

PRAGmatics

journal of community-based research

Can the people who
brought us the weekend
bring us
universal health care?



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For extensive health care information, see these web sites:

www.kaisernetwork.org

www.americansforhealthcare.org

www.cms.hhs.gov

www.coveringkidsandfamilies.org

www.rwjf.org

www.pnhp.org

www.hopkinsmedicine.org/HealthInformation/index.html

PRAGmatics is published by the Policy Research Action Group,
a collaborative partnership between Chicago-based universities—
Chicago State University, DePaul University, Loyola University Chicago,
National-Louis University, University of Illinois Chicago,
and numerous community-based organizations.

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PRAG is grateful to its
major funders,
W. K. Kellogg Foundation,
the John D. and
Catherine T. MacArthur
Foundation, and to
Loyola University Chicago,
our host institution.

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Vol. 7 No. 1
Spring
2004

Health Care for the Homeless— A Social Orientation to Health

By Tanya K. Larson

On any Monday morning, a crowd of people gathers outside a health care center in Uptown, waiting for the doors to open. By 8:30, there are more than thirty names on the sign-up sheet for walk-in services. Many of these people walked over from a local shelter. A few spent the night in the park or under an overpass. Homelessness is a condition unthinkable to many Chicagoans. Yet it is a bleak reality for more than 15,000 men, women, and children on any given night.

Across the city of Chicago, there are various hospitals, community health centers, and free clinics that provide limited medical care to the estimated 166,000 individuals who encounter homelessness annually. However, Heartland Health Outreach (HHO) is the only federally funded Health Care for the Homeless (HCH) project in the city. HHO provides a continuum of health care services with an organizational focus on homeless, immigrant, and refugee populations. In 2003, HHO served approximately 15,600 clients in need of mental health, primary care, and case management services.

The philosophy behind Heartland's HCH services includes a "transdisciplinary" approach which seeks individual and systemic solutions to end homelessness. The transdisciplinary approach endeavors to "transcend separate disciplinary approaches by encouraging teams to work jointly to address common problems by using a shared conceptual framework" (Conanan et al, 2002). Further, the concept of health is defined not as the absence of disease, but as a state of well-being. Providers look at the root causes of homelessness and find that poor health is a major contributor.

Health Care for the Homeless services are designed to provide comprehensive care in a culturally sensitive environment. In addition to primary and mental health care, clients can access dental services, addiction services, entitlement eligibility assistance, and housing assistance. Outreach, which entails services in non-traditional settings for the purposes of engagement and improving health outcomes, is a distinct feature of the model. HCH staff meet clients in shelters, street locations, parks, and motels. Through these efforts, people who are disconnected from institutional systems and are otherwise disenfranchised have opportunities to obtain information, referrals, and direct services.

Improved accessibility and utilization are central concepts in services for the homeless. Whether a person is experiencing episodic or chronic homelessness, there are considerable obstacles to accessing mainstream health care: lack of insurance, fragmented service systems, mistrust of

institutions, lack of information about services, and lack of transportation. In terms of utilization, problems with services might include provider attitudes toward the impoverished and homeless, language and cultural barriers, and lack of required documentation. Logically, finding food and shelter is prioritized higher than attending to health care issues.

Because the health needs of the homeless mirror the health trends in broader society, Heartland's HCH services reflect those provided to the mainstream population. Chronic health problems, such as diabetes, hypertension, obesity, and asthma, are increasingly prevalent in the United States. People experiencing homelessness are equally impacted by these health conditions, which are often exacerbated by barriers to access and poor living conditions. Living between shelters and the streets exposes people to harsh weather elements, communicable diseases, and high rates of violence. These stresses, in addition to poor nutrition, poor hygiene, and lack of sleep, inevitably weaken the body.

According to the Chicago Coalition for the Homeless, the rate of tuberculosis infection is three times higher among the population of homeless individuals than among the general population. Additionally, it is estimated that ten percent of the homeless people in Chicago are HIV positive. The management of conditions requiring regular, uninterrupted treatment, such as TB, HIV infection, addiction, and mental illness, is a complicated task for those who lack stable housing. As individuals without health insurance rarely seek preventive care, health plans to decrease communicable diseases and other chronic conditions become focal points in HCH interventions.

Too little attention is given in mainstream health services to the non-medical reasons why people go to their doctor's office. People with economic and social problems rely on their health care providers to address "complex, chronic, and multifaceted psychosocial and economic problems" through such basic services as provision of food, clothing, safety, and "various kinds of relief from social distresses" (Malone, 1998). With little control over the underlying determinants of health, homeless people seek out resources to meet their basic needs. To address some of the fundamentals, shower and laundry facilities, lunch bags, and clothing, are available at HHO.

Social workers, medical professionals, and mental health staff at Heartland's HCH clinic understand that homelessness is caused by a combination of structural barriers and personal vulnerabilities. This sensitivity paves the foundation for dignified and respectful assistance.

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U.S. Health Care— The Realities and the Feasibility of Change

By Stephen L. Thompson

As we approach the 2004 election the issue of health care may well emerge as the single most important issue. Intense pressure from rapidly rising insurance premiums, reduction or elimination of retiree health benefits, coupled with a reduction in coverage, has many Americans on edge and clamoring for change in the way we finance and deliver health care. Because of the complexity of this issue, I will use the triad of cost, quality and access to describe current health care system realities and then discuss the feasibility of change proposals put forth by both the Republicans and Democrats.

Cost

The U.S. spent around \$1.55 trillion on health care in 2002, which accounts for approximately 14.9% of the Gross Domestic Product (GDP).¹ Heffler et al, project that by the year 2013 we will spend \$3.36 trillion on health care and this amount will account for 18.4% of GDP. Of note, this number does not take into account the newly passed Medicare drug benefit, which within a very short time frame has increased its predicted cost from the original \$400 billion to \$530 to \$540 billion for the 10 year period 2004-2013.² One can only wonder what the true cost of this legislation will be, particularly when compared to the original Medicare legislation. Prior to passage in 1965, Medicare was estimated to cost \$238 million, however, the bill for the first year came in at \$1.9 billion.³ Given the sudden increase in cost projections and no ability to control the costs of medications it's a sure bet the actual cost for this new drug benefit will be much higher.

Another more familiar focal point of health care delivery is hospitals and hospital care. Not surprisingly, they are now the leading source of health care services expenditure growth because they employ large amounts of highly specialized labor and purchase large amounts of expensive technology.⁴ As competition for patients increases, spending on attractive enticements will continue unabated.

