richard Billingsley participates in the local Workers' Memorial Day event by helping to plant a tree commemorating workers killed on the job.

Workers' Memorial Day

Mourn for the Dead, Fight for the Living

Calendars don't list Workers' Memorial Day. We don't receive a paid vacation. But on April 28, people all across Illinois gathered to mourn the job related deaths of their fellow employees. Locally, the Champaign County AFL-CIO planted a tree in the west woods of Urbana's Crystal Lake Park to honor the 18 workers who died on the job in Champaign County since 1984.

Equipment like farm machinery, scaffolding, and even jet engines proves fatal to workers every year. Deaths on construction sites are all too frequent. Equally tragic are the less visible job related deaths from chemicals, asbestos, and other toxic substances which people handle every day.

While the erection of monuments and the planting of trees to honor those who have passed away are admirable gestures, we must also fight to eliminate these occupational hazards. Jane Wiles, who chairs the Health and Safety Committee of the Champaign County AFL-CIO, stresses the need to improve working conditions to avoid future tragedies. "We want to make the public aware of occupational hazards, and to highlight the need to improve the Occupational Health and Safety Act," explained Wiles.

The law Wiles referred to was designed to protect workers from job related injuries or illnesses. But without higher standards and stronger enforcement, these rights go unsupported. Injuries need to be reported, and safety regulations must be made more stringent to make the workplace a safe environment.

OOPS!

Although the new computer system was guaranteed to help us to keep better track of the support we receive from our members, several names were temporarily misplaced during the transfer. A very special thank you is owed to the following "Sustainers" of CCHCC, who were inadvertently omitted in our last newsletter.

Sandra Beak
Dr. & Mrs. Bloomfield
Gregory Girolami & Vera Maim
Victor & Sharon Treat

Also, we incorrectly spelled the name of Dorjan Hite, a volunteer with CCHCC's Phone-A-Thon; sorry, Dorjan!

CCHCC Briefs

Board Election Results

Election ballots for six at-large seats on CCHCC's Board of Directors were tabulated on April 15th and three new board members were elected, along with three board veterans. Elected as first time board members were Anna Marie Gire, Adriana Hibbler, and Vicky Hinton. Three current board members, Anna Clayton, Ed Ramthun, and Jeann Rice, were re-elected.

CCHCC's Board of Directors is responsible for setting the organization's overall policy, finance, and planning decisions. Each year half of the twelve at-large seats on the board come up for election. CCHCC Task Forces also elected two members to serve on the Board of Directors. Returning to the board as representatives of the Women's Health Task Force are Marlene Moshage and Imani Bazzell. Again representing the Low-Income Task Force are Abdul El-Jamal and Mamie Smith. The Senior Citizen Task Force returned Mabel Coombs to the Board, and elected Dorothy Utley as a new representative.

And a Special Thanks

Although we are excited about the election of three new at-large board members, we'll miss the three CCHCC board members who will be stepping down.

John Peterson was one of CCHCC's founders, and has been a guiding force behind CCHCC's work concerning health planning issues. Jacqueline Archey, a six year board veteran, has been an invaluable resource person and positive, energetic force on the board.

John Gifford, a one term board member, helped lay the initial groundwork for CCHCC's HMO campaign, but had to step down when he took a job in Indiana.

CCHCC cannot express enough gratitude for the contributions of all three outgoing board members to both the organization and the community at large. Thank you, John, Jacqueline, and John.

Support for Universal Health Care Grows

"The United States has the most arbitrary, capricious system of health care rationing in effect in any nation of the world," according to Dr. Arthur Flemming, Chair of the National Health Care Campaign.

Flemming made his observations at CCHCC's 13th Annual Awards Dinner, during his acceptence of CCHCC's Leadership Award. "I'm honored to be recognized by such a fine organization, but we all must demonstrate leadership if we are to turn this system around."

Creating a more equitable and cost-effective system which provides care equal to other nations was the focus of CCHCC's 13th annual Awards Dinner and Conference, held Saturday, April 7, in Urbana.

"Universal Health Care -- The Choice is Ours" featured several panel discussions, and culminated with Dr. Flemming's acceptance specch.

Professor Tom O'Rourke compares Candadian and U.S. health care, concluding "It's time for a change."

Members of several panel discussions, held earlier in the day, reached the same conclusions as Dr. Flemming, but for a variety of different reasons. Signe Gleason of the Illinois Nurses Association District #21, speaking on the panel "Support Grows for Universal Health Care," told of the need for a national health care system from the perspective of a health care provider, as did Dr. Ron Sable, a Chicago area physician.

