Health

By way of an experiment, I telephoned the chairman of the board of our community hospital in Connecticut and asked permission to attend the next board meeting.

"Why?" he asked.

"To keep track of what you're doing," I said.

"Whom do you represent?"

"Myself and my family. We live in the area your hospital serves."

Long pause. "I don't think you'd be interested," he said at last. "It's all pretty technical." That was that.

Weeks before I had attended a hospital board meeting in Seattle. The board members sat at a long table in full view of the audience; when one of them started to mumble inaudibly, people in the back rows shouted, "Louder—we can't hear you." When the board began a discussion of next year's budget, poring over sheets of figures, someone in the crowd asked to see the documents. Copies were duly distributed.

The difference between the two hospital boards is explained by the green and yellow placard on the Seattle boardroom wall:

YOUR COOPERATIVE
IS FOUNDED ON
THE ROCHDALE PRINCIPLES

- OPEN MEMBERSHIP
- ONE MEMBERSHIP—ONE VOTE
- NON-PROFIT

Only five health cooperatives exist in all the United States. Two are in Minnesota (in St. Paul and Two Harbors); one is in Washington, D.C.; and two others are in the state of Washington—a rural health center in Deer Park, 40 miles north of Spokane, and the Group Health Cooperative of Puget Sound, in the heart of Seattle. Of the five, Group Health Cooperative (GHC) is the largest and most successful.

In some respects health cooperatives are no different from hundreds of other health maintenance organizations (HMOs) around the country. Both rely on group medical practice—that is, upon a consortium of physicians who agree in advance to eschew traditional fee-for-service arrangements in favor either of set salaries or "capitation" fees (so much money per subscriber); and both depend upon prepayment, an annual premium that entitles the participant to full coverage under the plan.

Medical Democracy

Cooperatives, though, offer patients an additional advantage: a voice in the proceedings. The participant is neither client nor subscriber—he is an owner who joins with other owners to set policy, determine staff and generally oversee the entire operation. That is a radical notion in a country whose medical practitioners tend to view consumer control as less safe than open-heart surgery, but as any visitor to the Group Health Cooperative in Seattle can testify, it seems to work. Here is the world's largest medical co-op, controlled by the people who use it, with a full-time staff of 145 physicians serving 145,000 patients. The co-op owns and operates a 302-bed hospital as well as seven neighborhood and suburban clinics. An eighth clinic, along with a 150-bed hospital, is on the drawing boards.

If you live in the Seattle area, you can join GHC for $175. Thereafter your dues, for a family of four, will average approximately $45 per month, or $540 annually. This is not exactly cheap; for low-income families it is out of reach. But it is considerably less than what most middle-income families pay for full medical care, or would pay if they could afford it. GHC dues cover all surgery, hospitalization, clinic visits, drugs, x-rays, and housecalls by doctors or nurses. Maternity and postnatal care cost $200 extra; psychiatric therapy costs $5 per visit after 10 free sessions.

The patient gets to choose his own GHC doctor, and if that doctor does not suit him, he is free to try another. Moreover, the patient is en-

couraged to call his doctor as often as he feels the need. GHC physicians work for salaries ranging from $25,000 to $50,000; their incentive, indeed their instructions, are to generate health rather than business.

Critics of GHC have argued that salaried doctors can be lazy, while fee-for-service doctors, like all businessmen dependent upon consumer patronage, must stay on their mettle to keep the money rolling in. The argument has a surface plausibility but it does not seem to hold water at GHC. The co-op is attracting top graduates from the best medical schools, including Harvard, and turning away many more applicants than it needs. Once a physician is hired, he starts a two-year probationary period during which he is carefully evaluated, not just for professional competence but also for patient rapport and his suitability to group practice.

In the past eight years, of the 60-odd doctors who have entered this probationary period, four have been found unacceptable and four others have decided against group practice. "If a good relationship is established," says Dr. Harold F. Newman, GHC director, "we hope and expect that the doctor will stay with us until he retires." Most do. Only five per cent hand in their resignations.