Though the U.S. spends more money on health care than any other country, 'we continue to rank below comparable countries (Canada, Germany, United Kingdom) when it comes to health outcomes, e.g., infant mortality, measles immunization rates, and average life expectancy from birth. This contradiction stems from a badly fragmented health system that caters primarily to people with the means to

pay for their care. The not-so-hidden agenda involves a form of health rationing based on one's ability to pay. Rather than spend money on health initiatives that would benefit greater numbers of people, we choose to spend money on new technology and new acute care techniques that benefit a small portion of the population and add little to the populations' overall health. In short, we consume health care at the margins, which means the more we spend the less each dollar buys in added health value.

One last point involving health costs centers around

administrative waste.

Administrative expenses are another fast-rising part of national health expenditures.⁵

Government is often chastised for being inefficient while private companies are lauded for being efficient, however, data has shown the opposite to be true in health care. The U.S. spent

Though the U.S. spends more money on health care than any other country, we continue to rank below comparable countries (Canada, Germany, U.K.) when it comes to health outcomes, e.g., infant mortality, measles immunization rates, and average life expectancy from birth.

\$105 billion on administrative expenses for health care in 2002 (a 16.2% increase over 2001). Private administrative costs consume 12.8% while Medicare administrative costs are only 3%. These numbers do not make a compelling argument for cutting costs by trusting more of the system to private initiatives. And as costs continue to rapidly escalate we make it more difficult for those without the means to access care.

Access

The public is often told that it would be politically impossible to provide any kind of universal health insurance to the entire population. Of course with a proposal of this magnitude, it's not clear whether enough savings could be wrung out of the system to cover everyone. Some National Health Insurance advocates have emphatically stated that we can afford to switch to a National Health Plan right now without increasing costs because the amount of free care, bad debt, and administrative waste assumed by providers would surely lessen and help pay for increased access.⁶

As one of the only modernized nations without universal health coverage, the uninsured become yet another shortcoming of our health care system. Who are they and why don't they possess health insurance? Reasons include individuals who work for employers that do not offer health insurance, or work for employers who offer health

insurance to some but not all employees, or individuals who are eligible for the employer's plan but opt not to purchase it, probably because of the expense.⁷

The U.S. Census Bureau estimated that 15.2 per cent of the population (43.6 million people) did not possess health insurance coverage in 2002, an increase of 2.4 million people from 2001.⁸ Another source states that nearly 75 million people (1/3 of the population) lacked health insurance for at least part of the years 2001 and 2002.⁹ Twenty-four percent of this uninsured population was uninsured over the entire two-year period. While it is widely believed that the uninsured are unemployed, only 22.1 percent of the uninsured were unemployed, primarily due to disability, chronic illness, responsibilities as caregivers of family members, or those not actively looking for employment.¹⁰ As one's income increased the incidence of being uninsured decreased, however, the problem remained an issue at 400% of the poverty level. Most of the uninsured were between the ages of 17 and 65 (73%), although the distribution of uninsured in that age group was more heavily skewed towards the lower age groups. Medicare often covers those over the age of 65 while children below the age of 18 are covered through various state initiatives (CHIP, etc.) although their rate of uninsured runs around 27.1%. White, non-Hispanics made up the largest racial group of the uninsured; however, Hispanics and African-Americans were more likely to be uninsured than White, non-Hispanics.

Why is being insured important? To be uninsured in the U.S. means limited access to health care, and those uninsured adults with chronic conditions are less healthy than their insured counterparts, primarily because they delay or do not receive care for their conditions, which worsens their prognosis.¹¹ One study that compared five countries' health care systems reported that Canadian and British adults were "less likely to report going without physician care because of costs than were adults in Australia, New Zealand, or the U.S."¹² Further, they go on to report that while waiting times for elective surgeries were shorter in the U.S., it was financial barriers and stress that caused low-income adults to not seek care.

Compelling research looks at determinants of disease as an outgrowth of the patient's social and economic stratum, in that poor health is a direct result of poverty and income inequality rather than any personal health behaviors.¹³ Traditional medical care is an individualistic pursuit and we often blame health problems on bad personal choices, e.g., smoking, obesity, etc. What is lost in that world view is the bigger picture of disease patterns in the general population. Public health disciplines, e.g., epidemiology, are charged with the responsibility for examining the population's health rather than that of individual patients.

Most of the former and current debates surrounding

health care system problems focus on the provision of medical care. While it consumes most of the money directed towards health, individual medical care is not often cited as contributing the most towards increased longevity of the population. Of the 30 years improvement in life span during the 20th Century, medical care is responsible for only five of those years (3.7 years is attributed to medical treatments and 1.5 years results from clinical prevention services, e.g., immunizations and screening exams).¹⁴ The other 25 years of increased average life span occurred as a result of public health measures such as improved sanitation, less injuries from safer automobiles, etc., and what is truly amazing is that these improvements were accomplished for roughly 5 percent of all health expenditures.¹⁵ Clearly, we are not allocating health care resources in the right areas of the system.

Limited access as a result of being poor has long term health ramifications, not only in the inability to access medical care, but also in higher mortality and morbidity as a result of living in neighborhoods with endemic violence, unemployment, and unhealthy living arrangements. These patterns get lost when we treat the individual patient, so public health initiatives must be part of any discussion to improve health and access.

Why is being insured important?

Given what we pay why don't we get it?

Quality

Quality is the most difficult area of the three to measure.

Without a doubt, the U.S. health care system has made some major strides in treating illnesses that just a few years ago were considered incurable. For example, advances in the treatment of HIV/AIDS, diabetes, and other

chronic diseases have increased the life span of afflicted individuals, but limited access and high costs mitigate the effect of those advances. Certainly, high quality health care is better than low quality health care but having the best technology is not enough.¹⁶ The Commonwealth Fund on Health Care Quality states, "High-quality care involves meeting patients' personal needs and treating them equitably regardless of their race, ethnicity, gender, income, or health status." Given what we pay why don't we get it? Reasons range from poor communication between physician and patient, lack of preventive care or unwillingness to get tests, and management of specific diseases do not follow widely recognized care guidelines. They also found that one of every seven Americans in fair or poor health was dissatisfied with the quality of their health care.

