

Rebuilding the Local Health Care System

by John Peterson

This has been a difficult article to write. I am torn in a sort of an emotional dialectic that looks to what we are attempting to build, yet realizes the obstacles placed in the way to success. The amount of work that has yet to be started is multifaceted. At every step of the process, we will encounter powerful opposition. We must recognize health as the political issue that it has been for several decades.

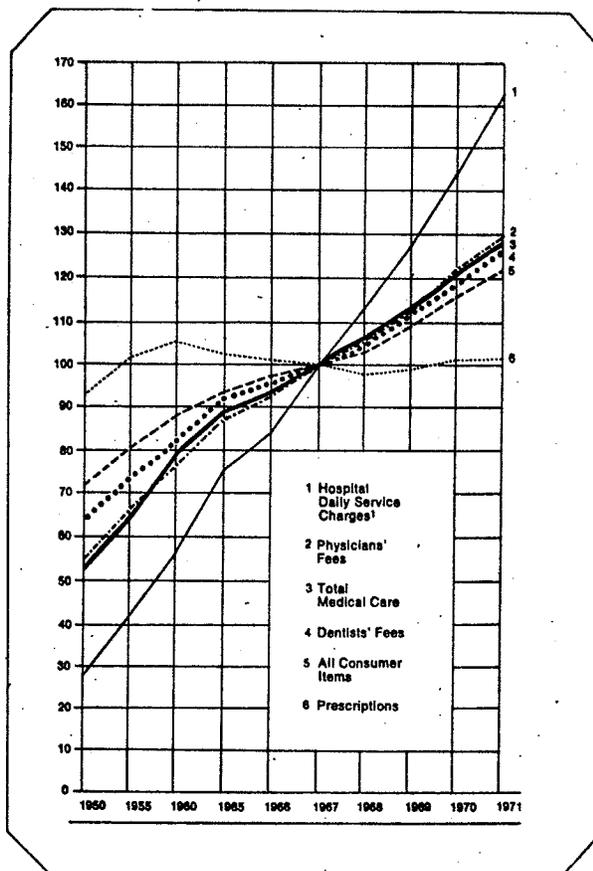
Many social service agencies went through organizational hell as funding dropped progressively to nothing over a brief two or three year period. Much of the staffs have been occupied with securing their continued existence. That situation is not going to change for several years to come, unless some way is developed to make them self-sustaining. Health Maintenance Organizations (HMO) are the first concrete possibilities in that vein for many years.

As the National Health Care System develops, federal incursions into the existing, fragmented network will take a succession of forms. Federal authority will expand to a regional base. Health care monies will be dispensed by regional offices. These offices will have some degree of autonomy depending, as usual, on the overall political situation. The National Comprehensive Health Planning concept was the initial manifestation. County-wide planning groups were to meet in a five or six county regional council. This council was to be research oriented, but these studies would serve as the basis for action. (Over the years, these councils would evolve into strong federal agencies. An eventual function of the regional offices will be to administer the national health insurance programs at the local level.)

Are these agencies to actually represent community-grass roots interests, or are they to be conduits for ever increasing hospital profits as Blue Cross and Medicare have become? Financial arrangements incorporated into the current health system enrich profit motivated institutions and individuals. The history of health in the last twenty years reflects this influence, its legislation is tailored to the wishes of those interests.

This has got to change. Any imagined health care system that does not place its priorities on keeping people healthy, is something less than a health care system. Through existing insurance companies and the federal government, health corporations and doctors are guaranteed profits at an untypically high inflationary rate. As fees are marked up, insurance plans raise their rates to the consumer. Strong review over physician activities is not exercised. Since insurance is geared to in-hospital rather than out-patient care, the tendency is to hospitalize unnecessarily in order to collect larger fees. Premiums are automatically raised as hospital directors and private doctors decide to increase the costs. The whole

Figure 6: Price Indices for Selected Health-Care Items and All Consumer Items, 1950-1971 (1967=100)



1/Includes charges to adult inpatients paying full rates for room and board, routine nursing care, and minor medical and surgical supplies.
Source: U. S. Social Security Administration, Social Security Bulletin, Vol. 35, No. 1 (January 1972), pp. 63, 64.

process is similar to AT&T's continuous rate increases due to greater equipment costs -- from Western Electric, a wholly owned subsidiary.