Panelist Signe Gleason, RN (left) and Dr. Ron Sable speak for universal care.

Jim O'Connor, Service Representative of United Auto Workers Region #4, told how skyrocketing health care costs have hurt the entire labor movement by costing workers jobs and benefits. In an ironic twist, Mr. O'Connor mentioned that many employers are now abandoning their ideological opposition to a universal system, because it is good business sense.

Also honored at CCHCC's dinner was Dr. Camilla Parham, recipient of the Provider of the Year award. Dr. Parham, Medical Director of the Frances Nelson Health Center, has been an outspoken advocate for consumer rights and for access to quality health care for everyone.

The winner of this year's Harry J. Baker Community Service Award was the Gay Community AIDS Project (GCAP). GCAP has worked tirelessly to educate the public about AIDS, despite the efforts of local representative Tim Johnson to cut their funding. (See article, page 5)

Long-time CCHCC and community activist Mamie Smith received the Henrietta De Boer Volunteer of the Year Award. Mrs. Smith serves on CCHCC's Board of Directors, the Low Income and Senior Citizen Task Forces, and never misses an opportunity to go to Springfield to educate our legislators.

Other award winners of the evening were University of Illinois sororities Alpha Xi Delta and Zeta Tau Alpha for Special Recognition/Volunteer Service, and Vicki Que of WILL AM/FM for Excellence in Health Care Reporting.

CCHCC also took the opportunity to present Mary Louise White with a Lifetime Achievement Award for her many contributions to our community. Mrs. White, who helped found Seniors Organizing Seniors in 1980, became one of CCHCC's strongest leaders during the 1980s, providing leadership on our Senior Citizen Task Force and Board of Directors.

On the lighter side, CCHCC also presented its first "Golden Bedpan Award." The joint winners of this dubious honor were the Illinois Department of Public Aid (IDPA) and Delta Dental, for their gross mismanagement of the state's Medicaid dental program.

Willa Mae Dibrell listens to panelists criticize patchwork reforms.

Seniors Vote to Tackle Medigap Mess

After receiving numerous complaints about skyrocketing insurance rates and deceptive or misleading sales tactics, CCHCC's Senior Citizen Task Force voted unanimously at their June meeting to begin a campaign aimed at addressing the serious problems associated with the Medicare supplemental insurance industry.

Medigap -- the $10 to $15 billion market of private health insurance designed to cover the gaps in Medicare -- has once again come under fire from the elderly and from government officials.

Many feel the insurance industry is gouging individuals living on fixed incomes with its 1990 premium increase of 40 to 60% or more, ripping off seniors by selling them expensive and worthless policies, and deliberately making insurance policies exceedingly complicated and confusing to consumers.

The Task Force vote and this latest round of criticism has come in response to the dramatic Medigap premium increases that followed on the heels of Congressional repeal of the Medicare Catastrophic Coverage Act.

Ironically, in Illinois the mechanisms for regulating and correcting several of the abuses of the Medigap industry are in place, but inactive. Illinois is one of only 12 states to have established a Medigap counseling program. This type of program has the potential to be extremely successful. Unfortunately, information about Illinois' counseling program is not reaching senior citizens. Not one of the seniors attending the Senior Task Force Meeting was familiar with the counseling program.

...66% of commercially sold group Medigap policies fail to meet the minimum legal requirements...

Illinois is also one of only 16 states which require the insurance industry to file for approval before instituting a rate hike. Yet, even though Illinois has established a process by which it can review the need for Medigap rate hikes, the National Association of Insurance Commissioners (NAIC) has found that there is essentially no difference in rate increases between Illinois and states that do not require prior approval.

Finally, Illinois also does a poor job of disseminating information to prospective purchasers about the ratio of premiums paid into an insurance company, versus the dollars paid out in benefits (loss ratio).

A recent investigation by the Government Accounting Office (GAO) found that 34% of individual policies, and 66% of commercially sold group Medigap policies, fail to meet the minimum legal requirements for loss ratios, and only two states actively provide this information to consumers.

Although the Medigap campaign is in its initial planning stages, a major emphasis of the strategy is sure to be a push for better state enforcement, along with better implementation, of the mechanisms already in place to protect seniors. The Task Force meets on the third Thursday of each month at 2:30 PM, in the Stevick Senior Center in downtown Champaign.