Since few Americans have the ability to switch health plans (particularly if they are in poor health), it appears the role of competition cannot be counted on to solve these quality problems as it might in other industries. While we have made great strides in treating some diseases and

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Medicare—The Nation’s Largest and Most Efficient Insurance Program

There already is an excellent health insurance plan that provides secure, affordable health care. It’s called Medicare—the nation’s largest and most efficient insurance program. It covers the vast majority of people over 65 years old and many seriously ill and disabled people under 65.¹

Medicare’s hospital insurance (and limited nursing home care) is paid for by a payroll tax of 1.45 percent on workers’ earnings that is matched by employers. Coverage for doctor’s fees and outpatient services is paid for by an individual premium (\$58.70 per month in 2003) and general federal revenues.²

Medicare’s administrative overhead is less than three percent. In stark contrast, the rest of the system wastes about 30 percent of total health spending on insurance company profits, bureaucratic red tape, and unnecessary procedures and equipment. Furthermore, because the current Medicare program covers so many people, it has the clout to obtain low discount rates with hospitals and doctors.³

It’s estimated that a national insurance program based on Medicare could save \$200 billion annually by eliminating high overhead costs, reducing unnecessary marketing, and cutting insurance company profits. It could negotiate deep discounts and make it possible to set and enforce overall spending limits. *The savings would be enough to provide comprehensive coverage for everyone.*⁴

But instead of *expanding and improving* the existing Medicare program to cover everyone, the special interests who profit from the current failed system are attacking it! With strong support from Pres. Bush and the AARP, Congress passed major changes to Medicare that encourage companies to cut or drop retiree benefits, lock in high drug prices and allow for eventual privatization.⁵

The new law undermines the traditional Medicare system by forcing beneficiaries to join HMOs and private insurance plans to access the new drug benefit. Private plans will tend to skim off the healthier, lower cost patients—making the traditional Medicare program less affordable for its remaining participants. Under the Bush plan, only the lowest income seniors and people with disabilities—many of whom were already eligible for Medicaid—will receive a subsidy for their premiums and deductibles.

The Medicare bill prohibits using its buying power to negotiate lower cost prescriptions with the pharmaceutical industry. While the dozens of new private plans will negotiate for discounts and rebates, they won’t have Medicare’s enormous bargaining power. The end result is that the already super-profitable drug manufacturers will reap extra billions at the taxpayers’ expense.⁶

One of the worst features of the new law is that it lets people under age 65 and their employers contribute to new tax-free Health Savings Accounts (HSAs) for use with high-deductible insurance. These kinds of plans tend to attract the well and the wealthy, further undermining the current system of job-based coverage which relies on large risk pools to help keep insurance affordable. HSAs will concentrate workers who are sicker and have higher medical expenses in conventional employer-sponsored insurance policies, further fueling the vicious circle of rising premium costs. In turn, this leads to more employers deciding to drop coverage or make it less affordable.

A little known section in the new law calls for “a nationwide public debate about improving the health care system to provide every American with the ability to obtain affordable health care coverage.” It mandates a 9-step, 2¼-year process for a “Working Group” appointed by the U.S. Comptroller General to hold public hearings, issue reports and make recommendations leading to new legislation in Congress.⁷

Advocates for comprehensive reform believe the working group’s mandate is too narrowly defined, limiting the debate largely to considering which types of care people think aren’t worth paying for. Instead of finding new approaches to making care more affordable or covering everyone, this process reinforces the current government’s ideologically-driven plan to force consumers to become more aware of the cost of their personal health care.⁸

The hope by many is that the Bush Medicare debacle “boomerangs”—awaking a sleeping giant of populist anger about health care profiteering while so many suffer needlessly. Combined with ongoing struggles by union members against health care cost shifting and community outrage about cuts in essential health care services, now is the time to link the anger and frustration over the new law into a broader effort to secure universal coverage based on many legislators’ original vision for Medicare: *health care for all*.

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¹For more information, contact the Centers for Medicare & Medicaid Services, 7500 Security Blvd., Baltimore, MD 21244. Tel: 800-772-1213, Web: www.medicare.gov. Another valuable resource is the Medicare Rights Center, 1460 Broadway, 17th Fl, New York, NY 10036 Tel: 212-869-3850 Web: www.medicarerights.org

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Could Labor Lead the Nation to Universal Health Care?

By Rand Wilson and Marianne McMullen

“The Labor Movement: The people who brought you the weekend.” Most of us have seen this bumper sticker. With Haiku-like brevity, it explains how organized labor was responsible for a dramatic social change that improved the quality of life for all working people.

Now consider this bumper sticker: “The Labor Movement: the people who brought you health care.” Could this happen? Can organized labor effectively organize and lead a movement for universal health care in the United States? We would argue that given the current crisis in contract negotiations over health care costs, labor has no choice but to assume this role. And furthermore, it has both the capacity and the opportunity to do it now.



Too big for the bargaining table

In 2003, health care insurance premiums increased by an average of 13.9 percent, a 13-year record. This increase motivated almost all employers to demand that employees and retirees pay a larger share of their health care benefits. Many employers are also raising workers' co-pays and deductibles to hold down costs, and are taking other steps that make it harder for families to use their benefits.¹

In the vast majority of non-union workplaces, the burden of medical cost inflation gets shifted from management to workers unilaterally, often causing real financial hardship for wage earners.

For the few workers lucky enough to be in a union, employers must negotiate with them over any changes to their insurance plans. With prices soaring out of control, collective bargaining over this issue has become as difficult as it was in the late 1980s and early 1990s, when insurance premiums rose by similar amounts.

The conflict over “who pays” has dragged almost every union into major health care-related bargaining disputes. But these battles over employees' share of premium costs do nothing in the overall war against rising health care costs. Who pays the bill won't prevent costs from rising again by the same amount or more next year.

Two opportunities for labor— cost shifting and retiree health

How workers and the labor movement respond to this bargaining challenge has important implications for the future of health care reform. The actions of union members—on the job, at the negotiating table, and, where necessary, on the picket line—can become a popular rallying point for the much larger number of people ill-served by our current system of private, job-based medical benefits.

The struggle over health care costs is a unique opportunity for organized labor to provide a compelling social vision that engages the non-union majority of working people. Several recent health care-related labor disputes have already brought this issue into the public's view. Last year about 18,000 workers struck for two days at GE over proposed health care concessions. Another high-profile dispute, involving 60,000 communications workers at Verizon in a protracted contract campaign, also successfully preserved employee benefits.

