Chapter 10

Health Care Systems

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Introduction

The cost of health care has increased sharply in the last decade, and many of the Nation's 7,000 existing hospitals are in serious financial trouble. As many as 1,400 hospitals–20 percent of the total number—showed deficits in 1977-78 and may be forced to close within the next 5 years; of these, perhaps 100 are in communities that have no other medical facilities, including about 30 large public hospitals in major metropolitan areas.[1] In response to these conditions, some hospitals have resorted to promotional campaigns to attract additional doctors and patients; critics point out, however, that such tactics may further inflate hospital costs by creating artificial demand and overuse of facilities.[2] Other hospitals are using market research as a means of avoiding the duplication of services and unnecessary competition for the declining numbers of patients. Some medical centers have begun to investigate the cost effectiveness of expensive procedures that may have only marginal benefits for patients or society at large.[3]

Similarly, the Department of Health and Human Services (DHHS) has begun to investigate the costs and benefits of a number of new medical procedures. Its Health Care Financing Administration (HCFA), which administers the medicare and medicaid programs, is required by law to pay for all "reasonable and necessary" medical services, but in the past this has been interpreted to mean all procedures that were medically safe and effective. Alarmed by the rising costs of these programs,[4] however, and by the possibility that they are diverting resources from large numbers of other patients who might be helped more by the same amounts of money, DHHS has directed HCFA to develop a new definition of "reasonable and necessary" services that considers a wider range of "medical, social, economic, and ethical consequences. "[5]

Another approach to the containment of health care costs is the health maintenance organization (HMO), which has occupied a prominent place in Federal health policy during the last decades As defined by the Health Maintenance Organizations Act of 1973 (Public Law 93-222), an HMO is both an insurer and a provider of health care: it provides a comprehensive package of ambulatory and hospital services to a defined, voluntarily enrolled population that pays a fixed annual per capita premium independent of the actual use of those services. Because the HMO exists in a primarily fee-for-service environment, it must compete for both enrollees and physicians; this means that the HMO must try to provide benefits and services comparable to those offered by its competitors. But because the HMO assumes at least part of the financial risk (or gain) of delivering services within a fixed or constrained budget, it has a direct financial incentive to provide those services more efficiently and to provide fewer unnecessary services; this will result in higher profits for the HMO, or lower premiums for its enrollees, or both.

Proponents of HMOS feel that they represent a "cost-effective" way to provide health care and a promising strategy for both controlling health care costs and encouraging a more rational allocation of resources to the Nation's health care needs. As such, claim their advocates, HMOS offer a "competitive market alternative" that is more desirable

[1] **I Spencer Rich,** "U.S. Begins Program to Bail Out Hospitals Serving Poor Areas," Washington Post, June 25, 1980, p. A18; Cristine Russell, "Hospital Assistance Plan Starts With $15.4 Million Project in N. Y.C.," Washington *Star*, June 25, 1980, p. A9.

[2] 'Joann S. Lublin, "Hospitals Turning to Bold Marketing to Lure Patients and Stay in Business," *Wall* Street *Journal*, Sept. 11, 1979, p. 33.

[3] Victor Cohn, "Can the U.S. Afford the New Medical Miracles?" Washington Post, May 9, 1980, p. A lO.

[4] For example, Congress directed medicare to begin paying for dialysis treatments and kidney transplants in 1972. At that time, it was estimated that the cost would be $250 million per year; but by fiscal year 1981 the cost had risen to $1.5 billion, and it is expected to reach $2,7 billion per year by 1984.

[5] Victor Cohn, "U.S. indicates Some Medicine May Be Too Costly, Washington Post, June 13, 1980, p. A2.

[6] The following **discussion is based on a recent** OTA report, *The Implications of Cost-Effectiveness* Analysis *of* Medical Technology (Washington, D. C.: Office of Technology Assessment, U.S. Congress, August 1980), OTA-H-126, especially ch. 10, "Health Maintenance Organizations," pp. 123-140.

than increased Federal regulation for achieving these goals.[7] Evidence does indeed show that HMO enrollees pay between 10 and 40 percent less in total health costs than comparable conventionally insured groups;[8] almost all of these cost savings are due to lower hospitalization rates, which are 25 to 35 percent below those of comparison groups.[9] A cost-benefit analysis of Federal assistance to new HMOS, conducted for the Office of Health Maintenance Organizations in 1979, found that Federal assistance costs are recovered (in the form of community health care savings) after 8 years of HMO operation; and the study projected even more substantial future savings.[10]

The Federal HMO program has been responsible for a great deal of the expansion in prepaid plans over the last decade, but the growing momentum of HMO development has also involved a "substantial private initiative."[11] This in turn reflects a growing concern with the quality as well as the costs of health care. As the delivery of health services became increasingly bureaucratized in the 1960's, it came under criticism from a number of client and consumer groups. Middle-class populations were displeased by the increasing depersonalization of medical care; minority and poverty groups complained of being discriminated against by practitioners and health care organizations; and health care in general was criticized as overspecialized, fragmented, and inaccessible, as well as too expensive. As a result, a broad social movement has developed with the aim of increasing consumer and community involvement in the delivery of health care.

[7] Kenneth E. Warner, "Health Maintenance Insurance: Toward an Optimal HMO," *Policy* Sciences, vol. 10, 1978-79, p. 121; The *Implications of* Cost-Effectiveness Analysis of Medical Technology, op. cit., p. 124.

[8] *The Implications of cOSt-Effectiveness* Analysis *of Medical Technology*, op. cit., pp. 123.

[9] Ibid., pp. 124. 127.