Community Rallies to Oppose Cutoff of AIDS Funding

State Representative Tim Johnson outraged community groups when, at his urging, the Illinois Department of Public Health (IDPH) cut funding for the Gay Community AIDS Project (GCAP). This Champaign-based AIDS education agency has widespread local support, including the endorsement of the Champaign-Urbana Public Health District. In spite of this, the IDPH cut the $20,000 grant GCAP had received for the past two years.

Rep. Johnson decided to oppose funding for GCAP because they are alledgedly circulating a pamphlet titled "Guidelines for AIDS Risk Reduction," which uses explicit language to describe sexual acts that spread AIDS; however, GCAP officials insist that they have not distributed the "Guidelines" since they began receiving grant money. According to GCAP officials, billboard and bus advertisements have replaced the pamphlets as their primary method for getting essential information about the spread of AIDS to the people most at risk. Ironically, the IDPH, which cut the funding, originally provided the pamphlets to GCAP and other AIDS education projects, because such information has proven effective in preventing the spread of AIDS.

A host of local organizations and leaders, including Planned Parenthood, Representative Helen Satterthwaite, and CCHCC have come out in support of the work done by GCAP. CCHCC's Board of Directors publicly described the IDPH's decision to cut off funding as a "serious mistake" and "counter to good public health policy."

GCAP and the local Public Health District were initially told by IDPH that funding had been held up by the Center for Disease Control (CDC), based in Atlanta. However, in a series of articles which appeared in the Rantoul Press, reporter Bob George uncovered numerous inconsistencies in IDPH's explanations for withholding the funding. Eventually, IDPH officials admitted that the CDC held up the funds at IDPH's request, and confirmed that local public health officials were not consulted about the decision, as they had claimed.

CCHCC took the opportunity at our annual conference to present GCAP with the Harry Baker Community Service Award, for their unselfish commitment to expanding public awareness about AIDS (see related article). "At a time when the AIDS epidemic is on the increase in our county," said CCHCC director Mike Doyle at the awards ceremony, "educational campaigns such as those conducted by GCAP are critical in preventing the spread of AIDS."

Legislative Update '89

Each Illinois General Assembly session covers a two year period. The current 86th Illinois session began in January of 1989, and will conclude in December of 1990. The second year of each session is also an election year, and is designed to deal only with emergency issues. Unfortunately, issues like building a new Chicago stadium (McDome) and legislative pay increases were perceived to be more of an emergency than providing accessible and affordable health care to Illinois citizens. Combined with budgetary constraints, very few bills made it through the committee process this year, including bills aimed at reforming HMOs and cleaning up the Delta Dental contract.

The 1990 legislative session did, however, break new ground on two important health care issues. For the first time ever, committees in both the House and Senate considered establishing a universal health care system here in Illinois. And after two years of work, our Rural and Urban Health Initiative became the main vehicle for addressing the growing rural health care crisis. Here's a closer look at those two proposals.

Universal Health Care (HB 3291 & SB 1587)

This year Illinois joined the ranks of at least a dozen other states in forging ahead with the development of a one-payer health care system for state residents. Last May, both the Senate Public Health and the House Insurance Committees voted to hold a series of public hearings throughout the state on the need for universal health care. "The debate for a national health care system is now front and center, and these public hearings will prove to our legislators the broad based community support for such a health care system," said Robert Creamer, Executive Director of Illinois Public Action. Thanks to CCHCC volunteers, who traveled to Springfield in May to talk to legislators, one of the House hearings is scheduled to be held this fall in Champaign-Urbana.

Rural & Urban Health Care Initiatives (SB 2277 & HB 3571)

The erosion of our health care system continued to intensify in 1990. Locally, the closure of Jarman Hospital in Tuscola, as well as continued federal cutbacks to community health centers, such as the Frances Nelson Health Center, added to the growing crisis. Furthermore, with the 1990 election just around the corner, a number of politicians who, in the past, voted against these initiatives, decided this year to support them.

"The debate for a national health care system is now front and center..."

With small, but growing, bi-partisan support, 5 Republicans joined 25 Democrats as SB 2277 passed the Senate on May 17. Although many were skeptical, we successfully passed SB 2277 in the Senate, with our five point program intact: community health center support; the Statewide Health Services Corps; the Re-utilization Hospital Program; emergency medical services; and Public Health District support.

