Medical Care Innovations of the United Mine Workers of America Welfare and Retirement Fund

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THE OVERWHELMING desire of organized labor, the largest single organized body of consumers, is ready access to comprehensive medical care at a cost which the economy can afford. This desire has not been fulfilled despite the fact that today nearly every jointly negotiated wage agreement makes some provision for payment of physician and hospital bills. When this demand was fortified by the 1946 success of the United Mine Workers of America in establishing their Welfare and Retirement Fund, there were only a handful of negotiated medical care programs. The Fund, 21 years later, still remains the only uniform, industrywide, self-insured program.

This demand more recently has been crystallized into a right to medical care, albeit for only certain segments of the population. Enactment of titles XVIII and XIX of the Social Security Amendments of 1965 theoretically has ended charity medicine. The nation may be one step closer to meeting organized labor's ultimate expectation of an adequate health program for all the people. Now that the desire for accessible, comprehensive medical care is partly fulfilled, it is relevant to assess the facts and try to ascertain the directions in which the nation is moving.

Rising Costs of Medical Care

Recently the major focus of attention has been on the rising costs of medical care. During the 12-month period ending June 1967 medical care prices rose by more than 2½ times the rate of increase for all other items in the Consumer Price Index. Medical care prices were up 7.3 percent compared with 2.7 percent for all other items (*1*).

Consumers paid over 7 percent more for physicians' services at the end of June 1967 than they had paid a year earlier. The annual increases in the seven types of physicians' services listed in the Consumer Price Index ranged from 4 percent for visits to a psychiatrist to nearly 9 percent for obstetrical care. Detailed data show that about one-third of the physicians increased their fees during the fiscal year ending June 1967, and the average increase for office visits amounted to 23.3 percent. There is no disagreement about the continuing rise in medical care costs. The only questions are how fast and how much the prices will increase.

Another aspect of medical care costs is that the United States spends about 6 percent of the gross national product for health services. Most other industrialized countries spend about 4 to 5 percent of their gross national product on health services.

The infant mortality rate, generally accepted as a sensitive indicator of the level of community health, is 14.2 per 1,000 live births in Sweden, 14.8 in the Netherlands, and 24.8 in

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the United States (*2*). Seventeen nations have a lower infant mortality rate than the United States. The maternal mortality rate is also a valuable health index. Sweden has a rate of 30 per 100,000 live births, Denmark 40, and the United States is ninth on the list with a rate of 80 (*3*).

Something must be changed if the recognition of the right to health, which means that all people should have equal access to equal life opportunities (*4*), is to be really implemented rather than become just a moribund legislative principle or slogan. Some recent figures for the United States show the following.

- The nonwhite infant mortality rate is three times as high as the rate for white infants.
- Maternal mortality rates are four times as high for nonwhite mothers as for white mothers.
- The mortality rate of the nonwhite population is twice as high as that of the white population.
- Life expectancy in America today is more than 7 years longer for the white population than for nonwhite persons.

When the right to health care services is denied, the end result is death. The improvement and maintenance of the health of the American people at a desirable level may well require more than the current expenditure of 6 percent of the gross national product as well as reorganization of the distribution of services.

Effect of Health Insurance

Rising medical care costs and expenditures reflect the recent increase in health insurance coverage which has stimulated the demand for health care throughout the nation. Four of every five persons now have some form of health insurance (*5*). However, only about 10 million persons are enrolled in the community-consumer plans or employer-employee union plans. The majority of this 10 million is provided relatively comprehensive physician services through group practice on a prepaid basis.

Voluntary health insurance has indeed grown and prospered. The 1966 premium income was approximately $10 billion. Despite this growth and prosperity, voluntary health insurance defrays only about 30 percent of the total cost of family medical care. As Baehr said, "After 30 years, comprehensive coverage for the costs of medical care still remains largely uninsurable for the simple reason that the predominant pattern of private medical practice continues to be solo practice on a fee-for-service basis as it was 100 years ago" (*6*).