[10] "Cost Benefit Analysis of Federal Assistance for HMO Development," prepared for Department of Health, Education, and Welfare, Washington, D.C., Apr. 5, 1979; cited in The Implications of *Cost-Effectiveness* Analysis *of Medical Technology*, op. cit., p. 124, note 2.

[11] Public Health Service, Office of Health Maintenance Organizations, National HMO Development Strategy Through 1988 (Washington, D.C.: Department of Health, Education, and Welfare, September 1979); cited in The Implications of Cost-Effectiveness Analysis *of Medical* Technology, op. cit., p. 125.

The first major mandate for public participation in health care was contained in the Economic Opportunity Act of 1964 (Public Law 88-452), which authorized the establishment of Neighborhood Health Centers in which community residents were to participate in formulating and implementing policy. The HMO Act also contains provisions calling for increased community participation the planning and operation of HMOs, and in recent years Congress has mandated programs to encourage public participation in emergency medical services, health planning agencies, and community mental health centers. Consumer participation has also been encouraged at the State and local levels and by the private sector.

In some of these programs, participation is open to actual consumers of medical services, or to those whose enrollment in prepaid plans entitles them to those services; in others, participation is open to community residents at large, whether or not they are clients of the health center. Participants may have purely advisory roles, or they may be given some formal decisionmaking powers. These efforts have had varying degrees of success in encouraging public participation in health care delivery; it is not clear, however, whether they have resulted in actual community control or whether such control has had any specific impact on the quality, effectiveness, or costs of local health care services. (For a further examination of this issue, see the discussion of public participation and institutional factors that follows the case study.)

The following case study focuses on one community's experience in developing a community-based HMO–the Hyde Park-Kenwood Community Health Center in Chicago, a not-for-profit, consumer-governed group health care center. The case study deals primarily with three central aspects of this local development project: 1) the impact of three payment systems (fee-for-service, prepaid health plan, and Government assistance) on health care costs and methods; 2) the degree to which the organizers have succeeded in involving community representatives in the management of the health care center; and 3) the implications of the Hyde Park-Kenwood experience for similar community projects elsewhere.

A Case Study of the Hyde Park- Kenwood Community Health Center

Community Setting

Hyde Park-Kenwood is a diverse community of 46,000 on Chicago's South Side. The area is primarily middle-class, although it also has a large number of low-income households and more than 20 percent of its inhabitants receive some form of Government aid. It is also a racially mixed area—58 percent white residents, 38 percent black, and the remainder oriental—but it exists in economic and social separation from the black ghettos that surround it on three sides.

The community is dependent on a few large local institutions, the most influential of which is the University of Chicago, which has spent millions of dollars over the past two decades on development projects in the area. The university also employs many local residents, provides a cultural base, and attracts people with technical expertise into the community.

Hyde Park-Kenwood has a long-standing tradition of political independence, social involvement, and organized citizen activism. Unlike neighboring communities, it has resisted urban renewal, and local citizens once chained themselves to trees to prevent the construction of an expressway. It also supports a number of successful consumer-run institutions, the most venerable of which is the 30-year-old Hyde Park Co-op, a large cooperative supermarket.

In spite of its relative affluence and influence, however, the Hyde Park-Kenwood area had suffered from a shortage of primary health care for at least two decades. Many of the neighborhood's doctors had retired or moved their practices, so that only a small number of physicians remained. Local residents obtained primary care from downtown physicians or from the emergency rooms and clinics of the nearby Michael Reese and University of Chicago Hospitals. Residents on State aid, in particular, were almost entirely dependent on hospital emergency rooms and clinics for primary care. Some local physicians were disillusioned with traditional health care delivery, and they were eager to participate in a project that offered an alternative.

Development

The original initiative for a community-based health care system came from a Hyde Park mother whose visits to her pediatrician had left her increasingly concerned about the unequal relations between doctors and patients. She and two other academics from the University of Chicago came together to work under the auspices of the Health Committee of the Hyde Park-Kenwood Community Conference, a community organization with a membership of 2,000 local residents.

The Conference had become involved in health care when the Mid-South Health planning Organization, an agency of the former Department of Health, Education, and Welfare (HEW), approached it in the early 1970's with the idea of developing a network of health care facilities throughout the South Side of Chicago. The Conference formed its Health Committee to keep abreast of the activities of the Mid-South Organization and to develop proposals for an alternative health care delivery facility for the Hyde Park-Kenwood community. Said one member of the Health Committee:

> We wanted an alternative to fragmented and inadequate health services, to individual physicians in private practice, to hospital emergency rooms for primary care. We envisioned a community-controlled health center, but we had no idea what form it might take.

In 1971, committee members met with several local physicians who were interested in setting up a group medical practice, and found that they shared similar views on the problems of health care delivery: outpatient medical services were insufficient, and the traditional, hierarchical doctor/patient relationship meant that the patient's real needs did not always receive proper consideration. The Health Committee also held additional discussions with other neighborhood physicians to elicit their suggestions and possible participation.

The Health Committee became convinced that the problems of health care delivery could be solved only by replacing the fee-for-service system with some kind of prepaid plan. Accordingly, it applied for and received a $40,000 grant from the Illinois Regional Medical Program, another health planning agency of HEW, to study the feasibility of setting up a prepaid group practice in Hyde Park. The full Conference then formed a Health Task Force and hired a fill-time health planner.

In 1972, the Health Task Force met with the Mid-South Planning Organization and considered joining a local center, funded by the Office of Equal Opportunity, that would serve several surrounding black communities in addition to the Hyde Park-Kenwood area. Given the disparate nature of the communities, however, this plan did not come to fruition. The Hyde Park-Kenwood organizers wanted to design a center more appropriate to the specific needs and desires of their particular community.

