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CONSUMERS ORGANIZE TO CHECK HEALTH SERVICES

by Donald Rubin and Edward T. Gluckmann

The consumer movement in the United States has been making rapid strides in the last two decades. There are magazines devoted to telling us which toothpaste is the best, which washing machine will wash the whitest, the value of one electric fan over another, and the best suntan lotion to use for an afternoon on the beach.

But there is an alarming scarcity of information about what ought to concern us the most—our health. For a long time "conventional wisdom and folklore" has told us that health is our most important possession. It is also one of our most expensive possessions. HEW reported in November, that in fiscal year 1972 the nation's health bill amounted to $83,400,000,000.

"Conventional wisdom" also tells us repeatedly that most Americans have a "free choice" in determining their health care. Do we? When a patient enters a hospital, does he always have a free choice of the anesthetist, X-ray technician, radiologist, surgeon, nurse, specialist, super-specialist, an understanding of the tests performed, and other multiple complex services?

Modern medicine today is too complex even for the individual practitioner to understand all of the new developments and ramifications. The physician must often turn to experts to assist him. Recently a White House appointed committee on health education disclosed its findings after a year's investigation which revealed that health education throughout America "is a neglected, under financed, unhealthy, fragmented activity" which requires a major overhaul.

In Need of Information

It has been obvious for a long time that health care consumers are in the need of major informational resources to assist them in their decision-making when they seek health care. The old days when we turned to the individual for almost all of our health-care information, when we considered the individual family doctor our sole health resource, are over. Free choice of medical care today has gone the way of the general store.

The health care consumer today really has no way to evaluate the health care services he must purchase. The buyer of a new automobile can turn to a number of magazines that evaluate automobiles. Or he can test drive the car, kick the tires, stroke the paint job, try to make a good deal with the salesman, talk to neighbors. If worst comes to worst after buying a car which is no good, one can always sell it at a loss if dissatisfied. One can hardly recover a damaged kidney or throw back the switch on a chronic life-time disorder.

The health care consumer, on admission to a hospital, is often shocked and dismayed to find nursing units understaffed, the physical plant inadequate, and life saving services often unavailable. Consumers do not have access to the flow of information available to health professionals, and whatever information is available is written in language that the average person cannot understand. Without this concise, accurate detailed information, the consumer cannot intelligently select the appropriate hospitals that can meet his needs.

Social agencies, union-management welfare programs, and consumer groups generally do not have the resources to monitor the differences in quality of care rendered at each hospital. Union and management representatives as major contractor groups, and government health officials, as protec-

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"Most consumers . . . depend on their neighbors' advice when seeking a physician."

tors of the public purse, often do not have in-depth information necessary to assure the highest quality of care at the lowest cost.

Most consumers facing immediate medical care problems depend on their neighbors' advice when seeking a physician, Often, a phone call to the local medical society, a near-by hospital, or to a physician found in a telephone directory are the methods used to obtain medical services.

Many patients rely exclusively on their own doctors for recommendations for referrals to a specialist or hospital. These methods, frequently based on personal friendships or special relationships, are not necessarily in the patient's best interests. None of these methods assures the consumer access to the appropriate and most skilled practitioner.

Inadequate Care

Physicians may admit patients to hospitals because ambulatory care insurance is adequate or they may own or have an interest in the hospital's operation. Patients often undergo surgical procedures that are not medically indicated, as verified in a 1960 study commissioned by the Teamsters Union. This study showed that this union's members and their families were receiving inadequate care and many patients were operated on unnecessarily. Despite this, the study revealed that most union members believed that they received good care.

Studies of hospital utilization rates by type of medical insurance show significantly lower admission rates for prepaid group practice patients than for fee-for-service patients.

Other commentaries and studies made over the years confirm that, based on medical need, a large percentage of inpatients should not have been hospitalized. These studies indicate that the number of hospital admissions and the frequency of surgery could be reduced if adequate information about hospital services was made available to the general public. The reductions in the number of admissions and surgical procedures would lead to significant savings for union-management welfare funds, consumers, and publically supported programs.

Ill Equipped

Without proper information, patients are admitted to local hospitals where the physicians have privileges; but these hospitals may not be equipped to treat them. In other cases, they are admitted to the most costly and well-known hospitals because the patients fear that the local hospitals may not be able to care for them properly. In the former situation, the patient receives inadequate care; in the latter, care at a greater cost.