Organized labor, after more than 20 years of experience with a multitude of voluntary health programs, is skeptical of this method of paying physician and hospital bills. Formerly staunch advocates of the voluntary approach now visualize a national program, comprehensive in scope and available to everyone, as the solution to the many problems encountered by union health programs.

Health insurance has not disturbed the patterns of the past. In fact, health insurance has reinforced the status quo and thereby obstructed resolution of problems concerned with control of quality, use of manpower, and the organization and distribution of medical care services. It is my belief, based on the Fund's experience, that better organization and use of services is the key to containing or moderating the rising costs of medical care. I seriously doubt that it is possible to lower these costs without impairing quality.

The Fund has used three major techniques in its 20-year achievement of providing high-quality medical care at a reasonable cost (*7–15*). From its inception the Fund has been committed to a program of comprehensive medical care including preventive, diagnostic, therapeutic, and rehabilitative services for all eligible beneficiaries. The number of beneficiaries has decreased from the initial 1,750,000 persons to about 500,000 where it has remained for the last decade. The annual expenditure for medical care is about $50 million, and payments are made each year to nearly 1,200 hospitals and 8,000 physicians in all 50 States and the District of Columbia. The Fund program is not like Blue Cross–Blue Shield, nor is it an indemnity program. Hospitals and physicians are paid fully and directly, not indirectly by partially reimbursing beneficiaries.

Control of Quality

The first major technique developed was the control of quality, which was an important element in controlling costs. Analyses of benefi-

ciaries' rapidly increasing hospital admission rates revealed that surgery was the major cause and that many of these operations were of questionable nature. Using quality criteria established by organized medicine, the Fund has for the past 12 years paid for surgery only if it was performed by a board-certified physician when feasible. Surgical rates dropped precipitously within 90 days of the implementation of this provision. The rates have since remained at a much lower level than previously prevailed.

Moreover, in many instances the Fund has required consultation by a board-certified physician before hospital admission of patients who did not require an operation. Closely associated with these provisions was the need to pay for specialists' office care to assure that beneficiaries were not being hospitalized for services that could be provided on an ambulatory basis.

Control of quality is also the reason the Fund has never established a fee schedule. No fee schedule yet devised allows for differences in physicians' training and ability. Neither does a fee schedule allow for differences among patients and the conditions for which they are seeking care. Moreover, no recorded experience clearly vindicates the position that fee schedules control charges.

The Fund's 20-year principle has been to pay reasonable fees with determinations of reasonableness made by physicians. The Fund has been guided by fees paid by others in the same geographic area, and it has never hesitated to seek the disciplinary restraint to the extent it is available in the ranks of organized medicine. Action has not always been helpful, even when the services of questionable quality have been provided by an unqualified physician. In the Fund's considerable experience it is naive to expect more. It is equally naive to expect a hospital utilization committee always to discipline an erring colleague effectively—particularly if he has a large referral practice.

Finally, the Fund has observed that respect of human rights and personal dignity usually is a key element in the provision of high-quality medical services. The manner of providing medical services cannot be deleted from evaluations of the quality of the services.

Use of the Managing Physician

The second technique in total patient care involves a single physician, the managing physician (*16*), who must be responsible for all medical care a patient receives. The managing physician usually is an internist who, by training and experience, is thoroughly familiar with the value of providing comprehensive medical care on an ambulatory basis. He also has no vested interest in surgery and is thus able to assess the need for hospitalization more objectively. Hospitals, as Draper has constantly maintained, are not ". . . the answer to all our medical needs" (*7*). Use of the managing physician thus has been one of the most effective techniques in assuring hospitalization only when it is medically indicated.

