

“IS COST-EFFECTIVE COMPREHENSIVE MEDICAL CARE  
POSSIBLE?”

At the outset I offer a brief clarification of the title chosen.

Early in my clinical career I became an associate of an esteemed elder medical statesman, Dr. James Hutton, who shared with me many philosophical pearls among which were:

- 1.) “The patient seeks your medical expertise and not your financial advice. Do what you deem is best for the patient and do not worry about payment issues”. This I will call the idealistic pinnacle.
  
- 2.) “Life is a compromise” – For example one enters this World experiencing a temperature shock going from a 98.6° environment to a 72° environment in a matter of minutes. If the body does not compromise this difference readily then problems ensue. This I will call the realistic or practical pinnacle.

The changes that evolved over the past 30 years have altered how the medical profession approaches its responsibilities. Suddenly we found ourselves coping with the issues of the status and availability of resources that support medical needs and these gave birth to the term “Cost-effective”. It became the clarion call for all those who supplied the financial resources.

Needless to say the medical profession abhorred this term from the outset, but in time the profession mellowed becoming more understanding and realistic of the need to work with this format thereby tolerating the term. However, the professional has to deal with his/her conscience and make efforts not to sacrifice principles and ethics, trying at all times to give each patient the best of care needed.

Hence we must accept that each of these philosophical principles (idealism and realism) need to co-exist in order to have a successful, comprehensive and compassionate health system.

I will now explore the question posed in my title and offer an answer. In doing so I begin by posing a series of key questions upon which I will elaborate and hopefully produce a satisfactory answer for you.

- 1.) Can an independent multi-specialty group practice thrive over the long-term without a profit motive?

- 2.) Can such a group deliver comprehensive quality care realistically?
- 3.) Can administrative costs be contained given today's ever-increasing regulations and pressures for more information and documentation?
- 4.) Can the entity assume capitated risk without passing such risks onto the medical staff – a staff that has no reliance on incentives or penalties?
- 5.) Can the entity limit its price increase year after year to below market inflation?
- 6.) Can such an entity enjoy an independent patient satisfaction audit of 85% - 92% in all categories audited?
- 7.) Can such an entity enjoy a high level of satisfaction among the professional as well as non-professional staffs?

Now for the answers! Good news, they are all yeses!

I am proud to say that I have had the privilege to help establish such an entity 50 years ago and to serve for the last 18 years as its Medical Director. It is, therefore, this pride that has

stimulated me to tell you its story – not to foster my career (after all I have only 20 years to go until retirement) but rather to share with you what I’ve observed because it is an entity whose identity has been a secret too long and it is my belief it can be replicated if offered for consideration and can serve as a model for delivering health care to many, many more.

Union Health Service began operations in 1955 as an outpatient health care facility in the Loop.

It was a concept that a group of very sophisticated and enlightened Union Leaders belonging to Local 25 of the Service Employees International Union conceived – and a concept that was promoted and led by a strong advocate for health care for workers – Ms. Olivia (Peg) Bautsch.

The arrangement that led to the UHS’s development was 2 fold:

- 1.) Successful negotiations with the management (owners) of the loop high rise office buildings for a total health and welfare package benefit for very low income janitresses and janitors whose average yearly compensation at the time was about \$3,000/year!

It should be noted that at the time better than 90% of those union members were immigrant Polish ladies.

- 2.) A special Legislative Statute (the Voluntary Health Service Organization in conjunction with the Taft-Hartley Act) was voted into law allowing a non-medical entity to develop and operate a medical entity.

Once the Health and Welfare package benefit became a reality the monies received by the Parent Union were allocated as follows to develop 2 units:

- 1.) The Health Care Unit wherein monies were directed to total outpatient services as well as all physician services whether in the outpatient setting or in-hospital. The Union contracted with UHS for these services.
- 2.) The Welfare Fund Unit administered by the Parent Union for payment of all facility fees – whether hospital or surgicenter and certain special services such as physical therapy.

I will confine my remarks to UHS per se.