Consultations were then held with the Illinois Regional Medical Program of HEW, community groups from adjacent neighborhoods, the University of Chicago, insurance companies, the Health Maintenance Organization Program of HEW, and the Group Health Association of America. In the course of these consultations, the Task Force was advised that its goal of a self-contained prepaid plan for the Hyde Park-Kenwood area was not feasible: the community was too small, and it had too few employers to establish the needed enrollment base. In addition, some local doctors who were willing to join a health center refused to do so unless they could also continue to serve their private patients on a fee-for-service basis.

In view of these problems, it was decided that the Health Center would not establish its own prepayment system. When it opened in June 1975, therefore, the Center offered health services to fee-for-service patients and those covered by Government aid. Later, when the Center was financially stable, it also contracted with existing prepaid plans in Chicago.

The Health Committee organizers had concluded, in the course of their investigations, that prepayment was a desirable financial mode, but there seems to have been little interest in or support for that goal outside the Committee. The physicians, for instance, were interested in group practice or preventive medicine, only one of them advocated prepayment. The decision against prepayment also appears to have been consistent with prevailing community sentiments. Whether the community should support prepayment is not the issue here—the evidence suggests that it did not, and the Committee's decision to use a mix of payment modes was therefore consonant with local values as well as the advice of outside experts.

Medical Services

The Hyde Park-Kenwood Community Health Center opened in June 1975 on the second floor of an older rehabilitated building in the central part of the community, and it now provides primary health care to 9,500 people. It is run by a Community Board of Directors, elected by the people who use the Center. The Board is responsible for setting policy and for administering the Health Center through an appointed executive director. It contracts with a separate Medical Group to provide health care services.

The 34-person Health Center staff, most of whom are local residents, consists of 8 physicians, 1 nurse practitioner, 1 nurse, 2 lab technicians, 5 medical assistants, 1 nutritionist, 1 health educator, and 15 administrative and clerical employees.

Medical services include general family practice, internal medicine, pediatrics, obstetrics and gynecology, and dermatology. The Health Center also contracts with outside specialists to provide certain medical services not available through its own staff. Physicians on the staff are affiliated with a number of Chicago hospitals, to which each may send his patients when necessary. In addition, the Center has a working relationship with nearby Illinois Central Hospital for secondary care and certain outpatient services for prepaid subscribers.

The Health Center currently contracts with two prepaid plans to provide all primary care, pediatrics, and ob/gyn; most secondary or specialized services; and certain hospital outpatient services for their subscribers. In return, the two plans handle the marketing of the benefits package to employers, collect the premiums, and reimburse

the Health Center monthly on a "cavitation" basis–a fixed amount for each enrollee, multiplied by the total number of enrollees. If services to enrollees cost the Center more than the cavitation received, the Center is at financial risk; if services cost less, the Center may use the surplus revenues as it wishes. This method of reimbursement (like that of all HMOs) is intended to give the Center an incentive for avoiding unnecessary services and practicing preventive care, thereby avoiding overutilization and incurring fewer health center visits by enrollees, while at the same time keeping them healthy.

Hospitalization costs for enrollees are paid directly by their plans, although the Health Center gets a rebate from the plans when the total number of hospital days used by enrollees falls below a preset figure based on average hospitalization rates for the State of Illinois.

Thus, in its prepaid aspect, the Health Center serves as the delivery outlet of an HMO system, and it currently serves more prepaid subscribers than any other delivery outlet on Chicago's South Side.[12] Because of the scarcity of similar outlets in other neighborhoods, prepaid users come from a wide geographic area to use the Center. Only 25 percent of the prepaid users of the Center live in the community, compared to 70 percent of those who pay on a fee-for-service basis and 30 percent of those who pay through medicare and medicaid.

From its inception, the Center has put strong emphasis on comprehensive health maintenance and preventive care. It offers a number of health education classes stressing "well care," such as La Maze, care of newborns, nutrition, and cardiopulmonary resuscitation. Consumers are encouraged to participate in these health education programs, which reflect a philosophy made explicit in the Health Center's statement of operating principles:

> The Health Center will foster innovation in such areas as health education, fuller use of health personnel, greater role of the consumer in continuity of care, and increased physician-community partnership in decisionmaking.

Costs and Modes of Payment

The Health Center became operational with less than $100,000 in startup grants, $40,000 of which came from the Federal Government. Another $110,000 was raised by selling debentures, in amounts of $100 or more, to members of the community. By fiscal year 1979, the Center was in the black, with an operating budget of $643,365.

Consumers pay for their health care in one of three ways: fee-for-service, Government assistance, or prepayment. On a fee-for-service basis, they are billed directly each time they use the Center, according to preestablished fees for each service provided; these fees are usually equal to or less than those charged by other health centers and private physicians in the area. Government assistance is provided through medicare (title XIX) for those eligible under social security, medicaid (title XVIII) for the medically indigent, or both for the elderly who are also medically indigent.

Service to prepaid users under the Federal HMO program did not begin until 1976, by which time the Center was in a better financial position and was able to hire an obstetrician-gynecologist, thereby meeting one of the requirements of the HMO legislation. By paying a fixed premium, individuals and their dependents who voluntarily enroll in a health plan through their employers, unions, or associations are entitled to health care benefits at no extra charge.

Enrollment in HMOs expanded throughout the Nation in 1975, when the Federal Government required that all employers of 25 or more workers who offered health plans must offer a "dual choice" between traditional health insurance and the HMO option, in locations where HMO plans existed. Because the HMO program was new and untried, the Center's financial expectations from prepaid care were uncertain. Few of the organizers thought that prepaid care would be profitable for the Health Center, let alone more profitable than fee-for-service. However, early returns showed that income from prepaid users, after subtracting outside services and administrative costs, was $18,882, or 300 percent above projections; had the

[12] Some HMOs are self-contained, with prepayment plan and delivery functions in a single administrative structure. In other cases, the plan handles the marketing and the assumption of financial risk, but contracts with an independent medical group to deliver the health benefits package. The Hyde Park-Kenwood Community Health Center is an example of the latter.

same patients used the Center on a fee-for-service basis, the net income would have been only $15,000.

