
THE RELEVANCE OF THE
KAISER-PERMANENTE EXPERIENCE
TO THE HEALTH SERVICES OF THE
EASTERN UNITED STATES*

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IN preparing this discussion I wondered how widespread the concept might be that our manner of organizing medical care should be considered a local or regional phenomenon. The wide-ranging discussion about the availability and accessibility of contemporary medical care and its high costs seems to be topical not only throughout the United States, but in all Western industrialized countries.

I propose to divide this presentation into five parts. I shall give, first, a brief description of the Kaiser-Permanente organization, although I know you are all fairly familiar with it; second, a discussion of some of the trends that seem to prevail in medical care; third, a description of how the Kaiser-Permanente system relates to these trends and with what results; fourth, a brief examination of what differences there may be between the urban East and the urban West; and, last, some brief comments on why prepaid group practice of the Kaiser-Permanente type has not spread rapidly into the urban East and elsewhere.

It seems redundant to describe the Kaiser-Permanente system to this audience. However when I have not done so in the past questions have reflected the lack of base-line information. Our system evolved from the premises that Dr. Sidney Garfield put into practice in the 1930's. Kaiser-Permanente has a particular dynamism that we believe relates to the *manner* of organization and not to the place or to the person. In the past I have stated that we have a "genetic code"; by this I have meant a set of linkages of the organizations that make up the Kaiser-Permanente system which, if significantly altered, result in a nonviable or sick program. I used this term originally about the time

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James D. Watson and Francis H. C. Crick received their Nobel Prize for demonstrating the structure of DNA and its influence on the building of cells, and the words were on my mind for that reason. It has led to much discussion since (and, I must say, to much derision) about the existence of any such thing as a genetic code for the organization of successful prepaid group practice. It certainly was not intended to imply that a genetic code allows for no variation, for indeed there are three billion viable extant examples of the human genetic code.

The Kaiser-Permanente plan has significant variations in each region and, whenever representatives from these regions gather, the variations are emphasized, but the similarities are overwhelmingly dominant. A number of new programs have been started in the last few years, often at eminent institutions of learning, some of which have paid close attention to the manner of interorganizational relations, and we are observing the results with great interest.

To begin with, the program must be sponsored by a nonprofit organization. In the last few months we have seen what amounts to a prospectus of a stock offering presented by entrepreneurs interested in conducting such an organization on a profit-making basis. Although our culture is changing rapidly I believe that ethical considerations should discourage any such idea.

Another fundamental premise is that the organization should be self-sustaining. Grants may be necessary to get such a program started; but they should be capable of amortization once the program is operating successfully. Membership payments for certain groups may have to come from taxes, but this in no way impairs the concept of the *program* as self-sustaining. The other side of the coin is that the program should not be called upon to effect large charitable benefits. The members who together are paying the costs of the program should not be taxed involuntarily for this purpose any more than the rest of the population.

Since the basic principles of the program are well known and oft-repeated, I shall describe them only briefly.

The first principle is the prepayment of monthly dues to mutualize the cost of medical care. The program is community-rated. There are many ways to have dues paid; Medicare, Medicaid, and Office of Economic Opportunity (OEO) groups have been adapted to the Kaiser-Permanente program with varying degrees of difficulty; that is, diffi-

culty for the administrators, not for the members. The coverage and the services provided must be comprehensive.

The second principle, group practice, means to us independent and autonomous medical groups which make contracts with the Kaiser Health Plan. All income is pooled. Members of the groups are full-time specialists, and they all practice in the group facilities.

The third principle is that of having medical-center facilities: a hospital and ambulatory clinical center where all services are available and are coordinated with neighborhood primary-care clinics situated in peripheral areas. All facilities use a single medical record, and all administrative services are unified. Today this is called "regional planning"; 25 years ago it was called integration and convenience of services for the members.

The fourth principle is voluntary enrollment. Since every individual must choose the program, obviously there must be an alternate choice; if there is not, we do not offer our program. There are no 100% groups. Neither employer nor union may choose the plan for all members, and there must be a periodic exercise of choice.

The fifth principle is capitation payment. The medical group is paid an annual capitation, as are the hospitals that serve the program. We believe that such budgetary systems lead to different motivation in the providers than fee-for-service or reimbursement of costs. When broadly comprehensive services are arranged and equal coverage of all types of services is provided, and when physicians have fiscal responsibility for services, a different pattern of use prevails.

This, then, is a thumbnail sketch of the concepts underlying the Kaiser-Permanente program.

