

The Development of the Social Mission of Kaiser Permanente

There are many ways to address the history of Kaiser Permanente and many available published versions (see references). For the inaugural issue of The Permanente Journal and to initiate the "A Moment in Time" column on the history of Kaiser Permanente, it seems appropriate to focus on the history and development of the social mission of the program. While many of the pioneer health care programs in the country have been converted to investor-owned companies, Kaiser Permanente has explicitly chosen to remain a nonprofit program. In the wake of that decision recent new accords have been reached between the Health Plan and the Permanente Medical Groups to reaffirm the social mission of the Program.

Therefore it seems particularly apposite at this pivotal time to examine the development of the Program's social mission, which has emerged from its history, with its roots buried deeply within the Kaiser Permanente culture. By social mission, in this context I mean the statement of overall social purpose that defines the role of Kaiser Permanente within the communities it serves. As we begin to craft the modern expression of that social purpose at the turn of the new century, we would do well to pause and consider the social basis of Kaiser Permanente and particularly how that shapes the recently articulated concept of "direct community benefit investment."^{*} The newly announced Kaiser Permanente direct community benefit program will be most clearly understood and appreciated if we consider it within the context of our rich past.

For the first 35 years of the Program's existence, at least until 1973 and the passage of the national Health Maintenance Organization Act, the social purpose of Kaiser Permanente and other nonprofit prepaid group and staff model plans was embodied in their very existence. Kaiser Permanente was founded at the end of World War II by our great physician leaders, such as Sidney R. Garfield and the founding partners in Northern California as well as Ernest W. Saward in the Northwest. Its main purpose was to demonstrate

a new way of delivering medical care to the American people. The same thing can be said about similar programs emerging at about the same time, such as the Group Health Cooperative of Puget Sound in Seattle, the Group Health Plan in the Minneapolis-St. Paul area, Group Health Association of Washington, D.C. and the Health Insurance Plan of Greater New York.

A wartime industrial health program, directed by Dr. Garfield, had been delivering health care services to thousands of industrial war-effort employees and their families at the shipyards in Oregon and California and at the many other industrial enterprises organized by Henry J. Kaiser and his associates. It was generally expected that the hundreds of physicians and thousands of other health care workers engaged in providing that care would go back to the fee-for-services world of medical care at the end of the war. But a handful of the pioneers in that wartime system envisioned a better way to organize and deliver health care services to people. They had the vision of the population-based clinical models that would come to be exemplified by modern integrated health care systems like our own. And they clearly understood the revolutionary power of the capitation payment method for reimbursing physicians. These understandings anchored the medical care programs that emerged first in Northern California and in Oregon, soon after in Southern California, and by the early 1960s in Hawaii. These four regions formed the nucleus of early Kaiser Permanente.

When we assess the current health care system it is easy to forget the nature of the system 50 years ago and the revolution in organizing and financing medical care that was created by our program and others like it. Fifty years ago, at the end of World War II, medical practice was almost entirely solo practice. Many people had no access to care. When the U.S. entered World War II in 1941 a very large proportion of the military inductees examined for military service were seeing a doctor for the first time in their lives. When medical care was given in those days, it was given in the doctor's office, or perhaps in the patient's home. The basis of physician payment was fee-for-service and the fee was paid out-of-pocket by the patient.

Our founders recognized the critical importance of capitation payment of physicians and the budgeting of hospitals as an organizing principle in the delivery of care to populations. And they recognized the concept that care could best be delivered to individual patients when physicians considered the na-

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^{*} Direct community benefit investments are resources that directly benefit the communities we serve. In a July 18, 1996 memo, David M. Lawrence, MD pointed out that current examples of Kaiser Permanente's direct community benefit investments include: our dues subsidy program; medical education programs, including residency training; free care for medically indigent; and premium rating subsidies. He pointed out in that memo that it is the intent of the Kaiser Permanente program to focus, over the next few years, on direct community benefit investments that: improve the health of children; improve the health of uninsured people through subsidized coverage or care; and advance medical knowledge through clinical and health services research.

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ture of the populations served. Those founders had a fundamental understanding that a capitated, group practice of medicine reversed the basic economics of health care and that paying for physician care via a capitation system created the potential for developing a totally different culture than the culture of fee-for-service medicine. In this new model physicians viewed their role obligations differently. Even the knowledge component of the culture of medicine was different under capitation than under fee-for-service. So, in order to change the American medical care system, the founders announced to the world that they were creating a new kind of health plan and went out to compete in the medical marketplace, with the encouragement and support of Henry J. Kaiser.

When one thinks about social mission organizations, it is easy to assume that these organizations are not business-like or hard competitors. But from the very beginning of this social experiment the program leaders understood the requirement for operating the medical care program under the strictest business principles. These leaders were not starry-eyed utopians or quixotic adventurers tilting at windmills. They were hardheaded, pragmatic medical managers who understood the need to manage their social experiments in the most aggressive manner in order to survive in what was an extremely hostile environment. The stories of surviving pioneers abound with legends about such measures as requiring employees to turn in a pencil stub in order to requisition a new pencil.

From this acute understanding of market realities sprang the concept of market-leading performance, of which we are hearing a great deal today. But Kaiser Permanente would not have survived those difficult lean years if the early program hadn't led the market in financial performance, and led it by a very wide margin. It was market-leading performance that ultimately brought the attention of the nation to the program's existence and created the opportunity for the peaceful revolution of American medicine that we have led.

A lot of water has passed over the Bonneville Dam since the launching of the prototypical programs in Oregon and in California that became Kaiser Permanente. There have been three generations of Program leadership since the pre-history of the shipyard days. The success of our revolution is marked by the plethora of imitators who are leading the charge to take over the health care market. Most observers have been astounded by the momentum that has been created by the rapid movement from fee-for-service to capitation payment systems in America. The developing relationship between purchasers of care,

investor-owned managed care companies, and vertically integrated health care systems has dramatically increased the use of capitation as the financial mechanism of choice within health care. It has quickly eroded Kaiser Permanente's historical competitive advantage, which was basically a function of significantly lower hospital utilization.

As Kaiser Permanente now faces the new market challenge three things are necessary for our very survival. The first is the acceptance that we have the potential to lead a new health care revolution—that is, a revolution in the way care is delivered to patients in a population-based health care system. This social purpose can be hard-wired into our very organizational being. Secondly, we need a dramatic reconfirmation of our commitment to market-leading performance. The sad truth is that we are not leading many of the markets in which we compete. That situation must change or our social purpose dies as our program dies. As our founders clearly understood, we absolutely must be able to produce an excess of revenue earned over the costs of providing high-quality and satisfying care for our members, even in the most competitive of our markets. The third and equally important imperative is the need to reconfirm our intent to use this earned surplus as a "social dividend" to fund our direct community benefit investment.

As this new journal expands and grows over the forthcoming months and years this column will provide the opportunity to rediscover the important elements of our past that will serve as a guide to our future development. Understanding the past provides the key to the future. And in the case of Kaiser Permanente, understanding how the past created our current culture provides the key to our purpose and lays the foundation for recreating Kaiser Permanente for the 21st Century. ❖

References:

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