In view of this, the Board decided to gradually increase the number of prepaid users. In 1977 the Center was certified as a delivery outlet by HEW and the Illinois Department of Health, enabling it to contract with other federally certified plans. The number of prepaid users increased by 1,900 from 1978 to 1979, or from 14 percent to 33 percent of all users. During the same time, the number of fee-for-service users rose by only 24 persons, and as a percentage of all users declined from 68 to 53 percent.

Recent financial statements show that the Center continues to be more profitable in its prepaid sector than in its fee-for-service sector. This is consistent with the experience of other HMOs which have demonstrated lower total health costs for prepaid users than for conventional health insurance plans.[13] One reason for this financial success appears to be the lower number of clinic visits and hospital days per prepaid enrollee: for 3 straight years the hospitalization rate for the Center's prepaid subscribers has been below the assumptions of their respective plans. As a result, the Center has received substantial rebates from the plans; for the year ending June 30, 1979, these rebates totaled $93,367.

A second reason, which is related to the first and may in fact explain it, is the financial structure of cavitation and prepayment, which gives the physicians an economic incentive to avoid excessive hospitalization by practicing preventive medicine and by encouraging self-care. Other possible explanations include the superior health status of prepaid enrollees, broader ambulatory care coverage, and the collective norms of group practice; opponents of prepayment also point to organizational arrangements that discourage prepaid enrollees from using services when they want to.

Nevertheless, while it would appear that the Health Center is prospering from its prepaid clientele, it is also dedicated to serving local residents better. As a result, it has recently decided to limit the number of its prepaid consumers in order to provide better service to members of its own community.

[13] George B. Strumpf, Frank H. Seubold, and Mildred B. Arrill, "Health Maintenance Organizations, 1971-1977: Issues and Answers," *J. of Community Health*, vol. 4, fall 1978, pp. 33-54.

Organization

The Health Center was established as two different corporations: the Community Health Center, governed by a Community Board of Directors that appoints an executive director to handle the administration of the Center, and the Medical Group, headed by a medical director. This dual organization was adopted in order to conform with the Illinois medical practice law, which forbids the employment of physicians by "laymen."

The Board has 27 directors, 24 of whom are elected by the dues-paying membership of the Health Center; the 3 other positions are filled by representatives of community organizations designated by the Board. All Board members must be dues-paying members of the Center, and a majority of the Board must also be users of the Center. Thus far, all Board members have been community residents. All prepaid and fee-for-service users are eligible for membership in the Health Center, as are all residents of the Hyde Park-Kenwood community. Annual membership dues are $5 for an individual and $8 for a family. However, although the Center's principles include consumer participation in policymaking, only 150 of its users are dues-paying members; and only members are entitled to vote for (or serve on) the Board and participate in Health Center Committees. A staff member is now working full time to increase membership, which also entitles the user to receive the Center newsletter and to enroll in health education courses at reduced rates.

The Board hires and fires and sets salaries for the staff. It also sets fees for health care, establishes programs in health education, chooses needed specialties, and determines the scale of services and facilities. When the decisions of the Board pertain to medical personnel, it must obtain the agreement of the medical director.

In 1978, three issues required cooperation between the Board and the Medical Group: the evaluation of each physician, the creation of a physicians compensation policy, and the hiring of a

new executive director. One of the physician evaluations was negative: the doctor was criticized for a lack of productivity and the type of health treatment he proposed. The two directors agreed that the physician would be offered a contract for 1 year rather than the usual 3, and that during that year he would seek another position. However, the medical director subsequently modified the evaluation process so that future evaluations would take place within the Medical Group itself, with the medical director reporting its conclusions to the Board for its final action.

In February 1978, a formal physicians' compensation policy was worked out jointly by the Board, the executive director, and the medical director. It established the range for salaries and additional benefits for physicians, as well as the criteria to be used by the executive and medical directors in evaluating each of the physicians. These two evaluations were to be used together in establishing any increase in salary, and the range of salaries was to be reviewed in the first quarter of each calendar year in the context of prevailing market values. This policy was a mutual undertaking of representatives from both corporations, apparently without disagreement.

When the executive director indicated her wish to resign, it was necessary for both groups to agree on the choice of a replacement. This process elicited heated disagreement: of the three final candidates, the Board preferred one and the Medical Group another. Both candidates were members of the community; the Board's choice was experienced and highly regarded in the health field; the Medical Group's choice had limited experience, but he was perceived by the physicians (some of whom were friends) to be charismatic and potentially excellent at grantsmanship and community outreach. In the end, the Medical Group chose not to veto the Board's choice, but the disagreement left a residue of resentment that emerged in the next confrontation between the two groups.

When the time for contract review came in 1979, the medical director presented salary requests that violated both the guidelines of the physicians' compensation policy and the agreement on evaluations of individual physicians. The medical director proposed that the Health Center should allocate salaries in a lump sum to the Medical Group, which would, through internal peer review, evaluate one another's merits and determine individual salary increases. The doctors were prepared not to come to work if their demands were not met.

The Board took an equally strong position, maintaining that all prior agreements must be honored and that it would not be fulfilling its responsibility to the consumers if it were to relinquish its power to evaluate and reward individual physicians. The two groups eventually compromised, agreeing *on* temporary salaries while *ne*gotiating teams reviewed the physicians' compensation policy. More will be said about this conflict in the discussion of institutional factors, below.