Blue Cross rates are not made available to the general public nor to Blue Cross's own subscriber groups. Without assurances that patients in the more costly hospitals are receiving appropriate and better care, these rates cannot be justified. Similarly, patients in the less costly hospitals may be receiving inadequate care unless professional standards are maintained.

One out of every seven people in the United States can expect to be admitted to a hospital in 1973. On the average, each American will visit a doctor at least four times annually and spend almost $.08 out of every $1 earned for health care. Over 29,000,000 people are annually admitted to more than 800,000 hospital beds. Americans will spend almost $95,000,000,000 for health care in 1973.

In southern New York alone, there are approximately 260 hospitals with nearly 140,000 beds and an average daily census of more than 125,000 patients. The magnitude and complexity of the services offered by these hospitals are staggering.

Medical costs have increased 65 percent from the base period of 1957-59 to 1970. Hospital room rates increased 188 percent during the same period. The average cost to hospitals per patient stay has risen from $244.95 in 1960 to $664.28 in 1970. As the costs of medical care continue to rise, more union-management welfare programs will experience the continued depletion of funds and individuals will have their life savings wiped out.

Costs, charges, and average lengths of stay vary greatly among hospitals. Blue Cross per diem reimbursement rates to hospitals in New York City now (based on audited costs) vary from $65 to $220 per day. There are no publications or other sources of information that relate total hospital charges (or costs) to the quality of care rendered.

A few public and private agencies have regulatory control over hospitals. This control is exercised by state agencies, as mandated by law, or by voluntary self-regulation commissions. These agencies and commissions have been less than effective in fulfilling their responsibilities to the general public and the individual patient.

Seal of Approval

The most important voluntary agency, the Joint Commission on the Accreditation of Hospitals, is unable independently to evaluate the quality of care in hospitals in the best interests of the consumers. The JCAH's board is composed of providers only (ie., the American Hospial Association, the American Medical College of Surgeons, and the American College of Physicians, etc.) and its accreditation programs are financially supported by the surveyed hospitals.

JCAH bestows the same seal of approval to a 1,000-bed hospital with a medical school affiliation and major research and training programs, as to a 29-bed hospital with none of these programs or affiliations.

New No-Profit Commission In N.Y. Will Accredit Hospital Services

What is being described as the nation's first consumer commission to accredit hospitals and health services, got underway in New York City this week with the publication of a report on proprietary hospitals in the city. The report names the owners of these hospitals and details the level of services in these privately-owned medical facilities.

Called the Consumer Commission on the Accreditation of Health Services, Inc., the organization is incorporated under the laws of New York State. According to Edward Gluckmann, executive vice president of the non-profit commission, it is an effort on the part of consumers and concerned health professionals in New York to provide consumers with factual data on the cost and quality of health services.

Mr. Gluckmann described it as "the first time an effort of this magnitude has been undertaken by a consumer organization in the health field."

The commission will collect, evaluate and publish information for health consumers covering the availability, quality and cost of medical services in New York City. It will also evaluate health institutions and publicize its findings in a series of profiles to appear in its own publication, "Health Perspectives." In addition, the commission intends to rate and accredit hospitals and other health services that meet clearly defined standards prepared by it.

Data on nursing homes, mental health centers, medical groups, drug plans and other institutions and facilities that deliver health care services will also be published, Mr. Gluckmann said.

"We believe the Consumer Commission is a beginning and a breakthrough to stabilize the dizzy escalation of hospital and medical costs in the New York area," Mr. Gluckmann said. "Many consumers today are finding it an impossible burden to meet out-of-pocket payments for medical costs which they often assume are fully met by existing health insurance coverage. Last year the entire nation spent $83 billion for all health services. As far as we can determine, this $83 billion will rise to over $100 billion within several years. The health consumer has an absolute right to know what he is purchasing, the range of services available to him, the quality of these services and the standards that govern the people who have the responsibility for delivering health care."