Attempts to redirect this monstrosity toward true health care have been resisted strongly over the last two decades. What happened recently is most illustrative. Comprehensive Health Planning was to be initiated in Champaign County early spring 1972. Public hearings were held in which officials from Carle Hospital and the UI medical school spearheaded an effort to quench a potential threat to their way of doing business. A blitz organizing drive turned whitewash aside. The hearings started to explore the range of human issues involved in comprehensive health care. Preven-

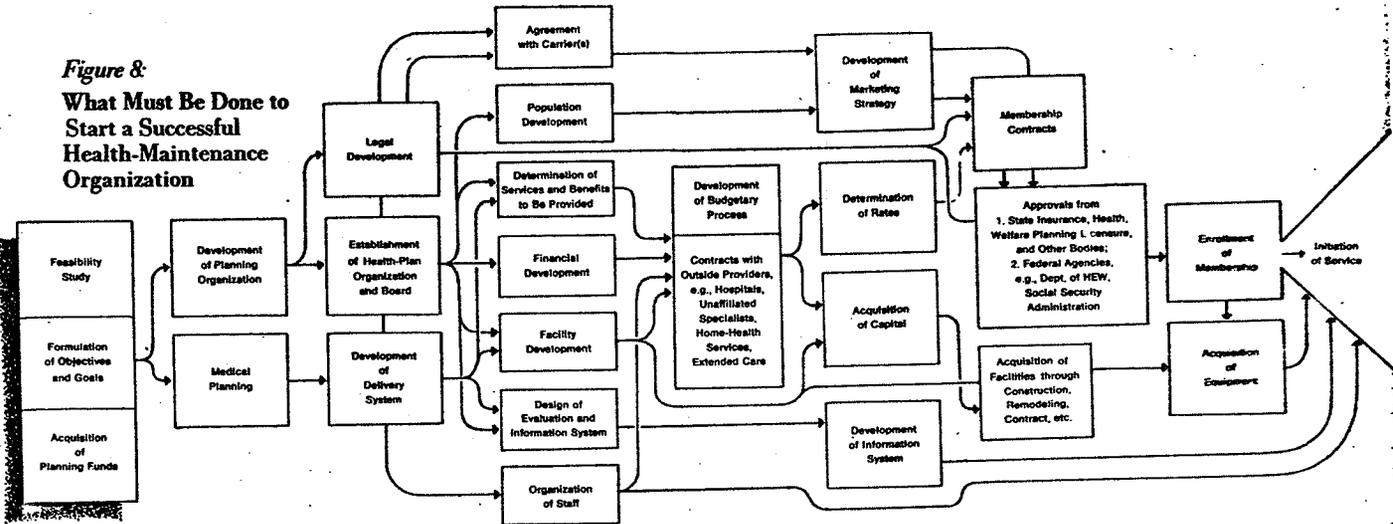
tive, not solely curative medicine; emerged as a consumer-based approach. The final step in CHP implementation was the selection of board representatives. Institutional representatives turned out more doctors than we even know existed. The council met a couple of times. It has not been heard from since. By destroying comprehensive planning, those who benefit financially from this set-up, have been able to cut-off support for alternative approaches to the health care problem.

The struggle over HMO's is fraught with additional complexities. If they are to become more than a facile transformation of what already exists, they must resist the tendency toward over hospitalization, uncoordinated services and lucrative

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Figure 8
What Must Be Done to Start a Successful Health-Maintenance Organization



specialized treatments. HMO's should be non-profit organizations with realistic physician remuneration and pre-payment policies that encourage continuous health maintenance over crisis care.

Despite these provisions, the possibilities for cooptation are still very real. HMO's already established in California, have been able to reduce costs by limiting their membership to the low-risk affluent sectors of society and the welfare supported poor. There have been some motions made in preventive medicine, but the financial stability of the organizations depends on low use of available services. The impulse is to provide less care and enroll more people. Since consumers have little formal voice in executive decisions, they are not assured of the comprehensive treatment they deserve.

It is only if the goals of the health organization are oriented toward the subscriber's good health, that HMO's can unselfishly serve their membership. This entails subscriber control of the organization's policies. Without subscriber direction, the concept is easily manipulated into other directions.

The only chance we have against the odds at this point is to prepare highly researched and strongly supported alternatives. If we can garner pilot project status, we have

a chance of influencing the outcome. But we must get the project off the ground before innovative proposals are lost to established policy. An HMO feasibility study is a critical

first step. From there we must reinstitute Champaign County's comprehensive planning to develop formal influence at the regional and state level. There are absolutely no

guarantees that it will work. This is a new avenue of approach that can gather a lot of committed talent behind it. For that reason only, it has a shot at pulling it off.

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