The most public clash so far in 2004 was in Southern California where 60,000 grocery workers were on strike in a bitter struggle to protect their health care benefits.² After the settlement, it led Douglas Dority, the president of the United Food and Commercial Workers union to say: “We must have national health care reform. No one company, no one union, no industry or group of workers alone can fix the health care system. We can patch it up. We can protect our members for another contract term, but the system continues to falter, exacting an increasing cost on both workers and employers and leaving more and more families without health care.”³

Continuing this strong resistance to cuts in benefits is the best way to motivate politically powerful employers to eventually support real reforms. However, if workers don't link their resistance with the larger fight for health care reforms that will benefit everyone, unions risk being seen as part of the problem. By resisting health care contract concessions with a broad demand for "health care for all," union members can help create pressure for a political solution to the national health crisis that affects millions.⁴

A second major reform opportunity for the labor movement is organizing retired union members to play a leading role in the movement for universal health care. Changes in accounting rules, the high cost of drugs, skyrocketing premiums, and plain old-fashioned corporate greed have left many union retirees and millions of other seniors without the benefit coverage they thought they would have for the rest of their lives. Twenty-five years ago, more than 80 percent of all medium- and large-sized firms offered medical benefits to their pensioners. Now only 40 percent do—and one-fifth of those firms have eliminated such benefits for new hires. More than 2 million seniors have also recently been tossed out of their HMO plans.⁵

President Bush's new Medicare law will compound the problem for workers and retirees. Incentives in the law actually encourage more companies to cut back or eliminate prescription drug benefits for retirees.⁶ The law also locks in higher drug prices by prohibiting Medicare from using its purchasing power to negotiate discounts. And by establishing new Health Savings Accounts, it promotes high-deductible insurance plans that will further undermine the current system of job-based coverage.

(For more on Medicare, please turn back to page 6.)

The Bush Medicare debacle is labor's best opportunity to take the entire reform movement to a higher level by going beyond discussion of the worst features of the new Medicare plan, and challenging politicians to improve and expand Medicare to secure universal coverage based on its original vision: *health care for all*.

Broadening the fight

If labor struggles against cost shifting are framed narrowly, they will, in effect, be seen as just another union special interest fight against give-backs by workers who already enjoy better-than-average coverage. But if resistance is framed in larger political terms by demanding fundamental reforms so that *everyone* is covered, these fights could attract much broader labor and community support. That basic philosophy led Jobs with Justice, a

national community-labor coalition, to organize a Health Care Action Day in 125 cities and towns last March.

Endorsed by eight unions and six national health care reform groups, the participating organizations undertook an unprecedented on-the-job mobilization of union members who are angry about pressure from their employers to pay for runaway health care costs. Activists in more than 260 local unions mobilized hundreds of thousands of members to put on Jobs with Justice stickers calling for health care for all.

In the days and weeks leading up to the day of action, union leaders provided members with educational materials about the causes of the health care crisis and how a national insurance plan that covers everyone is the best way to fix it.⁷

In addition to the workplace-based education, a second focus for Health Care Action Day was at the community level where local

Jobs with Justice coalitions organized more than 50 actions. Activists held demonstrations, educational forums and hearings, and organized events calling attention to the crushing burden of health care debt on working families. Delegations also lobbied their elected representatives and sought to pass city council resolutions. In a few areas, activists set up mock clinics to dispense "prescriptions for change."⁸

However, no one should have any illusions about a grassroots groundswell for universal coverage. Membership education has been so neglected that many trade unionists still view "universal health care" as something mainly benefiting someone else. The concept of a publicly funded, national insurance plan still strikes many union members as a formula for longer waits, inferior care, higher taxes and rationing—rather than as cradle-to-grave security and relief from out-of-pocket costs. Many more workplace educational activities will be needed to fully engage union members in a real debate about health care reform options and build wider support for a national solution.

Action at the state level

With the prospect of major health care reforms at the federal level seeming remote at best, another arena for membership education and involvement is in the states. For many union activists, political action closer to home provides a more realistic possibility to have a substantial impact. Success at the state level could also build additional pressure on Congress for a national solution.

Unions in Illinois, Maine, Maryland, Massachusetts and California have been supporting a variety of measures that would expand health care access and hold down costs at the state level.

In Illinois, two promising labor-backed initiatives are the Health Care Justice Act and the Healthy Illinois Campaign.

The Health Care Justice Act would set up a task force to conduct public hearings and establish a plan to cover everyone in Illinois by 2007. The bill calls for universal access to a full range of preventive, acute and long-term health care services.⁹

The Healthy Illinois Plan, just launched in February, is a new plan based on a model passed in Maine last year. The Service Employees International Union played a major role in passing the plan in Maine and, with the American Federation of State, County and Municipal Employees, is playing a leadership role in promoting the plan in Illinois. If passed, this plan could provide access to health care coverage for more than one million of the 1.7 million uninsured in Illinois. The Healthy Illinois Plan has three primary components:

1 Group Purchasing: A statewide group buying plan through which small employers and the self-employed can obtain insurance at a lower cost than they would if they bought individually or as part of a smaller group.

2 Cost Controls: A range of measures that include caps on costs and operating margins of insurers, hospitals and other health care providers.

3 Quality Controls: Creates the Illinois Quality Forum, which will promote health care best practices and provide consumers with information to compare provider performance.¹⁰

Cost controls are this plan's most controversial but arguably most important component. We already spend more than enough on health care. The challenge is to spend it more wisely with measures that control costs by curbing the excess profits that insurance companies, pharmaceutical companies, medical equipment manufacturers, and some hospitals make in the industry. As long as health care dollars are being used to make thousands of corporations and individuals fabulously wealthy, health care costs will be much higher than they have to be.

At a recent Chicago rally in support of people with high medical debt, Dr. Quentin Young pointed out that every nation that has won universal health care did so with the leadership of labor. In 2004 in the United States, the stage is set for a national movement for health care. If it's willing to take the part, labor is uniquely suited to play the lead role. It has the people, resources, and grassroots organization to take on the powerful special interests that would oppose reform.

A broad labor-led campaign would capture the imagination of all working people and potentially lead to a huge victory. Then no one would question whether unions were "still relevant" in America. Our new bumper sticker would succinctly tell the whole story.

Rand Wilson is the National Organizer for Jobs with Justice. Marianne McMullen, M.A.C., is Communications Director for the SEIU Illinois Council. See www.jwj.org & www.seiu-illinois.org

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including increasing our federal reimbursement levels. During the November, 2003 veto session, I successfully passed into law a plan that will leverage an additional \$430 million for health care in this state through a new assessment on hospitals that serve Medicaid patients. Revenues generated by this assessment will boost the amount the state receives in matching health care dollars from the federal government. For example, pending federal approval of the assessment plan, this proposal is scheduled to provide Loyola University Medical Center with approximately \$6.8 Million in new Medicaid funding for each of the next two fiscal years. In total, Illinois hospitals will receive a \$300 million funding boost in desperately needed federal Medicaid dollars.