A study of 2,845 hospitalized beneficiaries revealed that 18 had been admitted an average of 28 times in one 4-year period—one patient had been admitted 83 times (*17*). There had been little communication between the 17 physicians responsible for admitting these patients, and generally the physicians were unable to devote the time necessary for the beneficiary to fully understand the diagnosis and therapeutic regimen. Immediately arrangements were made for a managing physician who, with ready access to all the necessary specialty personnel and resources, could provide continuity of ambulatory medical care. Thus have hospital admissions and length of stay been controlled. In contrast to the limited medical care previously provided, the managing physician is concerned with the prevention and early detection of disease and disability, as well as the diagnosis and treatment of illness and injury and rehabilitation of the beneficiary.

A large element of the success the Fund has encountered in developing the managing physician technique is due to recognition of the difference in time and manpower required to provide the full spectrum of medical services. It takes far more time to guide a patient successfully through the maze of medical technology and develop an understanding of all that is involved than it does to treat episodic illness. Billing on a fee-for-service basis then becomes difficult if not intellectually and fiscally dishonest.

The Fund has developed a fee-for-time or a retainer method of payment which is used for paying about 70 percent of the participating physicians. The method is based on the amount of physicians' time devoted to beneficiaries and includes an equivalent percentage payment of the physicians' overhead costs (*18*). A surgeon paid on this basis is fully cognizant of the fact that his income is no longer geared to the outmoded "piecework" method of reimbursement. He knows that the Fund is equally concerned about his clinical judgment and his technical skill and willing to pay him for both.

Likewise, an internist is freed from the usual economic constraints of fee-for-service and is paid for his knowledge and ability. This method of payment has appreciably improved the quality of medical care provided beneficiaries, increased the number of qualified physicians available in mining communities, and reduced the amount of paperwork because the physician is paid a mutually agreed upon sum either monthly or semimonthly.

Support of Group Practice

A third technique stems from recognition of the concept that a physician can no longer operate as effectively or as efficiently on a solo basis. He needs ready access to all the allied health services. The managing physician is most effective and efficient when he is part of a multidiscipline group practice unit (*19*, *20*).

The Fund has been instrumental in stimulating the development and expansion of 37 group practice clinics in coal-mining communities. The central clinics with from 10 to 30 physicians have been developed on a regional basis with one to three small outlying offices staffed with from two to four physicians. Physicians in the clinics are board certified in the more frequently used specialties such as pediatrics, internal medicine, obstetrics and gynecology, surgery, radiology, and pathology. Other specialists are readily available from nearby teaching facilities. In each facility there are also general practitioners who are an integral part of the group.

In some clinics psychiatric teams consisting of psychiatrists, psychologists, and psychiatric social workers are available on a regularly scheduled basis. The health team also includes nurses, technicians, and family and rehabilitation counselors. Cooperative arrangements with other community agencies assure the availability of such additional health personnel and resources as may be necessary.

The Fund does not own or operate group practice clinics but purchases services from them the same as from other physicians or groups. The clinics are owned and operated by community nonprofit organizations, the membership of which, in many instances, consists largely of miners.

The Fund pays the organization monthly for that percentage of the total costs necessary to provide beneficiaries with services. The physicians, in turn, also have formed their own nonprofit organizations and the Fund pays them a single monthly retainer for that percentage of their time in the clinic or hospital devoted to the provision of medical care for beneficiaries. Although payment is made for services after they are provided, this procedure is in fact prepaid group practice in that the two monthly Fund payments are the equivalent of the total monthly membership payment which the beneficiaries would have to make to the organization owning and operating the clinics.

About one-third of the clinics are hospital based. Although none of the rest are so situated, the physicians do have privileges in nearby hospitals.

Group practice has proved to be the most effective and efficient manner of providing beneficiaries with high-quality, comprehensive, ambulatory medical care. Only in this manner has the Fund been able to control adequately hospital admissions which in some locations are at least 25 percent lower than previously prevailed (*21*). Group practice has also enabled the Fund to benefit from the economies effected by centrally located and jointly used equipment and supplies—a procedure which does not usually prevail among solo practitioners.

The beneficiaries who have had long experience with company physicians deeply appreciate the savings of their time and energy resulting from group practice. Beneficiaries also accept and approve the Fund's efforts to maintain them in a healthy ambulatory state.