When UHS began operation in 1955 the number of lives covered numbered about 8,000 and the only union using the Center was the parent, Local 25. However, it quickly became popular and others wanted to join. As a result the union found it more expedient to divest itself of its management in order to allow the Center to grow and operate as a free standing non-profit entity.

At the outset the medical practice plan was that of a group practice and in the 1950's it was not considered a managed care entity.

However, with the birth of the HMO laws the plan was forced to obtain an HMO license, but it never marketed its services to the general public. Further, the organization never received any funding from the federal government (like many of the early HMOs did).

As a practical matter, therefore, I am reluctant to label UHS as an HMO because it:

- a.) Does not capitate its physicians;
- b.) Does not interfere with the coveted doctor-patient relationship, making it quite clear to patients and physicians that the physician is in charge of the medical care of his/her patient and

this is done without interference from management. Our physician turn over rate is almost zero!

- c.) Although UHS has an Audit and UR-QA Committee (now expanded to a Clinical Services-Standards Committee) it should be emphasized that these committees are not punitive but rather educational in function – and are vehicles where-in the medical staff functions as advisory to the Medical Director’s office in setting policy as well as in governance of quality of care.
- d.) UHS does provide second opinions freely – usually using the depth of the specialists we have in-plan – or arranging for non-plan specialty services which we will pay.

At this juncture I would like to list a few important operational details:

- 1.) As of this date, the number of enrollees eligible for care at UHS is approximately 38,000.
- 2.) 85% of our enrollees belong to the sponsoring unions, Local 25 and Local 1 of the S.E.I.U. (Janitors and other building services employees).
- 3.) Physical plants

- a.) 1634 W. Polk Street – A 50,000 sq. foot “flag ship” facility serving 400 or more patients daily.
- b.) 3 Satellites – located northwest, southwest and in Oak Park.

NOTE: All are new and pristine facilities

- 4.) Composition of facilities
  - a.) The Central Unit at Polk St. is a full service facility.
  - b.) The Satellites – are limited primarily to Primary Care, Pediatrics, OB-Gyne services.
- 5.) I’ll digress a minute to mention a special service unit we developed in 2002.

It shows that UHS can accommodate flexibility when needed.

Several years ago the suburban janitors qualified for health and welfare benefits. This group petitioned the Parent Union, Local 25, to utilize the UHS facilities for health care.

Since a nucleus of these workers lived in the Aurora area – and since the number in Aurora were not enough to justify

establishing an actual facility (Satellite) UHS devised a PPO plan wherein we have contracted with a Primary Care group, a Pediatric group and 2 OB-Gyne groups in Aurora. These groups offer our enrollees the Primary Medical Care they need and through their consultative sources we arrange for specialty services as needed.

In this way we maintain this group's medical care almost entirely in their work and living area.

These practitioners are paid on an agreed upon fee for services model.

I am happy to report that this has worked well to date and the program has become a permanent part of our health care delivery system to be utilized in areas where the numbers of enrollees are not sufficient to warrant establishing a Satellite.

6.) Professional Staff

For the sake of time I will not categorize the numbers and divisions of our staff. Suffice it to say we have 90 physicians directly employed or under contract at UHS and these

physicians comfortably care for 99% of the medical issues our enrollees may have.

#### 7.) Credentials

Over 85% of our physicians, many of whom are multilingual, have their boards and maintain current re-certification as required. In 1994 we instituted a policy wherein a newly hired physician either has his/her boards or in the case of a recent graduate must become board certified within 3 years after completing his/her residency – in order to maintain employment.

#### 8.) Hospital System

We are contracted with approximately 12 hospitals – 6 of which are classified as our core hospitals where the large percentage of our staff practices and where the larger numbers of patients are serviced. This enables UHS to concentrate its purchasing power.

In order to have such a managed care facility succeed several basic tenets must prevail:

- 1.) An enrollee is obliged to utilize our facilities, services and professional experts in order to stay in-plan and not incur any out of pocket expenses.

Although we have to carefully educate our enrollees about our requirements and policies we also demonstrate flexibility for reasonable misunderstandings when out-of-plan circumstances occur.