With health care costs spiraling upward for both public and private insurance plans, I am confident that Illinois will maintain its commitment to quality, affordable and accessible health care services for our citizens. Other states may well continue placing their most vulnerable residents in harm's way with cuts in eligibility, enrollment and reimbursements to health care providers. But, to paraphrase the poet Robert Frost, we in Illinois will continue to take the road less traveled by, and that will make all the difference in the lives of thousands who rely on the state for these critical health services.

Jeff Schoenberg is a State Senator from the 9th District and former six term State Representative. Sen. Schoenberg is a member of the Senate Health & Human Services Committee. See www.legis.state.il.us/

Tenuous Economy Means Greater State Health Care Challenges

By Senator Jeff Schoenberg (D-Evanston)

As Illinois residents confront mounting economic uncertainty and escalating health care costs, anxieties over access to affordable health care dominate boardroom and dinner table discussions.

On the national level, the crisis continues to gain momentum as baby boomers begin to retire and 44 million people remain uninsured. Here in Illinois, the unprecedented \$5 billion budget deficit inherited by Gov. Rod Blagojevich's administration has jarred the administration and the legislature to work for creative solutions which will meet this crisis head on.

Yet, as states across the nation face record deficits and slash eligibility, enrollment and reimbursements for health

A recent national survey by The Kaiser Commission on Medicaid and the Uninsured singled out Illinois' Medicaid program as one of only three in the nation to significantly expand health coverage this year.

care related programs, Illinois has valiantly resisted this corrosive trend.

Growing our health care spending through KidCare, FamilyCare and other related programs in the face of this alarming trend reflects the values of the Blagojevich Administration and a deeply concerned, Democratic-led House and Senate. As vice chairman for both Senate Appropriations Committees and co-chairman of the state's Economic and Fiscal Commission, I have had a front-row seat as Illinois has wrestled with maintaining vital healthcare spending as a top priority in these tight fiscal times.

Illinois lawmakers have many difficult decisions awaiting, but we remain committed to innovative solutions that protect the health and safety of our children and families. In the proposed budget for Fiscal Year 2005, this budget cycle focus will be on coordination of resources, expanding access, and maximizing our federal reimbursements for Medicaid.

Coordination and Prevention

In the Governor's February budget message, the emphasis in health care shifted away from simply funding treatment services to greater coordination of these health services. *Health Vision Illinois* is an initiative designed to coordinate health care services offered by state agencies and other partners, such as community health centers, in order to improve health data collection, investigate disparity

issues, and emphasize the importance of health screening. Through greater coordination and cooperation, the state anticipates greater capabilities to avoid duplication and streamline services while saving money.

It is becoming more apparent that funding prevention efforts throughout the state is an important part of our health care agenda in Illinois. The proposed budget invests more health care dollars in educational outreach for breast and cervical cancer as well as more money for cancer screenings. The Department of Public Health intends to reach more than 30,000 women in hard-to-reach communities through this program. In addition, there is an increase in dollars aimed at HIV/AIDS prevention in communities of color. This funding will address the disproportionate growth in the infection rate, particularly among African Americans in this state.

Expanding Access

Another important element in the proposed budget is the increase in the accessibility of health care. The proposal includes a \$66 million increase in funding to expand Family Care to cover an additional 56,000 parents. In addition to that increase, KidCare raised the income cap for eligibility from 185% of Federal Poverty Level to 200%, making 20,000 more children eligible for health care coverage. These are important steps to ensuring that our most vulnerable children and families are able to access affordable health services. By expanding the number of lower-income children and their parents receiving health care coverage through these outreach efforts, patients will receive greater continuity in physician services while avoiding costly emergency room visits for treatment of common ailments and examinations.

Maximizing Federal Reimbursement

From the state's budget perspective, there is an important added incentive to matching lower-income families with superior health care services through KidCare and FamilyCare. Federal reimbursements for health care services in these two programs are pegged at 65 percent of cost, with the state picking up the remaining 35 percent. These reimbursement levels are especially welcome in Illinois, where Medicaid reimbursement levels have remained stuck at 50 percent since the late President Lyndon Johnson initiated the federal entitlement in the mid-1960s.

For Illinois to continue expanding health care services in the face of the ongoing economic slump, we must actively and aggressively pursue other new sources of revenue, *(Continued on page 9)*



An Interview with Quentin D. Young M.D. Director, Health and Medicine Policy Research Group

By Karen Ide and Clinton Stockwell, PRAGmatics

PRAGmatics—Will you please share with us a highlight from your long and successful career as a physician and as a human rights/health care activist?

Dr. Young—I guess my answer would be the civil rights movement medical arm. When the southern movement started activating, the medical community for human rights would show up spontaneously. We all know the climax with major changes in the legal status of Blacks in the South and the de facto status segregation in the North. The medical community was a do-good expression of liberal nurses and doctors who wanted to be part of the action. At first, we just thought we would be there like Red Cross workers and take care of people who had heat stroke or got beat up or bitten by a dog or whatever. We had people on staff down there for the long term but we also got volunteers who would come down from another part of the country, some for a week, or a month, or two. The function was to bear witness to the struggles of the people who are fighting for their rights and our presence was testimony to their legitimacy and our willingness to share their burdens. It sounds a little highfalutin, but that's what it's supposed to be. The doctors did turn out to have several functions. I'll give you one example. The public demonstrations were like a Japanese opera. There would be a demonstration called to protest the exclusion of eating places or school segregation or hospital segregation. The people would turn out, mostly young people, and demonstrate. The police would tell them to disperse. They wouldn't disperse and different things would happen—houses would get torn up—people would get arrested and taken to the hospital and taken to jail and very soon our task was evident. After the protesters were booked, we would go to the jail. A doctor with a tie and white coat, even though he was considered a “nigger lover” was treated with respect and deference by the police. We could go around and very ostentatiously say, “You're looking really good,” and the whole point was to have a doctor see these people before they got out of jail because the specialty of the house was very often to brutalize the protestors. But a doctor there having seen them was pretty close to expert testimony, so bruises that were there the next day would clearly and unarguably be due to something that happened overnight. So that was one of the functions that was interesting to note. The whole effort was probably a high point of my career in terms of mixing my activism with medicine.

PRAGmatics—Today, March 4, has been designated “Health Care Action Day” by many activist groups across the country. Do you feel this movement is picking up steam? Do you see any prospects for its realization in this country in some form in the near future?