A number of trends occur in medical care that greatly affect the expectations and attitudes of the public. This is, of course, but part of a pattern of changes that have been brought about by science and technology, by greater degrees of education both formal and informal, by more effective informational media, and also by the vastly greater affluence of most members of society, despite the sharp contrasts in income that still exist. The belief that medical care has a great deal to offer underlies its definition as a basic human right. This is the basis of the current and ever-increasing interest of the consumer in participation in the organization of medical care.

At the beginning of this century medical care was sought only in

crises. It is still sought largely in an episodic manner but certainly no longer only in crises. More and more, health maintenance is taken seriously. For several decades health educators have advocated the benefit of periodic health examinations. Only a very small fraction of the public responded in the past. Today there is far greater confidence in science and technology; there is greater affluence; and there is health insurance in which larger numbers are participating. An attempt is being made to cope with this huge demand by automated multiphasic testing for its sparing of physicians. However, it is as yet unclear whether, like the sorcerer's apprentice, we have started something without understanding how to control it.

The trend toward expanded technology is clear and need not be elaborated here. The problems of medical manpower—not only as to quantity but also as to new kinds and new uses—have been well publicized because of their great importance. The continued and, I believe, irreversible trend toward specialization among physicians is likewise manifest. There are significant developments in assessing the quality of medical practice, in giving greater access to medical care through regional planning and controlling costs through similar planning, and in bringing the kinds of management skills that first came to our attention in the medical-care field in the U.S. Department of Defense 10 or 15 years ago.

If these are the trends of medical care in the United States, how does the Kaiser-Permanente plan fit them? Insofar as the plan matches these trends it has relevance—not to any special region but to the entire country. Public expectations have been met. It is seen at once that there is a system and an institution organized for the delivery of health services. If the public is to have an effective voice in the kinds of services it receives it must relate to some kind of organized setting, to an institution that will be responsive and in which it may participate in arranging these vital and personal health services.

Each personal physician in the group relates to others in a team function. The patient values his relation with his personal physician and relies on him, as does any patient. However, he understands at once that there is great value in the unit medical record and that all his radiographs and laboratory findings, from whatever specialist, are all recorded in the same chart, whether he has been an ambulatory or a bed patient. The services are available to him 24 hours a day thanks to the team con-

cept. The patient knows that if he requires service in the middle of the night and his personal physician is not at hand the unit medical record will serve as a relevant background by which to judge the new emergency. Here is easy access, comprehensiveness, and continuity. One does not have to search for it; it is there already.

The technical facilities, the equipment, and the specialists who use them can be as great as the demographic base will support. In the group setting the new types of health professionals can be used effectively. There is a proper framework of control and a scale of operations to make their use feasible, as well as a budgetary method of payment that provides economic incentives to integrate every effective health professional into the medical team. The techniques of contemporary management can be readily brought to bear upon the delivery of health services because organization and scale make possible system planning, budgeting, cost-benefit analysis, and the use of a computer. Innovation in systems has great rewards. The cumulative effect of these many savings from better-designed systems reduces the cost of health care. Comprehensive coverage and the organization of comprehensive services ensures that in this framework the appropriate service will be used.

The trend toward audit of the quality of medical care is more readily carried out by the organized group. First, there is the selection of the members of the group. These are departmentalized and under the control of the chiefs of service. A unified medical record is used for all services and the work of any member of the team is constantly visible to colleagues. The system of auditing is essentially the same for outpatients and inpatients.

Public acceptance of this program is perhaps the best test of its relevance. Every subscriber has a voluntary choice and must exercise it annually. Please remember that we are not just insuring these persons—we are providing medical services—and to do this we must create the clinics and hospitals, find the physicians, nurses, and other kinds of health personnel in the right amount, in the right place, and at the right time. In each geographic area where the program exists there has been heavy involvement in the creation of these facilities for medical care and a constant process of planning and replanning the organization of services in response to needs. Therefore, throughout extensive periods of time in each of the different regions, membership in the program has been closed to new groups because facilities could not be built as rapidly

as the demand grew. Despite this the program has grown from 30,000 members in early 1946 to half a million in 1955, to a million in 1962, and to 2 million in 1969. Whether we shall be able to double that total again in a few years depends on factors as far removed from the manner of the organization of health services as the money supply and interest rates, for to double the total again would involve a capital investment of over 300 million dollars at current construction costs.

Perhaps equally illustrative of public acceptance and on a scale more readily managed is an analysis of the Federal Employees Health Benefits Program. The government makes a health-insurance contribution for each federal employee, but a significant amount of the health-insurance premium must be deducted from the salary of the employee. The method of enrollment prohibits solicitation. Information on the programs available comes through material prepared and distributed by the personnel office of the government. Because of its comprehensiveness the Kaiser program—though it does save families significant out-of-pocket costs—does not have low premiums. So when the choice is made it is not between a low-premium Kaiser plan and a high-premium plan.