Preventive Care

Members of the staff and their families use the medical facilities—another element favoring diligence and efficiency. But probably the strongest force is the cooperative philosophy, which sets high standards and makes stringent demands. The first paragraph in GHC's charter preamble, written 26 years ago, pledges the co-op to devote "special attention . . . to preventive medicine." In effect, the cooperative has adopted a view of medicine similar to that of the ancient Chinese, who paid their village doctor an annual sum *if* the village had enjoyed good health that year.

This philosophy has raised the quality of care and lowered the cost. In 1970, for example, while the national per capita cost of health care was $226, for GHC members it was $143. The biggest savings were in hospital expenses, which averaged $112 nationally but only $37 per GHC member. The incidence of tonsillectomies and "female surgery" at the GHC hospital is about half the national average. And the infant mortality rate in the Seattle area is nearly twice the rate found among GHC families.

To be sure, some of these statistics are skewed by the makeup of the membership, which is both middle-class and middle-aged, and therefore not as susceptible to illness as either the poor or the elderly. GHC officials insist, however, that even when such factors are taken into account, the cooperative's performance is superior to that of other health care systems. "By every statistical unit we have been able to apply," notes Dr. William A. MacColl, one of the co-op's original staff physicians, "the differences have turned out in our favor."

Other differences are less easy to measure. How, say, does consumer participation at GHC differ from that practiced by the 9 million Americans who belong to the various prepayment medical programs throughout the country? These include New York's Health Insurance Plan (HIP), a creation of Fiorello LaGuardia, and the various Kaiser health centers that serve 2 million subscribers, mainly on the West Coast. In theory, at least, GHC members have a larger say in policy —some of it direct, more of it through a representative, democratic structure. Not every member is an active participant, but all tend to feel that the cooperative belongs to them.

"It must be understood from the outset," notes Doctor William MacColl, "that consumers founded the organization, own it and through their own Board of Trustees . . . oversee the entire operation." The board has 11 members, elected in staggered terms every two years. Most of the board members also chair a standing subcommittee—on community affairs, for instance, or fiscal management—made up of staff people and co-op members. These committees meet each month and the results of their deliberations are publicized in the co-op's bimonthly newsletter, "View."

Patient Advice

If a member has a suggestion, he can bring it to a committee or directly to the board; if he has a grievance, he can take it to the Member-Relations Department. "It's a place where members are sure they'll be heard," says Lorraine Jacobsen, who heads it. Mrs. Jacobsen and her staff handle about 700 letters and telephone calls each month, most of them from people confused about their bills or what services their contracts entitle them to.

But some complaints—about two a day—require investigation. Recently a woman who had gone to a GHC clinic because of a sore throat complained that the doctor "just glanced down my throat and sent me home." A few days later, the woman said, she came down with pneumonia. As it does with all complaints, Member-Relations sent copies of this one both to the doctor involved and to his superior. "They are expected to respond to every grievance," says Mrs. Jacobsen.

In this case the doctor pointed out that the woman had no fever when he examined her. Her sore throat did not appear to be serious, he said. The explanation may not have been entirely satisfactory to the woman, but at least it was understandable. The incident may make the doctor more alert next time, too. The performance of all physicians—of all staff members, in fact—is reviewed annually. "If someone has five or six complaints in his folder," observes Mrs. Jacobsen, "they'll be weighed in the review. We've—how shall I

say it?—lost several doctors that way."

Some patients bypass the Member-Relations Department and take their grievances directly to their doctors. At GHC there is a give-and-take between staff and patients rare in medical annals. "The members are always giving us advice," a hospital nurse told me. "Everything from how to reorganize our shifts to what color we should paint the bathroom walls." I asked her if she listened. "You're damn right I listen," she said with a smile. "They *own* this place."

Model for the Future?

It can be argued—and frequently is by supporters of other group health units—that cooperatives have no special monopoly on consumer participation. Kaiser, HIP, etc., also have regularly used subscriber grievance machinery. Besides, as one Washington lobbyist for a group health maintenance organization puts it, "the participation of sports fans does not make for a winning football team"—which is to say, leave it to the experts.