Dr. Young—Well, it's definitely picking up steam. And the reason turns out to be not the good one: that do-good solitary social justice consciousness in the country, but rather, I'm sorry to say—it's because the system is so disorganized, so chaotic, so costly, and so harmful, that it is garnering enemies. But maybe that is the obvious way that most social change takes place. Human slavery was abolished after a bloody civil war and because it was incompatible with our nation's continuing existence. So the abolitionists and many wonderful people who had strong ideological and moral objections took great risks, gave their lives. But the vast majority who participated in the rejection of slavery did it for elementary, mundane, materialistic reasons and I think that is what is happening now, and it's happening very fast. Today is “Universal Health Care Day.” Our group, Physicians for a National Health Program, is dedicated to that single issue—even though there is not a lot of enthusiasm for the concept of universal health care out there. But, we know that everybody should have it. The most evil elements in the health system are the Hospital Insurance Association and the Group Health Association. These are the holding companies for the big corporate interests that are taking over. They really don't care whether it is universal health care just as long as they control it and get the money. We are much more explicit and worry about the universal aspect because other forces are precluding explicit solutions like ours, which is single payer national health insurance, government-run, based on the tax system. We feel universal health care is no longer the best answer; it's the only answer. There was a time when there were alternatives that might have worked, but that day is passed. We've had too much of a transfer of power from patients and physicians, for that matter, to giant corporate interests that are dedicated to the goal of maximizing profits, which accounts for much of the distress in the American health system.

PRAGmatics—In the U.S. as elsewhere, there is a debate as to whether quality health care is a right or a commodity. Is it possible to reconcile these opposing values, and is the goal of quality health care as a right for all people attainable?

Dr. Young—I certainly believe it's attainable. It has been attained in certain countries that aren't very different from us. I totally come down on the side of health care being a human right. It's very hard for me to see a coherent, let alone a moral or decent argument against it, because illness doesn't distribute itself according to the ability to care for yourself and be cared for. It strikes children. It strikes the poor. It strikes the most needy and most ill-protected disproportionately. That's the correlation. Cardinal

Bernardin said it best. He said, "Health care is so important to human life and dignity that it is the responsibility of society to offer access to decent health care to every person." I was pleased that he didn't say "every citizen" but "every person." So the answer is that it should be considered a right guaranteed by society, which means it must be a responsibility of the government.

We've had a failed experiment in marketplace medicine over the last fifteen years. People forget that 20 years ago, there was no such thing as a for-profit hospital. One of the greater achievements in this country in the Tocquevillian sense of nongovernmental organizations and the American penchant for organizing to solve problems was our hospitals. They were invariably nonprofit, secular or religious entities, based on community; and, the hospital board of directors was always the elite leaders in the community. Our argument is that the record of America's hospitals under that circumstance was impeccable. But a lot of it wasn't. There was a lot of legal segregation in the south and de facto segregation in the northern hospitals. However, at the end of the day, they were community-responsive and responsible, and they got great support for that great subsidy. They got low taxes. They got free services from the city. In many circumstances, Chicago for example, big urban developments surrounded them that made their environment more attractive and more functional, and it was a deal. They would in return meet community needs; around the clock emergency services, obstetrical services, specialized services for kids with mental illness or venereal disease. The government played a huge role but it was essentially a volunteer communitarian kind of thing. That has been put on the back burner during the growth of for-profit hospitals.

One of the most serious consequences of the for-profit health system is that there is a significant and dangerous decline of nurses, from what was once two million. Very few people are going into nursing and many are leaving. And this is not just a luxury item. They are the caring in the health care system. So we have to reject commodification. We think it's an abomination and should not be tolerated. It should be eliminated from the health care transaction. We've had the experiment. It's failed. And we must stop the damage it's doing.

PRAGmatics—What is your assessment of the recently passed Medicare legislation? Since it is not due to go into effect until January 2006, can something else be drafted to amend or replace the Medicare bill before it is enacted?

Dr. Young—It's an abomination. It's a terrible, terrible bill and we're in favor of its repeal. I'm happy to see that the best leaders in Congress, starting with Jan Schakowsky, have adopted that strategy. We regrouped after it was forced across the line. Many organizations are calling for the law to be rescinded because they now have a better understanding of what the bill contains. It is a scam.

PRAGmatics—What is your opinion about the costs of prescription drugs? What should be done about that?

Dr. Young—First, we must insist that doctors do not give unnecessary drugs. An example is the use of antibiotics for the common cold—a huge multi-billion dollar event. It shouldn't happen. This is the wasting of drugs and the creation of resistant organisms. Second, we must use many more generic drugs. The amount that we spend on brand name "aspirin-like" drugs alone is ridiculous and unnecessary. That money could be spent on drugs for far more beneficial purposes. And it will take more patient education. It takes peer review. For health reasons, I would also restrict the kind of advertising allowed for medications. And of course, it's obvious I want to negotiate the lowest price and I would be for price controls if they were recalcitrant. I want the multi-billion dollar trading and profiting of companies from federal tax revenue-supported research ended.

This health system has what I call three running sores. One is the absence of a generous, comprehensive drug benefit. That's a terrible thing and there's all kinds of ways that it hurts patients, including killing them. The second one, of course, is mental health. The system operates with an idiotic limitation on mental health services on almost every contract you have—six visits a year—as if someone is going to get sick on that basis. And then you have the exclusions. And the third one and possibly the most serious one, is the failure to plan for long term care. We have a time-line in our system in terms of the seniority of the baby boomers and there's a major central issue in terms of the nature of our society. Are we going to stockpile all of our old disabled people in institutions at great cost or are we going to find ways to have community and family surround them and make life more decent and foster communitarian reality? Those are the things that are just totally neglected among marketplace solutions for profit making. So I think the reason we say that single payer is the only solution is because there is no other way to find the many billions you need to solve these problems, and we could do it because the money is there. We would get the money by ending the 15 to 30 percent administrative costs. And if 1 percent of the total costs for administration equals \$17 Billion savings, that is quite impressive. It can be saved. Other countries do it. We have done it with the Medicare system.

Quentin Young graduated from Northwestern Medical School and did his residency at Cook County Hospital in Chicago. From 1972-1981, he served as Chairman of the Department of Medicine at Cook County. From 1943-1945, he served in the U.S. Army and later in the U.S. Public Health Service.