However, soon after our success, numerous special interests and some leading politicians began working to attach their special needs to SB 2277. When Republicans offered a different proposal in a bill drafted by the Department of Public Health, serious negotiations got underway to merge the two bills.

Unfortunately, as negotiations intensified on what the final package would look like, some of the solutions to this program soon took a back seat to partisan interests. As the legislative session moved into its last month, SB 2277 took on a life of its own as the power brokers began dissecting the bill. For example, Southern Illinois University (SIU) Medical School, which recently positioned itself as a consultant to southern rural Illinois communities in need of health services, sought half of the $16 million package. Arguing that the University of Illinois received a $25 million bailout for its hospital, SIU claimed it wanted equal treatment.

Leading the fight on behalf of CCHCC and other consumer oriented constituencies was the Campaign for Better Health Care (CBHC). Having drafted the original bill and organized support around the state for the past two years, CBHC sought to protect the original intent of the bill.

"We're proud of the tremendous progress we've made in the past 18 months," explained CBHC staffer Jim Duffett. "We've been able to define the debate and move our legislation further than most, but it is also somewhat frustrating to see the power brokers muscle their way in at the end and try to claim all the credit."

One of the main objectives which CBHC sought to accomplish in the negotiations was to maintain a clearly defined role for, and support of, community health centers. And although CBHC may have lacked the clout and prestige of the State Medical Society, SIU, or statewide politicians involved in the negotiations, their tenacity finally paid off.

"Without CBHC's insistance that community health centers be included, most of the other players would have quickly eliminated that component of the bill," explained one Senate staffer involved in the negotiations. "But CBHC took the time to develop key legislative allies, and when push came to shove, those politicans stood by CBHC."

City Investigates

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Undaunted, five of the women worked with the Task Force to file a formal complaint against Christie Clinic for human rights violations, as stipulated in Champaign City Codes. The Champaign Human Rights Ordinanance (Chapter 17, article 4, section 17-56) insures that "It shall be an unlawful practice to, for a reason based on discrimination ... deny, directly or indirectly ... services, facilities ... of any place of public accomodations."

The testimony from the complainants documented various ways that Christie violated their human rights. Each woman faced a similar experience of being refused care in mid-pregnancy. Corina Ramsey testified that "after I was no longer covered under my HMO, I brought in a form from Public Aid to my [primary Ob/Gyn] physician to verify my pregnancy. At that time, my doctor refused to see me as a patient any more, and his nurse sent me to the business office. It was at the business office that I was told they wouldn't treat me, because I was going to be on Medicaid."

After hearing testimony from Corina and other women about their experiences at Christie Clinic, Human Relations Commission member Ann Thompson stated that "when you have evidence that strong, you can hardly ignore it." After further discussion on the issues presented, the Commission voted to conduct a complete investigation of Christie Clinic's policies. HRC member Ed Ryan added that "I'd like [the investigation] to culminate in a public hearing with the providers and the consumers."

"when you have evidence that strong, you can hardly ignore it."

Specifically, the vote of the Commission directed Human Rights Officer Ernestine Jackson to conduct a thorough investigation into Christie's policies. In response to the vote, Task Force member Mary Kelly articulated the sentiment of many involved with this issue, saying "We are pleased with the actions of the commission, but we are determined to see that this investigation is thorough and extensive."

Recently, there have been some doubts raised about the committment of the city administration to commit the resources necessary to pursue this issue. "Given that top city officials have worked closely with Christie over the years on issues related to city bonds for the clinic's expansion and, most recently, the Burham-Mercy merger, I have some reservations about how aggressively Christie Clinic will be held accountable to Champaign City codes," said CCHCC member Debbie Doyle.

CCHCC's Low Income Task Force plans to pursue this precedent setting challenge in order to hold Christie Clinic accountable to the laws of our city, because, as Task Force member Pattie Muhammad stated, "This is an issue of surviving -- of literally life or death."

Big Business

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certain benefits, despite the fact that the average state's mandates add only about 2% to 5% to the cost of a typical plan.

Making consumers more cost conscious through higher co-payments, deductibles, dollar limits on benefits, and restriction of benefits to catastrophic care are also offered as cost control solutions by those who oppose government involvement in health care. But this approach flies in the face of reality -- frivolous visits to the doctor are not the driving force behind health care inflation. The largest expense for any health plan is hospitalization, and consumers have little choice in this area. Also, cost effective preventive care is delayed by high co-payments and deductibles.