Of the five plans offered federal employees in Portland, where I am most familiar with the program, not only do most employees choose the Kaiser program, but this program is chosen by almost as many as the other four programs combined. Each successive open enrollment has recorded a larger number of persons who have chosen this program. This, we feel, is a significant evaluation. I might also add that the utilization of hospitals by these federal employees in the Portland region follows the national pattern of prepaid group practice that charges a significantly reduced amount of usage. For the most recent year for which we have figures (1968) the utilization rate of nonmaternity hospitals is essentially half that of federal employees enrolled in other programs.

The Federal Employee Health Benefits Act of 1959 may serve as an interesting model for a national health insurance plan. This act provides for standards of comprehensiveness, noncancelability, and review. It involves competitive underwriting and hence is less inflationary. With the periodic choice of competing programs and partial self-payment by payroll deduction there are inherent incentives favoring the most effective program. This “experiment” has been applied to 8 million persons and is well accepted in its 10th year.

I think it worthwhile to reiterate our experience with hospitalization under Medicare Part "A" in Portland. The national rate is approximately 3,600 acute-care general hospital days per 1,000 patients per annum. Those Medicare patients on the Portland program use half this number, less than 1,800 days; and I might add that the figure for those 75 years of age and over is only 2,200 days.

Our experience with the OEO population served by the program in Portland is comparable to utilization in our community-rated program despite an extensive outreach and transportation service. We have found the OEO program well adapted to our community-wide service. The greatest injustice of the current health scene, the inequality of access, is abolished for all enrolled.

Having briefly reviewed the Kaiser-Permanente system, the trends in health services in the United States and how the Kaiser-Permanente system adapts to and fits them and, having noted the results, I come at last to the question of how this system is relevant to the eastern urban areas of the United States. Let me hasten to say that I have no intimate knowledge of these areas although I was born and raised and had all my schooling and residency training here and although my parents have lived here all their lives. I have now only the visitor's view of the many strikes that cause so much public inconvenience and of the performance of the Long Island Railroad. Most of the ingredients for a successful program such as ours seem present in all of the large Eastern cities. Our membership is based on the employed population much as is the income tax and Social Security tax of the federal government. The attitudes and expectations of health care of the Eastern urbanite, as revealed by all the public information media, seem typical of other sectors of the country.

There are, however, some legislative and regulatory difficulties to be overcome in the East. I am no expert on the law, but I understand that in New York State the insurance commissioner does not allow the pooling of funds for hospitalization with funds for medical services, although there is a bill in one of the state legislative committees at the present time intended to correct this narrow view of health financing. In Pennsylvania permission was given to carry out a prepaid group practice program within the past year, but only in a restricted manner. Just a few years ago the Supreme Court of the State of New Jersey struck down the restrictive regulations in the law there. Dr. I. S. Falk

and his colleagues fought a vigorous battle a few years ago in the state legislature of Connecticut against a law that empowers only a particular program to function in that state. And only 10 years ago restrictions in the state of Ohio were removed by legislation that permitted the Community Health Foundation program to function in Cleveland.

On the West Coast the legislative background is quite different. The program was already in operation there before special interests had time to think of restrictive legislation.

The Kaiser-Permanente program has withstood the tests of cultural transplantation fairly well. Oregon is very unlike California. It is much like New England but without any similar historical sense of the 17th or 18th centuries. The city of Portland is called "The Old Lady of the Willamette"—not without reason. Many years ago it was said that if the program worked there it will work anywhere. It does indeed work there. Ten years ago there was great doubt that the program could make the transcultural jump to Honolulu with its very different population. It not only did so but is now locally regarded as part of the concept of "aloha." When the program was introduced into Cordoba, Argentina, in 1962, once again the cry arose, "We're different. It won't work here." It did and does work, and exactly to the extent that it follows the genetic code. In 1963 in Cleveland there was the same cry, "We're different." The success of the program there speaks for itself.

Another interesting difference between East and West Coast urban areas is the more comprehensive coverage of ambulatory services generally prevailing in the West; hence the larger fringe-benefit payments to health and welfare trusts for this purpose. Prepaid group practice programs started in certain East Coast cities have encountered difficulty in having the premiums covered by such contributions because of the low local level of comprehensiveness. Kaiser's existence as a competitive factor in the West Coast market for 25 years may have played an etiologic role in this difference.