But it seems unlikely that Kaiser officials get the sort of grassroots soundings that reach GHC officials. Take the Kaiser and GHC responses to the medical cost-squeeze. Kaiser has failed to add new services (it doesn't offer full coverage for drugs, x-rays, lab fees, or housecalls) and has raised payments, although not to GHC's level. GHC, meanwhile, has added new services and increased the dues, because the membership wanted it that way. "Each time the members have been given a choice of raising dues or curtailing services," says Dr. MacColl, "they have voted overwhelmingly to raise dues." Kaiser's subscribers might have made the same choice, or they might not have. We will never know.

In recent months people whose business it is to find a way out of this country's medical miasma have been zeroing in on the Seattle cooperative. Each day, it seems, the staff plays host to politicians, government bureaucrats and consultants investigating "health delivery systems." Visiting legislators have pronounced GHC a "model for the future" and have rushed back to Washington, presumably to give the future shape and substance. Yet little of the cooperative viewpoint has shown up in any of the brace of health reform bills now being offered in the Congress.

Can the Seattle model be widely applied? How did GHC happen? Was it a "natural" occurrence, or was it a maverick, a sort of medical serendipity?

Medical cooperatives may be rare in this country, but they are not new. A decade before the Civil War, a group of French immigrants in San Francisco organized a French Mutual Benefit Society, built a hospital and started a prepaid health plan. A few years later Cuban immigrants living in Tampa did the same thing. And in 1924 workers for the Standard Oil Company of Louisiana established a medical and hospital associations, open to whites only, that entitled member-families to total health care for $6.75 per month.

But it remained for the Farmers Union Cooperative of Elk City, Oklahoma, organized in 1929, to serve as midwife to the modern-day medical co-op. Two years earlier Dr. Michael A. Shadid, a Syrian immigrant, had opened a tiny hospital there. Like the other two hospitals in Elk City, Shadid's was private, profitable and hopelessly inadequate. The doctor worried about the cost and quality of medical services in rural Oklahoma. He had little respect for his colleagues. "I had seen the suffering resulting from their mistakes, their neglect, and their grasping for money," he later wrote in his autobiography, *A Doctor for the People* (1939). "But what could I do about it? They were respected members of their local medical associations. . . . Honor among thieves!"

A farmer once explained to Shadid why he preferred chiropractors to doctors: "Operations! We had three of them in my family before I learned my lesson. The doctor said we had to have 'em and when I told him I didn't have the money, he said he'd loan it to me, with my farm as security. Well, he got the farm."

Shortly after opening his hospital, Shadid read the results of a national study conducted by Dr. Ray Lyman Wilbur, which said half the illness in the country occurred among people earning less than $1,200 a year. "These were the sort of people who lived in and around Elk City," wrote Shadid. "So I set about to work out some plan for . . . my patients, my neighbors and my friends."

Shadid went to his friends and suggested they form an association to improve community health. There are many ways to do this, but in those days in Oklahoma the cooperative way appealed most. The farmers decided that to get their new co-op started they would sell membership stock for $50 per share, and then members would pay a few dollars a month to cover the cost of medical care.

Headway was slow at first; the Depression was on and not many farmers could afford to risk $50. But by now Shadid was too deep in his dream to be denied. He floated a substantial loan to the struggling cooperative to finance construction of a clinic, a fact that confounded many of his colleagues.

Creeping Shadidism

Elk City was both the Rochdale and the Concord of modern health cooperatism: Rochdale, because it gave control of policy not to doctors but to patients; Concord, because it fired the opening shots in what was to be a long, bitter war between health co-ops and the American Medical Association. From the beginning, members of the local medical society reacted to the co-op in much the same manner that cattlemen react to a move-in by sheepmen. They were convinced the co-

operative would ruin their business.

Shadid had been a member of the county medical society for two decades, and not once during all that time had his colleagues found cause to complain of his conduct. But as the clinic began to go up in Elk City, some doctors started to mutter about his "ethics"; they cast about for a way to throw him out of the club. Finding no probable cause for removal, the society resorted to deep surgery: It officially disbanded, and when it reorganized two months later, Shadid's name was not on the roster.