"The emergence of the Commission brings us to an end of the era where the health consumer has no real voice in the delivery of health services because of a lack of relevant information. No longer will health care users and purchasers be in the dark about the availability and cost of the services offered. The consumer commission will put the health facts before the consumers of New York who welcome the opportunity to have hard factual and technical information available. This will make it possible for them to make intelligent decisions about how to pay for their health care; where to get the quality of care American medicine can deliver, and propose alternative delivery systems that meet their needs."

Denenberg Releases 12-Point 'Citizen's Bill Of Hospital Rights'—Calls It A 'First'

HARRISBURG, Pa.—A 12-point "Citizen's Bill of Hospital Rights" outlining what the patient and the public should expect from hospitals, has been released by Insurance Commissioner Herbert S. Denenberg.

The "rights" set forth in the 8-page document, according to Commissioner Denenberg, are "based on law" or are otherwise enforceable through procedures to which patients have access. Denenberg said that this is the first such bill of rights for hospital patients ever formulated by a government agency, adding somewhat superfluously, "and it is also the most comprehensive one issued to date."

The "rights" listed in the "bill" include, a right to good quality care and high professional standards, continuously monitored and reviewed. Secondly, there is the right to economical care and also rights to a voice in the management, control and planning of hospitals. Other rights are access to information about a patient's treatment, control over the nature of the treatment, prompt and courteous action on complaints, and full access to information about the patient's medical history. The public has a right to expect a hospital to behave as a consumer advocate rather than as a business headquarters for

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Uniform Health-Care Program Offered By Sen. Long For 25-30 Million U.S. Poor

(By Insurance Advocate Correspondent)

WASHINGTON, D.C. (WIB) — A uniform health-care program for some 25 to 30 million poor people throughout the United States has been offered by Senate Finance Committee Chairman Russell B. Long (D-La.).

The plan that would replace Medicaid was outlined by Long in a speech for the AFL-CIO state convention in Baton Rouge, La. The program was also simultaneously announced in Washington.

Long said his plan would cost about $5.3 billion more than the $9 billion the federal government and the states now pay for Medicaid, which has frequently been criticized as inadequate and with spotty coverage and benefits for the poor.

As visualized by Long, the plan to replace Medicaid would be nationally administered, financed by general revenues, and would provide benefits to any person with an annual income under $2,400. The eligibility cutoff for couples would be $3,600 a year, and for a family of four $4,800, rising by $600 for each additional member of the family.

If medical bills reduced higher family income to these levels, the family would then be covered.

The Louisiana Democrat noted this would not happen often, since private health insurance coverage would be cheaper than paying the bills in order to qualify.

Beneficiaries would receive free hospital care for 60 days, skilled nursing facilities and intermediate care facilities, plus out-of-hospital doctor-visit privileges for a nominal co-payment of around $2 to $3 for each such visit made.

The Long proposal is one of many plans to improve the health care for the nation's poor. Long's Finance Committee has jurisdiction over such plans, but final action on Long's program—or any other health plan—appears unlikely this year and may not even come in 1974.

One of the stumbling blocks is the House Ways and Means Committee which is to take up international trade and tax reform proposals, both of which are very complex subjects. This means the House will not get around to considering health benefit legislation for some time to come.

Long is coupling his low-income plan with a second proposal, providing a federal Social Security-financed plan for virtually all persons of all ages and incomes to cover the costs of catastrophic illness.

The government would pay most of an individual's hospital and doctor costs after he has been in the hospital for 60 days or has incurred $2,000 or more in physician's charges. From the 61st day on, the government would pay all but $17.50 a day of hospital costs. It would pay 80% of any doctor costs above $2,000.

The two plans are designed to mesh. The first proposal for the poor covers the first 60 days in the hospital, and then the individual would be taken care of under the catastrophic plan starting the 61st day.

The only major gap in Long's plan is coverage for middle-income people and higher-income people for the first 60 days in the hospital or the first $2,000 in doctor bills, before their coverage under catastrophic insurance begins. Long would have such individuals cover this gap with their own private insurance.

Long's plan is fairly close to the one the Nixon Administration proposed in the last Congress. It does not go as far as the plan offered by Sen. Edward Kennedy (D-Mass.) which would set up a universal national health insurance system covering virtually all health-care costs for everyone and financed through payroll taxes.

Long said his two plans will cost around $8.9 billion compared with an estimated $70 billion for the Kennedy plan.