The Caterpillar Corporation is one firm that has reluctantly come to the conclusion that a unversal health care program may be the only rational solution. At a presentation before the Decatur Area Labor-Management Committee, Mr. William Beale, Caterpillar's Supervisor of Compensation, expressed his frustration with controlling health care costs.

"We have tried every cost containment strategy available, and although we've plugged some holes in the dike, we have been unable to adequately address the problem of skyrocketing costs," explained Beale. "There is a clear need to address the problem at a higher level. Caterpillar hasn't endorsed any specific proposals, but we recognize the need to develop a universal solution."

Fortunately, more and more businesses are recognizing that unworkable, ideological proposals are not what the public demands, and are also not in their own economic interests. In recent agreements, AT&T joined with the Communications Workers of America, and Bethlehem Steel joined with the United Steelworkers to support a national health plan. As the health care crisis worsens, more firms are likely to follow.

This article is based on a story which originally appeared in the January, 1990 issue of Health Care News, published by the National Health Care Campaign. Next: what labor unions are doing to mobilize around national health care.

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The Politics of National Health Care

Big Business Grapples with Common Sense vs. Ideology

This is the first in a series of articles about the politics surrounding the growing momentum for a universal health care plan. This article looks at growing support in the business community.

Although the portion of our population covered by private health insurance has steadily declined in the 1980s, the majority of Americans still obtain health insurance coverage through employer-based plans. But as health care costs skyrocket, employers are increasingly convinced that the private health insurance system as we know it is collapsing. Large employers who have historically offered comprehensive benefits with minimal or no employee contributions are feeling the health care crisis for specific reasons:

- **In a competitive world market, American businesses are at a clear disadvantage due to our high health costs.**
- **New corporate accounting rules will soon require companies to specify liability for the health care benefits promised to current and future retirees. This change will dramatically affect the balance sheets of corporations.**
- **Cost control strategies initiated in the early 1980s have reached the limits of their potential savings, and health care inflation is worse than ever.**

Not only are businesses struggling to afford full coverage for their own workers, if they buy private insurance they are also paying an uncompensated care charge, which defrays some of the cost of health care for the uninsured. That charge is increasing as the number of uninsured grows, as other companies fail to provide coverage for their employees, and as public health programs are facing budget cuts. In fact, the inequity of paying for other companies' workers led big businesses in Massachusetts to support a bill requiring companies to either provide their employees with health insurance, or pay into a public health fund to do so.

Organized labor is agressively defending against shifting costs to workers and their families. Recent strikes agaisnt Pittston Coal and the "Baby Bells" are only the tip of the iceberg. In 1986, health benefits were a major issue in work stoppages involving 18% of the workers who went on strike. By 1989, that share had jumped to 78% of all striking workers, making it the number one strike issue, and costing the economy $1.1 billion in lost productivity.

This cost-shifting merry-go-round is helping to unite segments of business, consumers, labor, and even some insurers and medical providers in declaring a state of crisis in our health care system. Segments of the business community have recognized that haggling over who picks up an ever-increasing tab means that nobody wins. These employers, such as Chrysler and American Airlines, have concluded that our fragmented system of multiple payers is a fundamental barrier to effective cost containment and improved access. With thousands of health plans, no one payer can effectively control health care inflation by squeezing waste out of the system. Instead, individual payers try to limit their own costs by shifting them onto someone else. That's why the national health care plans in every industrialized country have been more effective in controlling costs, through the use of a centralized payment system which sets hospital budgets and physician fee schedules. A similar payment system would reduce American health care costs and eliminate excessive administrative costs.

It is important to appreciate that the business community is deeply divided on how to expand the government role in health care. Almost all firms want government to give them tax breaks for providing health care. A large portion of the business community wants government to intervene in regulating the private insurance industry in order to lower rates. But many businesses still oppose creation of a single, national health plan. That opposition includes both big and small businesses, and is largely driven by ideology.

This segment of the business community continues to endorse pro-competitive purchasing strategies to control costs, despite the failure of this approach, with its endless cost-shifting. Tax incentives for small employers and Medicaid buy-in programs for low income workers are also supported by these businesses. But experience has shown that voluntary incentives cannot address the needs of the uninsured, and that a Medicaid card does not mean access to care.

Supporters of free market medicine often advocate forms of cost-shifting onto individual consumers. They want to eliminate the ability of states to mandate that health insurance policies include

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