Critical Factors

Public Perception and Participation

The organizers of the Hyde Park-Kenwood Community Health Center had relatively little difficulty in gaining access to public forums and decisionmaking bodies. They were, in fact, greatly aided in their efforts by the existence, approval, and active support of both local community groups and Federal health planning agencies. The Hyde Park-Kenwood Community Conference had already formed its Health Committee to investigate alternative health care systems, and similar efforts were being undertaken by the Woodlawn and Kenwood-Oakland Community Organizations, citizens' groups in adjacent neighborhoods. The Health Committee had been formed in response to an initiative from HEW's Mid-South Health Planning Organization, and the efforts of the Health Center Task Force were also greatly assisted by the cooperation and encouragement of two other HEW agencies, the Illinois Regional Medical Program and the Office of Health Main-

tenance Organizations. To a lesser degree, their efforts were also supported by the tradition of activism in the community and the example of its well-established cooperative supermarket.

Although the project was initiated by local residents, however, and although all of the subsequent members of the Board of Directors and most of the Center's staff have likewise been residents of the community, underrepresentation of the local community has led to concern about whether the consumer's interest is being adequately represented. While the community generally accepts and supports the Center, only about 10 percent of the population of Hyde Park-Kenwood uses the Health Center, and less than half of its total users are local residents.

Only 150 of the Center's 9,500 users are dues-paying members. Prepaid users account for more than a third of the Center's patient visits and income, but 75 percent of these users live outside the Hyde Park-Kenwood community and they, too, have been consistently underrepresented in Health Center governance. Furthermore, medicare and medicaid patients—whether local residents or not—are ineligible for membership in the Center and are therefore completely excluded from governance. Use by fee-for-service patients (most of whom are local residents) has also been declining. Many local residents who would like to belong to the Center on a prepaid basis are ineligible for such coverage, precisely because the Health Committee decided not to establish its own prepayment plan.

It should be noted, however, that very few complaints about the Center have been registered with the HMO headquarters for Illinois. A survey of prepaid users indicated that they are satisfied with the Center, despite the fact that they are a "captive audience" due to the scarcity of other prepaid outlets in Chicago. Nevertheless, there is a growing feeling at the Center that the rising number of prepaid users is in conflict with the practice of community control, and the Board has recently decided to limit their numbers. It is not immediately clear, however, why service to nonresident prepaid enrollees necessarily conflicts with the goals of the Center. Its facilities are not overcrowded, nor are community residents who want service being turned away.

If the purpose of community control was to bring about specific local goals—such as community cohesion, creating a training ground for local leaders, building confidence among the disadvantaged, or responding to the unique health needs of the area[14]—then it might be argued that such goals are potentially threatened by the large number of prepaid users who are not local residents. The purpose of community control at this Center, however, was to provide accessible ambulatory care to those members of the community who wish it, and in so doing to reduce the customary social distance between doctor and patient, to encourage self-help and prevention, and to eliminate the profit motive as the exclusive basis for the physician's interaction with patients. None of these more limited goals seems impaired by the present arrangement.

It is also possible that consumers and community representatives could work together effectively in Center governance. One study of hospital boards has shown that mixed boards of consumers and community representatives have greater influence on hospital operations than do boards made up of only consumers or only community representatives.[15] Community representatives bring an external perspective: they know who lives in the area and what their needs are; they also serve as a channel for local opinion; and they help to give the Center legitimacy in the community. Consumer representatives, on the other hand, bring an internal perspective: they know particularly well how the Center actually works, and how it might work better. These different interests and abilities could mesh on the Board in such a way as to improve both the Center's health care delivery and its service to the community.

Membership patterns and their influence on public participation are a legitimate concern for the Center, its users, and the community at large. Similar election patterns may exist in other situations, such as local school boards or State legislatures, and the principle of community govern-

[14] Melvin Mogulof, "Advocates for Themselves: Citizen Participation in Federally Supported Community Organizations," Community *Mental Health J.*, vol. 10, 1974, pp. 66-76.

[15] Jonathan M. Metsch and James E. Veney, "A Model of the Adaptive Behavior of Hospital Administrators to the Mandate to Implement Consumer Participation," Medical Care, vol. 12, April 1974, pp. 338-350.

ance remains valid regardless of how many citizens chose to participate in the process. Nevertheless, when less than 2 percent of the Center's clients actually participate in governing the organization that serves them, it leaves what should be a democratic institution open to charges of elitism. To correct this situation, the Center has hired a full-time staff member to encourage both consumers and local residents to become members of the Center. A further step that might be taken is to open membership to those receiving Government assistance, who represent 20 percent of the community and 30 percent of the Center's consumers, by offering reduced membership fees for medicaid patients and free membership for senior citizens.

Essential Resources

The Health Center had little difficulty in acquiring the needed material resources, and it was particularly fortunate to be located in a community rich in the needed human resources. The Center is located in a rehabilitated building rather than in a newly constructed facility. Medical equipment was provided by the physicians in the Medical Group, many of whom had existing practices in the area. Assistance in planning and organizing the Center was provided by community volunteers who conducted a market survey, drafted legal documents, wrote grant proposals, prepared budget projections, and designed sales brochures. Health professionals, bankers, lawyers, architects, and physicians—all of them local residents—also contributed their professional skills. Two internists practicing in the community helped during the organizational stages and later joined the staff, bringing along their patients, most of whom were also members of the community. Similar resources would be available in few low-income communities.

Technical Information and Expertise

As noted above, the Hyde Park-Kenwood community is very rich in both citizen action and professional skills. Physicians and other health care professionals living in the area participated in the development and operation of the Health Center, technical information and management know-how were also readily available, in large part because of the presence of the University of Chicago. This was fortunate for Hyde Park-Kenwood, but it raises serious questions about the transferability of their experience and methods to other, less favored communities. Theirs was not a unique case, but neither was it typical of the low-income rural and inner-city communities where the need for primary care facilities is greatest.