There is a meaningful review process which usually begins at the Medical Director's desk where empathy and reasonable interpretation is needed.

Above all, the patient must get a clear answer to his or her concerns. Yes, there is an appeal process should there be discontent with unfavorable decisions.

- 2.) UHS will direct enrollees to UHS affiliated hospitals thereby attempting to maintain continuity of care between the outpatient and inpatient services.
- 3.) Extended weekend and evening hours have been arranged in order to minimize E.R. usage. Also since UHS has Electron

Medical Records the physician seeing those patients during those hours have available to them the patient's file for reference.

- 4.) There is a Pediatrician and a Primary Care Physician on call each day 7 days a week – actually all sub specialists are subject to call as needed. Each call is referred to the appropriate professional on call and that physician responds by calling the patient and properly triaging disposition.
- 5.) Special large ticket services such as MRI, CT Scans are directed to the high quality facilities which have negotiated favorable rates with UHS.

As with all systems there are some trade offs. Some disadvantages include:

- 1.) Members do not have the luxury of flexibility to see a non-plan physician of his/her choosing. However, I can assure you this system is most acceptable to our clientele since we do provide considerable depth within our system – and reasonable latitude for non-plan consultations.
- 2.) Ideally a group of 100,000 to 150,000 enrollees – would offer

a better balance in that this number would allow UHS to have at least 3 major hubs plus additional Satellites thereby guaranteeing that better access is available conveniently North, South and Centrally in the Chicago area.

- 3.) Although we have a pharmacy that dispenses medications at near cost the program's benefits would be greatly enhanced with a pharmacy benefit.
- 4.) The other limitation is the availability of transplants. The program does include corneal implants, bone marrow transplants and kidney transplants. However, I should point out that the other transplants and pharmacy benefits are factors controlled by the contractual arrangements made by the various employers with the unions for medical care of their employees. UHS can and will add such services whenever negotiations for additional health benefits are successful between the unions and the employers.
- 5.) You may be critical of the fact that UHS is not at risk for facility costs and therefore, it represents a Skewed Hybrid. I am happy to report that UHS does offer a full risk HMO comprehensive health care plan which was developed to service the needs of a Federal employees'

group and 3 other Union Groups. It features all of the above services plus a co-pay pharmacy plan (without formulary) and a full array of all approved transplant procedures and a modest dental plan.

Although the number in these groups is small representing about 15% of our enrollees UHS is able to administer it successfully keeping our administrative expenses at 7% and our average premium increase for this group to approximately 8%.

At the outset I asked if cost-effective comprehensive health care is possible. The organization I have described has raised its premium (otherwise called capitation) an average of only 3.4% over the last eight years! Health insurance inflation over that period averaged 11.5%! The bottom line is – this system is cost-effective.

UHS prides itself with the fact that with approximately a yearly budget of 38 million dollars that approximately 91% of all its revenues are directed to patient care with 7 – 7 1/2% being administrative cost and about 1 1/2 being a profit margin; these profit funds being used when needed for capital improvements. It is significant to point out that there are no stockholders to consider and almost no marketing expenses, no advertising costs and no solicitation expenses – all these usually amounting to 16% on

average in other plans. Also we are a tax free entity (a 20% savings). In other words the health care dollar can and is directed to the health needs of our enrollees!

You may now wonder why I have chosen to discuss the UHS tonight and its health care delivery system. These are my personal views – views of a dreamer if you will.

There are 3 good reasons I believe

- 1.) To show how an organization – in this case a compassionate labor union- conceived and developed a cost-effective health plan that cost the recipients nothing (except for medication) yet would cover 99% of all medical services.
- 2.) To show-case our health care plan in such a way that it becomes public knowledge – thereby, serving as a stimulus to the community of payors to explore its replication potential.
- 3.) And to explore with you its potential to bring comprehensive medical care – cost-effectively – to a much larger population. I would predict such a system of health care developed on a wide scale has the potential to benefit 80% of the population if

structured properly. The term “affordable” then becomes a reality.

- 4.) Hopefully to convert the economies realized by payors (both private and government) to establish a reservoir of funds that can be used to provide medical care to those millions that are not insured.