(Continued on opposite page)

PRAGmatics—A few years ago, Community Renewal Society was an advocate of a theme called “building healthy communities.” What needs to be done so that economically depressed and marginalized communities in urban centers, such as Chicago, can have a more acceptable standard of health?

Dr. Young—Up until now I’ve been talking exclusively about a technical solution, mainly the financing of health care. My heart is in the last question. Rudolph Virchow, the remarkable mid-19th Century physician, who is considered the founder of modern public health, modern psychology and modern pathology, understood the centrality of social conditions to health status and preached it, and his preachments have stood the test of time. What I think CRS was addressing, was a solution to the causes of ill health and that it was not only with doctors but in resolving a variety of afflictions of social problems in the oppressed or depressed poverty community. In this country this is often synonymous with situations facing racial minorities and it’s everything you can think of—clean air, decent housing, good nutrition, social stability, good education—all the good things that we know are necessary. Those are the correlates to good health. When we solve those problems, then how good a heart and lung apparatus you have or how skilled you are at operating on different organs fades because it’s the environmental stresses that are the big of health. We’re very, very enthusiastic about this. Within our physicians group, we see the importance of social justice issues in enhancing the health status of people. We see the present system with heavy emphasis on treatment and profit-making as absolutely anathema or at war with the issues we mentioned. We see many diseases that can only be susceptible to control or elimination by a public health model. We see a frightening and not as yet understood surge of life-threatening asthma in the inner city. We see new diseases all the time that don’t respond to or antibiotics and are then heightened by the bioterrorist brouhaha. We’re talking about Mad Cow, SARS and HIV/AIDS. All these things are there and more keep coming and we have to increasingly say, “What are the strategies? What are the long term strategies that can allow us to rid these threats as they come and then control them?” So I’m interpreting that this is what CRS advocated and we identify with that very closely.

PRAGmatics—Chicago recently built a new facility—Stroger Hospital. Our question is, as you look at this city with respect to others in the country, where is Chicago in terms of its symbolic and real place in delivering health care and how real is the symbol of the new public hospital with respect to health care?

Dr. Young—The answer is a good news-bad news answer. I and many others, ultimately the elite in the business community, were convinced that with the old hospital being nonfunctional for many reasons—most of them structural—what the pathway was we would take. It was very sharply divided with harsh debate, at least initially, and the hospital council, or private hospitals were saying to just give them the money and they would absorb the count. I was on several committees that examined the problem and ultimately made the case successfully that by far the best way to go was to build a new hospital. Unfortunately, the maximum bonding available would only allow the building of one with about 450 beds. You should have 3400 beds. That was the same kind of hospital you have today, but at the time they made that decision, the hospital was running with about 1200. The bad news is, although it is a marvelous state-of-the-art hospital, it is going to be overwhelmed by sheer numbers with the status quo. But it’s a great achievement. There hasn’t been a new public hospital in this country, I would say, for the last 30 years, and so to get a major one is significant. Charity in New Orleans, Philadelphia General, and other public hospitals were closed. However, the greatest achievement is the establishment of 32 high grade solid buildings as excellent facilities in many communities and the suburbs, and that is the real safety net and certainly is a cushion against the growing need for public services. So that gives you some comfort but people still pay inordinate rates for getting prescriptions filled. So the system constantly gets overwhelmed by the limitations of the private sector. Where is Chicago relative to other cities? It’s probably better than most, but it isn’t that much better. We have this really sharp cleavage between people who are poor without insurance but are not ready for Medicare, and then Medicaid, which is designed for them, being the wild card in the budget crunched economy. Most of the states have serious budget deficits and the biggest budget item is Medicaid. It always looks tempting to the pols, and the hungrier they get the more they slash. But it doesn’t have to be this way. We have the money. We have the workforce, a health workforce that is the envy of the world in terms of scientists, doctors, technicians, nurses, and basic health workers. We have physical plants, hospitals, and all the high-tech equipment. So the system is all there. In countries like Canada or England, the problem isn’t the system, it’s the money! In the U.S., it isn’t the money, it’s the system!

In addition to his distinguished career as a physician, Dr. Young has been a leader in public health policy and medical and social justice issues for more than fifty years. In 1951 he was a founder of the Committee to End Discrimination in Chicago medical institutions. In the 1960s he served as National Chairman of the Medical Committee for Human Rights.

In 1980, Dr. Young founded the Chicago-based Health & Medicine Policy Research Group, a group that addresses health needs in Illinois. He is currently Chairman. Dr. Young volunteers as National Coordinator of Physicians for a National Health Program (PNHP), a national research and education organization with more than 10,000 members representing every state and specialty. PNHP was founded in 1987 and has physician spokespersons across the country who advocate for a single-payer national health program. See www.hmprg.org & www.pnhp.org

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syndromes, other areas identified for improvement include prevention (e.g., immunization rates) and management of chronic diseases (e.g., diabetes management and medication errors).¹⁷ In short, we have uneven quality in American health care.

Consider these problems with the asymmetry in information between providers and patients and it's no wonder the U.S. system doesn't work very well. This "knowledge" asymmetry affects the efficiency of the health care market by not allowing consumers to make effective and efficient choices regarding the quality and the costs of that care.¹⁸ The National Committee for Quality Assurance (NCQA) has addressed the issue of quality through ranking of health plans based on specific criteria, e.g., asthma medication usage, high blood pressure treatment, smoking cessation, etc. Their 2000 "NCQA's State of Managed Care Report" found "strong, direct correlation between the percent of reporting health plans in a given region that have earned NCQA Accreditation and the region's overall performance."¹⁹ For quality reporting to have a meaningful effect in improving overall health care quality, plans must be mandated to measure and report quality so that purchasers of health care services know what they are buying and can make meaningful comparisons between plans. And yet the U.S. system resists reporting quality measures and health outcomes.

How Did We Get Here?