Financing

Funds for the Center were first allocated by the Illinois Regional Medical Program, a now-defunct agency of HEW, in the form of a $40,000 planning grant. When those funds were nearly exhausted, volunteer fundraisers were able to raise a total of $110,000 by selling debentures (in denominations of $100 or more) to local residents and employees at the nearby University of Chicago. Additional funds were secured in 1977 from the Robert Wood Johnson Foundation.

One of the innovative features of this project was the manner in which the local community participated directly in its funding through the purchase of debentures. The Health Committee had the creativity and the courage to try this unique approach; and the community had the funds with which to respond, as well as enough confidence in the venture to do so. Perhaps the community's prior experience with cooperatives gave legitimacy to this funding approach, by the same token, it is possible that bank financing would also have been available because of the credit-worthiness and management capabilities of the organizers.

The applicability of this technique may be limited to middle-class areas, and this once again raises questions about the transferability of the Hyde Park-Kenwood experience. Where the technique is appropriate, however, it provides an opportunity for community residents to finance as well as develop their own institutions. One question not addressed in the study team's report is the terms under which these loans are to be repaid and how those terms might affect the finances and operations of the Health Center.

Institutional Factors

Opposition to community control of health care delivery has come primarily from inside rather than outside the Health Center. It was not opposed by health insurance companies, in fact, it was the initiative of Blue Cross of Chicago in devising HMO plans that could be serviced in a variety of health facilities that enabled the Health Center to develop an HMO outlet for South Side residents. Its development has decreased the number of patients seeking primary care in local hospitals, to which the Center still sends patients for secondary and specialized care.

However, some observers from outside the Center—private physicians and representatives of conventional health facilities—have criticized the concept of community control on the following grounds:

- The profit motive produces better health care by allowing the marketplace to work: consumers are the best judges of the health care they receive, and they can exercise influence by giving or withholding patronage of a physician or health facility.
- Community control puts politics before health, it is cumbersome, slow, and results in less efficient health care.
- The essential relationship in health care is between doctor and patient; any attempt to interject a community board or other intermediary into this relationship destroys mutual concern and respect.
- Community control diffuses medical responsibility; if physicians are to be ultimately responsible for the health care they deliver, they should also have full control over the policies for delivering that care.
- It is unfair to make doctors, who have invested so much time and money in their education and experience, submit to the authority of a community board.
- A community board may give the impression of community control, but it is often controlled by an elite few, worse yet, such a board can be coopted by the very people it is set up to control, leaving the consumer with less representation than before.

Other critics supported the concept of community control but differed over exactly what the concept should mean. Some pointed out that community control does not need to be formalized: it can be exercised through many established channels, including civic organizations, church groups, and newspapers. Others suggested that health care facilities can interact with the community in terms of both input and outreach, and that they serve the community best through health education programs or teen counseling in the schools. A few admitted that community involvement is important during the formative stages but insisted that, once the facility is operational, all decisions should be left to health professionals; a community board is desirable, but should serve only in an advisory capacity.

Within the Hyde Park-Kenwood Health Center itself, the executive director felt that the Board should be involved in financial planning, policymaking, soliciting community input, and initiating and evaluating programs, but should not concern itself with implementation of these plans, policies, and programs. A number of Board members, on the other hand, felt that they should be less complacent and passive, and more active in initiating programs and fighting for the interests of the community. The prevailing feeling among these Board members was that the physicians have not grasped the meaning of community governance, nor do they understand that in exchange for giving up certain privileges (including unlimited income and the ability to set their own hours) they gain certain rewards (including regular hours and freedom from insurance paperwork, financial recordkeeping, and personnel problems).

The manner in which medical professionals and consumers share power, however, is an ongoing problem, and in this regard the struggle at the Health Center is not unique. In studies of other health care centers, researchers have found that physicians usually seek to control the conditions of their work. [16] The efforts of the Hyde Park-Ken-

[16] Eliot Friedson, The Profession of Medicine (New York: Dodd, Mead, 1970); and Marcia Steinberg, "Multiple Leadership in Prepaid Group Practice: Interaction Among Administrators, Physicians, Consumers, and Community Members," presented at the annual conference of the Group Health Institute, New York, June 1978.

wood physicians to do so by setting salaries, controlling the evaluation of their colleagues, and deciding which physicians to hire is typical of physician behavior in traditional organizational settings. These settings—e.g., conventional hospitals—provide a system of professional authority in which physicians control both the content and the conditions of their work. The entry of consumers into decisionmaking roles thus destabilizes arrangements already in existence between physicians, administrators, and other groups.

It is still too soon to say what a new division of authority would look like, since the widespread involvement of community groups only dates from the first legislation authorizing Neighborhood Health Centers in 1964. However, it is possible to see the probable shape of the new patterns by looking at sites where consumers have policymaking or advisory authority, such as the Neighborhood Health Centers, some group practices, and some hospitals. As the consumer or community board carries out its role, disagreements tend to occur with administrators, physicians, and other parties with decisionmaking powers, such as Government agencies. Issues of concern include the hiring and firing of the medical staff and the executive director, decisions about what new services are to be offered, and budget allocations. As the parties try to resolve their differences, a new distribution of authority develops, and the distinction between physician and nonphysician reappears. In the end, physicians usually obtain effective control over salaries and medical staff, with some limited form of review by the community boards. The board exercises advisory or decisionmaking roles over matters pertaining to organizational policy, particularly the selection of services to be offered, but seldom penetrates areas of organizational decisionmaking that have traditionally been controlled by physicians. [17]

If experience is a guide, therefore, eventual resolution of the disagreements between the Board of Directors and the Medical Group at the Hyde Park-Kenwood Health Center will probably be one which grants the Medical Group the authority it seeks.