It is my belief that as others explore the benefits of the model presented – individuals who are much more adept and smarter than I am – that a multimodel framework can be constructed wherein a City the size of Chicago can be serviced by a variety of such individual units each being administered separately but by agreement working together as a network. This network would operate with a central coordinating board, which would interface with all the individual unit boards – and through such an interface enrollees could have a huge choice of practitioners as well as a huge choice of hospitals and specialists.

The concept I envision recognizes the need for each unit to be a comfortable size so that the personal touch is not lost which many times is an unpleasant development of a mammoth organization. Each unit, therefore, adopting our LOGO – “Not Too Big To Care”.

My experiences at UHS suggest to me that an optimum enrollment for each unit would be about 100,000 to 125,000 enrollees. This size is manageable, it allows for a good array of practitioners and hospitals for each unit and avoids the hazards of “cold” administration.

There are many operation details that can and must be worked out and these we need not explore at this time since the views of one person are not sufficient to develop such a model. My challenge, tonight, was to give you a model that can be the basis for a new health care delivery system.

I realize that many will label this system as socialized medicine. In terms of being comprehensive and affordable this is true but with very important exceptions:

- 1.) There is no central authority – Government not involved!  
Actually Government would become a consumer.
- 2.) All Boards would have representative composition such as
  - a.) Physician representatives
  - b.) Management representatives
  - c.) Labor representatives

- d.) And at least 2 at-large community representatives
- 3.) Although a Central coordinating Board would be needed to function as a vehicle organizing and effecting cooperation between units it should be pointed out such a Central Board would not be dictatorial or punitive.
- 4.) There is no taxation involved – the whole system operates under the free enterprise mantel which, contrary to popular opinion, is consistent with a non-profit structure.
- 5.) There is a built-in system of checks and balances when individual physician judgments are respected and recipient members can freely select their primary care physician within the system.
- 6.) And I want to make it clear that UHS is not positioning itself to develop and control such an expanded health system. Our mission has been and is to serve our sponsoring unions. We would, however, welcome others to take the lead for other markets.

In my estimation there will be ample opportunity to develop such systems in many areas of the USA , although modifications must be realized

so that mid-size cities and suburban areas have an opportunity to participate. In smaller cities, suburban and rural areas the model we developed for Aurora – a form of PPO – can work.

I know I do not have all the answers – however, the one thing I hope I have accomplished is to alert you to a system that has proven it can work for a specific dedicated number of enrollees. Expansion and amplification of those ideas become the task of many others who have the talent and the desire to fix a health system that has stumbled and unfortunately is unavailable to 40 plus million citizens. What I can say is that UHS represents an ENIGMA that became a reality! –and why not explore its merits.

I did not select my topic tonight just to report such an ENIGMA. I selected it with the hope that it becomes the basis of action by the community.

Therefore, as I close I wish to offer two challenges:

- 1.) First is to the Institute of Medicine to take the lead in studying the feasibility of what has been presented – and to establish a road map showing such a plan can become a reality. You have

the great depth and variety of talent that is needed for such a study and to implement such a project.

- 2.) Second – Corporate America and Government I challenge to be pro-active in the planning of how your health care dollar is used – rather than just be passive payors – become active in directing resources to the actual source that delivers care to your employees. There is in my estimation huge savings to be realized and such monies can be re-channeled to provide health care for the myriads who have none. This shame we must erase no matter what one’s politics are.

I thank all of you for your attention and I thank the Society once again for the honor bestowed upon me and for allowing me to share our UHS story with you. I also thank UHS for the opportunity to serve the Board and the superb medical, administrative, nursing and support staffs that have made UHS the success it is. And finally I want to thank my wife who has been waiting for me to retire but who knows I am committed and stays committed with me for these ideals.

Presentation made Tuesday, May 17, 2005

Institute of Medicine of Chicago Annual Awards Night

Angelo P. Creticos, M.D.

2004 Honoree of the Henry P. Russe, M.D. Award

Citation for Exemplary Compassion in Health Care