With the county medical society safe from Shadidism (read cooperatism), the state medical society took up the fight, pressuring the state Board of Examiners to revoke Shadid's license. "Unethical conduct" was the charge. But the attack misfired. The Farmers' Union, which enjoyed a measure of political clout in Oklahoma, interceded on the doctor's behalf. At last, in 1931, the Elk City cooperative clinic opened; a few years later members built a 100-bed hospital, a home for nurses and a laundry plant. Elk City had become the medical center of western Oklahoma, and Shadid had proved it possible to deliver inexpensive, competent medical care in facilities owned and controlled by the patients.

Elk City Legacy

In August 1966 the Elk City medical complex ceased to be a cooperative, a victim of urban migration and an aged membership dependent upon Medicare-type programs. Weeks later, Dr. Shadid died. Shadid was a medical trustbuster; he viewed health cooperatism as an essential wedge into the AMA's awesome and solid phalanx. For more than three decades he tirelessly inveighed against the evils of medical monopoly and preached the gospel of cooperatism. It was, by and large, a fruitless task; but in a few places, like Seattle, the ideas he planted took root.

While attending a cooperatives conference in California in the summer of 1945, Shadid had met Robert Mitchell, a Seattle man long interested in organizing a medical co-op for the Puget Sound region. Mitchell promptly arranged a speaking tour for him throughout the Pacific Northwest.

The lectures attracted surprisingly large crowds. It was the right time. A wartime doctors' shortage had made people painfully aware of their unmet health needs, and medical insurance in those days offered niggardly coverage for exorbitant premiums. It was also the right place. Washington was a state old enough to boast a cooperative tradition, yet still young enough to experiment. As one of the GHC founders observed. "We couldn't have done it in Chicago."

Seattle Story

The people who finally did it in Seattle were members of the Grange, the Pacific Supply Cooperative (a wholesaler) and the Puget Sound Cooperative (a grocery store). These, plus the Aero-Mechanics Union Local 751, drafted a charter and began to sell $100 memberships in the new co-op. (Thanks to the aero-mechanics, the charter committed the new co-op to "collective bargaining . . . adequate compensation and fair working conditions. . . ." As Richard Handschin, GHC's research director, has pointed out, "To some in the field of health care . . . such words as collective bargaining ring heresy; to us they are heritage.")

The new group purchased a doctor-owned medical facility, including a 55-bed hospital and small clinic, for $144,000. The clinic, a private health maintenance organization, already was providing medical service to prepaying subscribers. Thus the cooperative opened on January 2, 1947, with instant income from 17,000 contract subscribers (it continues to make such contracts, mostly with industrial employes), but with only 450 cooperative members.

By the end of 1947 membership was up to 1,000, but that growth was not fast enough to meet the shareholders' pressing obligations. Desperate, the co-op hired a professional sales firm and launched a hard-sell promotional campaign. In one year membership shot up 200 per cent, and by the end of 1950 it was approaching the 6,000 mark. (Nowadays GHC does no selling; its problem is to keep the annual growth rate down to 10 per cent.)

AMA Blackball

Even so, the cooperative was not yet respectable—it had not won the community's confidence—and one did not have to look far to find the reason. The King County Medical Society, the AMA's local chapter, was reacting exactly on schedule. With one or two crucial variations, it was repeating the Elk City scenario, hoping to blot out the young co-op by blackballing its doctors from the society.

In practical terms, this meant GHC doctors could only practice in their own hospital, a state of affairs that threatened more harm to patients than to doctors. The hardships imposed by the AMA's lockout were clearly spelled out in 1950 Senate hearings on a national health bill before a subcommittee chaired by Senator Hubert H. Humphrey, Dr. John O. McNeel, GHC's chief of staff, was among those testifying.

HUMPHREY: What happens now if family Jones suddenly has critical illness in the family, or someone has to have an immediate operation? They know no other doctor and the only doctor they love and trust is [the GHC doctor].

MCNEEL: We would have to take them to our own hospital.

HUMPHREY: Let us say, for example, it required a particular kind of facility that you did not have in your hospital and it was in the public hospital. You still could not get in?

MCNEEL: That is right. We would have to turn the case over to one of

the doctors of the staff of the other hospital.