[17] Lawrence Koseki and John M. Hayakawa, "Consumer Participation and Community Organization Practice: Implications of National Health Insurance," Medical Care, vol. 17, March 1979, pp. 244-254; Milvoy S. Seacat, "Neighborhood Health Centers: A Decade of Experience," J. of Community Health, vol. 3, 1977, pp. 156-168; Steinberg, op. cit.; Marcia Steinberg, "The Relative Emphasis Upon Physician Practice and Organizational Affairs of a Consumer Council in a Prepaid Group Practice Health Plan," J. of Community Health, vol. 4, summer 1979, pp. 3 12-320; Ann Stokes, David Banta, and Samuel Putnam, "The Columbia Point Health Association: Evolution of a Community Health Board," Am. J. of Pub. Health, vol. 62, September 1972, pp. 1229-1234; and Daniel I. Zwick, "Some Accomplishments and Findings of Neighborhood Health Centers," Milbank Memorial Fund Quarterly, vol. 50, pt. 1, October 1972, pp. 387-420.

Federal Policy

Background

Over the last 10 to 20 years the primary focus of Federal health care policy has shifted from the availability of health care to its costs. About 26 percent of the Nation's health care costs were paid through medicare or medicaid assistance in 1977, when the total expenditures added up to $142 billion. By 1979, expenditures had risen to about $206 billion–a little more than 9 percent of the gross national product. At the present rate of increase, health care costs will double in less than 5 years, a rate of increase far in excess of general inflation. This pattern has held for 30 years: between 1950 and 1978, while overall inflation was 171 percent, physician costs rose 304 percent and hospital costs jumped 997 percent. [18]

The rapid increases in health care costs has led to a concurrent rise in Federal expenditures through the medical assistance programs of medicare and medicaid. In addition, the many low-income families who remain ineligible for such aid have become more vulnerable to catastrophic medical expenses: 7 million families have uninsured health care expenses in excess of 15 percent of their incomes; between 10 million and 20 mil-

[18] Sen. Edward M. Kennedy, "A National Health Insurance: A Plan to Control Medical Costs and Improve Care," Phi Kappa Phi -1., vol. 60, No. 2, spring 1980, p. 30.

lion Americans have no health insurance at all; and as many as 65 million have insurance that is inadequate to cover office visits or routine tests. [19] Families with incomes below $10,000 are twice as likely to be without health insurance as families with larger incomes, and one-third of those not covered by insurance are fully employed heads of households—10 percent of the U.S. work force.[20] Collectively, low-income people seem to be in poorer health than middle- and high-income groups, and continued ill health can lead to low productivity, high absenteeism, unemployability, and chronic dependence on public assistance programs.[21]

Cost is not the only barrier to adequate health care. Availability of physicians, facilities and specialized diagnostic and treatment equipment remains a problem in many communities.[22] The combination of these factors can, in some cases, bring about a situation in which medical services are in effect "rationed."[23] And while the primary focus of many Federal programs remains on the direct containment of costs, many people now feel that the current voluntary cost ceilings, while needed, are not the only way to address the rising costs and declining availability of health care. Among the alternatives that have been included in recent Federal legislation and assistance programs are preventive medicine, including improved nutrition; self-care and well-care, as opposed to crisis care; and community participation in the planning and operation of local health care delivery.

Legislation

Previous Federal involvement in health care delivery is typified by the Hospital Survey and Construction Act of 1946 (60 Stat. 1040, as amended), which initially authorized $75 million for grants-in-aid to the States for the construction of hospital facilities. Since its beginnings in the 1940's, this program has disbursed over $4 billion in Federal funds for more than 12,000 projects, involving 7,000 medical facilities in over 4,000 communities. The program is administered by the Bureau of Health Facilities of DHHS, which is also responsible for the programs of direct loans and loan guarantees authorized by the Public Health Service Act of 1944 (58 Stat. 682, as amended), as well as the hospital mortgage insurance program authorized by the National Housing Act (48 Stat. 1246, as amended), formerly administered by the Department of Housing and Urban Development. Increasingly, however, due to subsequent amendments and funding changes, the Bureau of Health Facilities has ceased to fund large amounts of new hospital construction. It has instead become responsible for monitoring the economic viability of existing hospitals and enforcing compliance with a section of the Public Health Service Act that requires health care facilities (in exchange for Federal financial assistance) to provide community services and certain categories of uncompensated care for their low-income patients.[24]

As was mentioned in the introduction to this chapter, the central piece of legislation dealing with public participation in health care was the Economic Opportunity Act of 1964 (Public Law 88-452). This Act authorized the establishment of Neighborhood Health Centers and required the participation of local residents in the formulation and implementation of policies in these centers. Another section of the Act established the Community Food and Nutrition Program of the Community Services Administration; this preventive-care program is discussed at length in the Federal policy section of ch. 4.

Other legislation mandating consumer and community participation in health care delivery are the Health Maintenance Organizations Act of 1973 (Public Law 93-222), which authorized the creation of community-based HMOs; the National Health Planning and Research Develop-

[19] Ibid.

[20] Sen. Robert Dole, "Catastrophic Health insurance: A Practical Alternative," *Phi Kappa* Phi -1., vol. 60, No. 2, spring 1980, p. 29.

[21] Charles E. Lewis, Rashi Fecir, and David Mechanic, A Right to *Health*: The Problem of Access to Primary Medical Care (New York: John Wiley, 1976), p. 165.