Although there is a physician shortage, recruiting physicians for group practice is easier

now than it was a few years ago. Apparently the providers of service also are convinced of the values of group practice.

Conclusion

The three techniques discussed are sufficiently flexible to be applied in a variety of circumstances. While these techniques have been presented as separate items, group practice emerges as a good organizational pattern for implementing quality controls and promoting use of the managing physician. It is my conviction that prepaid group practice has particular relevance for consumer organizations and the numerous health and welfare funds which have been secured by collective bargaining in recent years and which are all confronted with a rising demand for comprehensive medical care of assured good quality.

Twenty years ago there were no blueprints of the course to pursue. Despite the initial concern about the enormity of the task confronting the Fund and the overt and sometimes covert strategems to which organized medicine resorted, a system has been evolved which provides the beneficiaries with high-quality, comprehensive medical care at a reasonable cost. This objective was the initial mandate of the Fund's Board of Trustees, and it still stands.

"American medicine is in a state of ferment" (*22*). The physician shortage, however, cannot be permitted to make the brew too heady. Medical care programs without physicians and physicians without patients are equally ridiculous. Both groups, producers and consumers, need each other. Thus, it is incumbent upon everyone to maintain the flow of services at a price the consumer can afford to pay without impairing—and possibly even improving—the quality of services. The solution lies in the organization and distribution of services in such a manner that every resource is used to the best advantage and no person is receiving less medical care than the most effective system could make available to him.

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Education Notes

Ph.D. Program in Urban and Regional Planning. The University of Michigan is offering an interdisciplinary program leading to a doctoral degree in urban and regional planning.

The curriculum, under the direction of the program committee on urban and regional planning, combines the faculties and the research and teaching facilities of the college of literature, science and the arts, college of engineering, school of natural resources, law school, school of education, college of architecture and design, school of public health, and school of business administration.

The period of study for students qualifying for regular admission would typically involve no less than 2 nor more than 3 years of full-time coursework. There are no general language requirements although the doctoral program committee may request competence in a foreign language if the applicant plans research outside the United States.

The basic requirement for admission is evidence of an undergraduate degree completed in high standing. Although less time and fewer courses may be required of those experienced in professional planning or having degrees in related fields, such as economics or political science, the program is designed to accommodate almost any undergraduate major.

Applicants for the degree program must demonstrate competence by completing formal coursework and through satisfactory performance on qualifying examinations within five core subject-matter areas—environmental design and resource appraisal, analytic tools for urban and regional analysis, social group interaction processes, economic development of urban and regional areas, and governmental planning process.

Scholarships, research fellowships, teaching fellowships, and traineeships are available to applicants with superior qualifications.

Further information and application forms are available from the Admissions Office, Horace H. Rackham School of Graduate Studies, University of Michigan, Ann Arbor 48104.

Care of Premature and Other High-Risk Infants. The institutes for physicians and nurses in the care of premature and other high-risk infants at the New York Hospital-Cornell Medical Center, sponsored by the New York State Department of Health and the U.S. Children's Bureau, will begin their 20th year in the fall of 1968. The institutes are designed to meet the needs of physicians and nurses in charge of hospital nurseries for high-risk and premature infants and special centers for infant care and of medical and nursing directors and consultants in State and local programs for the care of such infants.

Five institutes are scheduled between September 1968 and May 1969. The sessions are 2 weeks for physicians and 4 weeks for nurses.

Physicians	*Nurses*
September 16–27	September 3–27
November 11–22	October 28–November 22
January 20–31	January 6–31
March 17–28	March 3–28
May 12–23	April 28–May 23

Attendance at each institute is limited to six physicians and six nurses. Early application for the institutes is essential because plans are contingent on the number of applications received.

Participants pay no tuition, and stipends are provided to cover other expenses. For additional information write to Box 143, Institutes in the Care of Premature and Other High-Risk Infants, New York Hospital, 525 East 68th Street, New York, N.Y. 10021.