I have frequently encountered individuals with unrealistic expectations of the program. In Portland we have demonstrated thoroughly over the past three years that an indigent population can be integrated with the dues-paying health-plan membership to produce a true community program. It is highly questionable, however, whether the program can be sustained for a massive indigent population alone.

Physicians are attracted to a career commitment to the program

when they see it is a broad community program. They are reluctant to accept any label from people they serve, whether it be an employer, union, poverty group, or any other group. If the membership is broadly representative of the community and has freely chosen the program over realistic alternatives, then physicians will be attracted to it on the basis of the kind of medical care it provides.

If the Eastern urban areas are viewed in this light the Kaiser-Permanente program is applicable. If the experience in Cleveland is regarded as Eastern enough, it validates this impression.

This brings us to the last of my topics: the question of why the Kaiser-Permanente program has not spread rapidly all over the country.

First, let me state the obvious fact that the program has grown in an exponential manner and, at the same time, has had to provide the facilities for its rapidly increasing membership; in doing so it has needed all its talents as well as all the capital and manpower available. The growth on the West Coast has by no means reached a plateau. Therefore, the question may be rephrased, "Why hasn't prepaid group practice spread to the Eastern cities?"

Aside from the legislative and regulatory restrictions previously discussed, there are three cardinal reasons: membership, money, and manpower. The enrollment of a membership base for such a program takes time to create, and this initially is a very slow process. To create the kind of integrated facilities, hospital-based with outlying neighborhood centers and staffed by a broad range of specialists, requires the support of a large membership. A mature system is attractive and has a constant growth in dual choices. But a small initial membership will not support such a program. One needs an enrollment mechanism that overcomes this prolonged period of inadequate membership. The national Blue Cross organization has been quite perceptive about this, and if it is not handicapped by restrictive regulation, as indeed it seems to be, it could cooperate in providing a dual choice within the Blue Cross enrollment. This could rapidly become a significant method of initiating prepaid group practice for the delivery of medical care. Certainly a national health insurance could conceivably be created in a form that would enhance the enrollment process in this kind of system with the previously mentioned Federal Employees Health Benefits Act as a partial prototype. However, I must add that this national insurance plan could not easily be so created if it were written in the form of the Medicare Law;

for the Title 18 regulations, at least in the way they are being administered, take little cognizance of the dynamics of prepaid group practice and its budgetary system of payment.

All the newly started programs are having significant problems with enrollment. Until a better solution is found for this prolonged initial period there will be no epidemic of prepaid group practice.

The other problems are certainly worth noting but less serious. Money is required, capital for the ambulatory facilities that make group practice a practical reality and for initial costs. While it is desirable to have the program control a hospital—and it must be at least hospital-related—it does not require the creation of a new hospital. But for fully integrated functioning, an integrated management and administration of all the medical-care facilities is desirable.

The last difficulty to overcome—the professional manpower shortage—is specifically characteristic of the national problem. We have a highly inflationary sellers' market for physicians' professional services. One must provide balanced comprehensive services in a program of this kind. There are a number of specialties in medicine for which the annual supply seems to bear little relation to demand. The imbalance in the supply of the various medical specialties is a significant handicap to the organization of comprehensive services.

There is one further problem that affects the spread of prepaid group practice in the United States: the sponsorship of such programs. The sponsorship of the Kaiser program was unique, and its eminent success ensures the continuity of a distinguished board of directors. It is essential that the program represent no special interest group in the community. Recently its sponsorship by distinguished universities has been salutary, but it is doubtful that this can be a general pattern. How such programs should be sponsored, and by whom, and with what capabilities seems to be an unresolved dilemma of the consumer movement.

In summary: the Kaiser-Permanente program, an eminent success as demonstrated by its public acceptance in those metropolitan areas where it now exists, seems to be readily applicable to fulfilling the public's expectations in Eastern urban areas. But it must first overcome restrictive legislation and regulatory barriers; it must solve the problem of significant communitywide enrollment to initiate such a program; it must have sources of capital available to create the initial group facilities and to cover starting expenses; it must compete in an inflationary sellers'

market for professional manpower; and it must find able, representative, community sponsorship that understands the program and will dedicate itself to this cause. Not only must it do these things, but it must do them all at the same time. The timing of each factor must be precise or money and morale will evaporate. It is possible that answers will be found in the established mechanism of the Blue Cross or in that of some other dominant carrier in a given area. It is also possible that the spread of organized delivery systems of this type awaits universal entitlement through a national health insurance; but here one must see to it that such developments are permitted by the act and not prohibited, as they were, in effect, under Medicare.