[22] For a more thorough discussion of these factors, see the previous OTA reports, The *Implications of* Cost-Effectiveness Analysis of Medical *Technology* (OTA-H-126, August 1980); Forecasts of Physician *Supply and Requirements* (OTA-H-1 13, April 1980); Assessing the *Efficacy and Safety of Medical* Technologies (OTA-H-75, September 1978); and *Development of* Medical Technology: Opportunity for Assessment (OTA-H-34, August 1976).

[23] Lewis, Fecir, and Mechanic, op. cit., p. 15.

[24] See Florence B. Fiori, director, Bureau of Health Facilities, "Bureau of Health Facilities' increasing Responsibilities in Assuring Medical Care for the Needy and Services Without Discrimination," *Pub. Health* Reports, vol. 95, No. 2, March-April 1980, pp. 164-173.

ment Act of 1974 (Public Law 93-641), which established local health system agencies and State health coordinating councils like those that contributed to the creation of the Hyde Park-Kenwood Health Center (see above); and title 111 of the Community Mental Health Center Amendments of 1975 (Public Law 94-63). Congressional concern with the costs and benefits of medical care, particularly new techniques and equipment, is also reflected in the passage of the Health Services Research, Health Statistics, and Health Care Technology Act of 1978 (Public Law 95-623). This Act provides for the establishment of a National Center for Health Care Technology, under the auspices of DHHS, charged with undertaking and supporting a variety of programs aimed at identifying potential issues and consequences of the development and application of new health care technologies.

Issues and Options

User and community participation in health care delivery seems to be widely accepted as a matter of Federal policy, but the implementation of this policy—through the establishment of local, consumer-run delivery systems like the Hyde Park-Kenwood Community Health Center–will be affected by two larger issues:

- the relationship of Federal and State health care efforts; and
- the effectiveness of preventive medicine and other innovative, low-cost health care techniques.

ISSUE 1:
Conflicts Between Federal and State Health Care Efforts.

Federal legislation has established a number of programs for achieving U.S. health care goals, but interviews in Hyde Park-Kenwood and other communities as well as in Washington, D. C., suggest that in some cases these Federal programs may not be adequately coordinated with related State programs. In addition, there seems to have been no specific attempt to coordinate the local efforts of Federal programs in health care with related programs such as nutrition or food production (see chs. 4 and 6). In other cases, however, State laws appear to be barriers to some specific programs and contradictory to Federal intentions generally.

State medical practice laws can, in some instances, be impediments to effective community participation in health center governance and health care delivery. In the Hyde Park-Kenwood case study, for instance, Illinois law prohibited the hiring of physicians by laymen. The resulting dual organization of the Center has led to internal conflicts that may jeopardize the goal of community participation that is embodied in the Economic Opportunity and HMO Acts. Virginia law also makes it illegal for nonphysicians to engage in "the prevention, diagnosis, and treatment of human physical or mental ailments, conditions, diseases, pain or infirmities by any means or methods."[25] This and similar State medical practice laws may restrict the use of well-care and other preventive medicine techniques administered by nurse practitioners or health care paraprofessionals.

Option 1: Review of State and Federal Health Care Laws and Programs.—Congress may wish to identify these potential conflicts by directing DHHS to expand its annual review of State and Federal health care legislation to include a more detailed examination of the following points:

- the goals of the various laws and programs, the priorities (explicit or implicit) among these goals, and the areas in which State law is in potential conflict with Federal policy; and
- the degree and adequacy of communication and coordination between Federal programs and State health care efforts.

ISSUE 2:
Community Health Centers and Innovative Health Care Techniques.

The innovativeness of the Hyde Park-Kenwood Community Health Center was medical as well as organizational. Their well-care programs include encouraging the patient to participate in his own treatment and encouraging community members to participate in health education classes on such

[25] Lori B. Andrews and **Lowell S.** Levin, **"Self-Care and the Law,"** *Social Policy*, vol. 9, No. 4, January-February 1979, p. 44.

subjects as nutrition, child care, and personal health maintenance.

Other health care centers have also begun to include self-care instruction in their regular services. The Midpeninsula Health Service in Palo Alto, Calif., offers a daily telephone call-in hour to eliminate unnecessary clinic visits and to minimize the use of lab tests, equipment, and drugs. At Helping Hand, a community clinic in St. Paul, Minn., patients are given a pamphlet describing their condition and its treatment or are referred to an appropriate health education class. Other clinics offer rebates to their patients for taking courses in self-monitoring skills, such as taking their own blood pressure or preparing throat and stool samples.

The principal goal of these and other well-care and self-care techniques is to help the members of the community to improve their general health. There is as yet no conclusive proof of the value of these techniques or their impact on future medical needs and costs. Secondary effects of preventive medicine, however, might include a reduction in the number of subsequent clinic visits; a resultant increase in the efficiency with which existing health care services are utilized; and–ultimately–a potential reduction in health care expenditures for the individual, the local community, and the Nation. As noted above, however, some State medical practice laws may effectively bar the adoption of these techniques by forbidding community members from participating in the delivery of clinic services or the teaching of health care in the school system.

Option 2: Investigate the Potential Benefits of Preventive Care Techniques and the Barriers to Their Adoption in Community Health Centers.–Congress may wish to investigate the potential benefits—both medical and economic—of self-care and other preventive techniques as part of a comprehensive, community-based health maintenance program. In parallel with such an investigation, the legislative and program review proposed above might also attempt to identify potential barriers to the adoption of these techniques by local health care centers. It has also been suggested that broadening the HMO prepayment package to include both life and morbidity/disability insurance, as well as medical insurance, would provide insurers with a financial incentive to learn the value and effects of health education and preventive care. [26]

[26] Warner, op. cit., p. 127.