The GHC doctors were not eager for an open conflict with the King County Medical Society. They tended to temporize, reminding members that the co-op was small and weak, while the AMA was rich and powerful. But in a genuine cooperative the members usually get what they want, and what they wanted in this case was an end to the lockout. In the summer of 1950 they took their case to court, charging the medical society, as well as several hospitals and physicians, with conspiring to acquire a monopoly by boycotting prepaid group medical practice in the county.

The legal attack was masterminded by GHC attorney Jack Cluck, a colorful civil libertarian accustomed to representing co-ops and labor unions. (As usual, Cluck drastically reduced his fee.) The trial lasted two months. Cluck subpoenaed dozens of witnesses, including all past and present officers of the society, and kept them on the stand for days at a time. None of these men claimed any personal animus toward the GHC; they merely repeated that the society's bylaws barred from membership physicians who worked for the cooperative, because the cooperative had not been officially approved by the society. The circularity was at times too much even for society officials. As one of them commented, "We are a bit up a stump."

Here to Stay

Cluck zeroed in on the boycott, seeking to dramatize both the extent of the plot and the zeal of the plotters. He brought out in court that although the Seattle General Hospital was on the brink of financial ruin, with too many beds and not enough patients to fill them, it refused to admit patients treated by co-op physicians.

It was all in vain, or so it seemed when the Superior Court decided in favor of the King County Medical Society and its co-defendants. But the following year the State Supreme Court reversed that decision and ordered the society to call off its boycott. In Seattle at least, the war was over. "The old dodo birds of the Society are out now," says Cluck. "The new doctors may not like us, but they know we're not going to go away."

White Knight

The history of Seattle's Group Health Cooperative, successful as it has been, leaves one uncertain about future imitations. GHC has its roots in the old cooperative movement, which reached its zenith in the mid-'30s; it is extremely doubtful that people unschooled in the cooperative way would have found the time and energy, the patience and generosity, this enterprise desperately required. Also, the amount of money needed to launch such a venture today is staggeringly higher than the $144,000 that launched GHC. One million dollars might just provide a modest beginning, according to estimates published recently by the Group Health Association of America.

On the other hand, the consumer health movement is stronger now than it was 25 years ago. And, as Senator Edward M. Kennedy recently observed, the concept of group health maintenance organizations, once the *bête noire* of the medical profession, "has suddenly become the white knight." One need only glance at the piles of pending health legislation to grant the senator his point.

No less than eight different health bills are before Congress, and the three that are being most seriously discussed all contain schemes to promote HMOs in one form or another. These are the Administration's bill, submitted as the National Health Standards Act; Kennedy's Health Security bill; and the Rogers-Roy bill, named for its sponsor, Congressman Paul Rogers of Florida, and for its author, William Roy, who is both a physician and lawyer from Topeka, Kansas.

What these bills have in common is a commitment to group practice, comprehensive care and prepayment by subscribers. All three proposals envision the construction of hundreds of new HMO facilities, to be federally subsidized at every stage of the organizing effort. What these bills *lack* in common is specific encouragement to consumer cooperatives. While co-ops are not ruled out, the major thrust of the proposals is to invest ownership and control of HMOs in doctors, administrators and self-perpetuating boards. In short, the model for the future appears to be the Kaiser plan, not the Seattle plan.

Rally to the Cause

It is true that the proposals pay occasional lip service to consumer influence. The Rogers-Roy bill, for example, would require a program that "assures its members a meaningful role in the making of policy for the health maintenance organization." But nowhere in the bill can one find how that "meaningful role" is to be played, or what redress a thwarted consumer might seek.

In sum, then, the future of health cooperatives in America appears exceedingly dim, unless the cooperative movement, such as it is, suddenly rallies to the cause. At present the troops are barely stirring. The Group Health Association of America, chief lobbyist in Washington for the HMO idea, seems willing to settle for any bill within reason that will give HMOs a fighting chance. One can see its point—God knows, we need *something*—but one can also see, in the not-so-distant future, an epidemic of HMO scandals having to do with pocketed subsidies, shoddy service and creeping administrative arrogance.

And I can hear myself calling my regional HMO board chairman and asking permission to attend the next meeting. "Why?" he will ask. "Whom do you represent?"