None of our current problems are new. Both Franklin Roosevelt and Harry Truman proposed national health insurance programs in the 1930s and 1940s but neither gained enough congressional support. Our current employer-based health insurance system evolved out of World War II as a wage freeze made benefit provision of health insurance a low cost but meaningful non-wage incentive to employees. Over ten years ago, President Clinton attempted to enact a "managed competition" plan, only to have it rejected by Congress in part as a result of strong opposition by conservatives and the health insurance industry (particularly the very effective Harry and Louis ads of the HIAA).²⁰

Since the early 1990s, we have witnessed an initial slowing of growth in the health care sector due to increasing administrative controls on both the supply and demand side, through more careful governmental regulation of certificates of need, and the utilization of managed care as a technique to control patient access to more expensive care through the use of physician gatekeepers (primary care physicians) as well as prior authorization for major procedures. For a while the strategy worked in controlling the percentage of national health expenditure growth but larger increases returned beginning in 2000.²¹ A reasonable person might conclude that the system is not sustainable in its present form, and why recent polls rank health care as a top priority in the 2004 election.²²

All the presidential candidates have proposed changes

ranging from incremental fixes to significant restructuring of our system as we now know it. The underlying principles of health care in the U.S. involve a complex interplay of several factors, some of which we have already discussed. They include government regulation, sense of compassion, financial incentive to the provider, technological advances, freedom of choice, private insurance based on employment status, acute care-based, imperfect information and something that is unique to the U.S. in that health care is not viewed as a right of the population. Add to this mix a good deal of anxiety over further governmental involvement in providing health care to the population, plus an economy in a weakened state with individuals losing their jobs and health insurance at the same time, and the private market as currently structured appears to be incapable of providing health care to a wider population.

Economist Kenneth Arrow pointed out over 40 years ago why the health care system is not responsive to free market initiatives. His general welfare theorems state that perfect markets need to meet three competitive preconditions.²³ They are: 1) the *existence* of competitive equilibrium, 2) the *marketability* of all goods and services relevant to costs and utilities, and 3) *nonincreasing returns* (emphasis in original). The third point reflects that there is some set of prices that will clear all markets. To that end it is no surprise that there are some individuals in the United States who are such a high risk of consuming large amounts of health care that they are in essence uninsurable. Optimally, health insurance, like other forms of insurance, is supposed to take a population of individuals with varying risks of health care utilization and spread that risk across a large pool of individuals, but the system has drifted away from a

...the system has drifted away from a community rating structure (insuring a whole community regardless of individual risk factors) to an experience rating (based on individual need patterns of the insured)

community rating structure (insuring a whole community regardless of individual risk factors) to an experience rating (based on individual need patterns of the insured). Those who need and use more health care will pay much more for insurance (if it's even available at any price to them) than those who don't.

Since health insurance continues to be tied to employment, those who are likely to consume huge amounts of health care services are also most likely to be unemployed and thus without insurance. Individuals are also more likely to consume increasing amounts of health care as they age, and like the unemployed, find themselves without insurance. In response to these market failures the government passed Medicaid and Medicare legislation in 1965 to provide insurance to these two populations who could not buy insurance in the private market at any price. Unfortunately, it was not extended to the entire population.

Double-digit increases in health costs, the role of medications in our lives and our ability to pay for them, and the proliferation of new expensive technology has given rise to a health care crisis that won't go away without drastic changes in the way the system operates. Daniel Henninger of *The Wall Street Journal* remarks that the next explosion in health costs and medical advances will be "patient rage."²⁴

What are the proposed cures?

Proposals range from increasing the presence of the free market in health care (through the use of tax credits) to increasing the role of government in the form of insurance mandates up to and including a single-payer system (similar to Canada).²⁵

The Republican Congress and President Bush recently signed into law a new Medicare Drug Bill that will increase spending by \$400 billion to the latest estimate of \$534 billion over the next 10 years. It is difficult to envision how we can rein in health care costs and still afford to enact a hugely expensive new federal entitlement program. Ironically, President Bush's position has been to reject any governmental solution for the uninsured and instead rely on private market solutions and tax credits to cover the uninsured. In addition, there is scant mention of how costs will be contained, particularly drug costs. One has to wonder how individuals who don't have enough funds to pay for health insurance will somehow become more desirable to private health insurers, particularly if they have health problems. Currently we forgo revenue on health benefits because of tax exemptions of \$188 billion and the bulk of that money is credited to filers with incomes over \$50,000.²⁶ For an individual to receive the tax credit they would have to forgo other necessities to purchase health care to get the tax credit. Unless the new tax subsidies are large, the number of individuals choosing this option would be low.²⁷ In short, nothing in the President's proposal is new, nor will it address any of the problems confronting the uninsured nor the huge increases in costs.

Democrats focus on increasing coverage through expansion of existing programs, i.e., Medicare, Medicaid, or buy-in to the Federal Employee Health Benefit Plan and they plan on funding it through the repeal of President Bush's tax cuts.²⁸ Almost all Democrats mandate coverage for children either through expansion of programs (Medicaid and the State Children's Health Insurance Program (SCHIP)) or through tax credits. Interestingly, only U.S. Representative, Dennis Kucinich, who remains a long shot candidate for president, advocates a Canadian style Single Payer Model. According to the Kaiser Commission on Medicaid and the Uninsured the estimated cost of a single payer option is about \$2.2 trillion by the year 2013.²⁹ This is roughly \$1.1 trillion less than what has been predicted costs would increase to if we keep on the same course we are currently on, however, another estimate puts it at \$6 trillion over 10 years.³⁰ Redirection of current government health spending would finance this National Health Plan through a 7.7% payroll tax on employers plus elimination of current health tax deductions. While this appears to be the most viable option to some, it remains the

most difficult politically because of our opposition to government programs and the bureaucracies they engender.

Given our rancorous political climate, it's no surprise that most of these proposed changes in policy on either side are incremental and none cause a fundamental shift towards high quality based on sound scientific principles. Incremental changes will do little to fix a horribly broken system. If little or nothing is done, health care costs will continue to significantly increase; access will significantly decrease; and, more of us will suffer serious consequences. In other words, we will continue to spend more and more money for less and less health.

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Resources for this article are available on PRAG's web site. at www.luc.edu/curl/prag or they may be requested by e-mail to kide@luc.edu or sthompson@nl.edu

(Larson—Continued from page 3)

As there are few environments in which homeless individuals feel valued, clinics like HHO create "a sense of place and a kind of identity for the socially displaced and dispossessed" (Malone, 1998). Inclusion, recognition, and companionship sometimes supplant health care as the primary reason for seeking services. HCH staff use these encounters as opportunities for relationship-building and education.

Incorporating a social orientation into the medical model underscores physical health and well-being as not only a human need, but a human right. Collaboration between local social services providers, the involvement of homeless and formerly homeless individuals in the planning process, and culturally competent services are essential in the design of comprehensive care for this population. Heartland Health Outreach is committed to "providing paths from harm to hope" through integrated systems crafted to improve the well-being of individuals and communities.

Tanya K. Larson is the Manager of Primary Care Services at Heartland Health Outreach and the Project Director of the Partnership for Health Care Access collaborative between HHO and Community Counseling Centers of Chicago. See www.heartland-alliance.org & www.c4chicago.org

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