THE KAISER PLAN

Editorial: HMO's

When Forbes and Fortune magazines run successive articles contending that health maintenance organizations (HMO’s) are “sensible surgery for swelling medical costs,” we know that big business is interested. When the supermarket magazine Family Circle publishes a story entitled “Is There An HMO In Your Future?” we realize that the official word is spreading to the American people.

Yet most Americans don't understand the HMO concept. An HMO is a health care organization which is intended to provide comprehensive services to a voluntarily enrolled membership at a prepaid fixed fee. Usually an HMO is affiliated with one or several hospitals. It may be funded privately, publicly or by a combination of both; it may be for-profit or “non-profit.” Doctors can practice full-time or part-time within the HMO, and can be salaried or paid fee-for-service.

Only three years ago there were 30 HMO’s. Today there are over 60 with eight million subscribers. At least 46 insurance companies are participating in or have “exploratory interest” in operating 63 HMO’s. Blue Cross hopes to open 280 by the mid 1980’s.

Big business is also joining the bandwagon: the elite policy-forming organization, the Committee for Economic Development representing most American business leaders and with considerable clout on a variety of government policies, endorses HMO’s in its April, 1973 report.

Westinghouse is studying the possibility of starting one in Florida. Texas Instruments is already involved in setting up one, and Litton Industries wants to give “seed money” for a number of HMO’s. Connecticut General Life Insurance Company and the Equitable Life Assurance Society have made significant commitments to HMO’s. Connecticut General’s new subsidiary operates them in New York, Arizona and Maryland and Equitable organized and recruited subscribers for the Lovelace-Bataan HMO in Albuquerque.

One of the most successful HMO’s is the Kaiser-Permanente medical care program, a prepaid group practice which has been operating in California for over 30 years. Kaiser’s membership in California, Portland, Hawaii, Denver and Cleveland exceeds two and a half million.

Other HMO models have emerged that are different from Kaiser. Most notable are the foundations for medical care, created by private doctors (See BULLETIN, February, 1973). A foundation, unlike Kaiser, is not a visible institution but simply a mechanism through which paper and money flow. Care is provided in private doctors’ offices and hospitals where the doctors have admitting privileges. Patients pay insurance companies, insurance companies pay the foundation, and the foundation pays the doctor or hospital.
Prepaid health plans (PHP's), particularly growing out of California's Medicaid program, are another HMO innovation. The state pays the PHP a fee for each Medicaid patient enrolled and the PHP provides care at its own clinics or at separate doctors' offices and hospitals through contracts.

The main success that HMO's can claim is cost reduction. Kaiser can provide a package of services at lower cost than identical services would cost in "mainstream" medicine. The way in which an HMO reduces cost is by lowering the use of services by its members. Kaiser members, for example, spend half as many days in the hospital as a similar population of Blue Cross/Blue Shield subscribers. And the amount of surgery performed by Kaiser compared to fee-for-service practice is distinctly lower.

In the case of hospitalization and surgery, which most Americans are subjected to in dangerous and costly excess, HMO's can perform a positive service. But HMO's will also tend to lower the availability of services that are not presently performed in excess. At Kaiser, ambulatory care is not easily accessible—large numbers of patients complain of several week waits for appointments, of rushed impersonal treatment, and of being unable to find and keep a personal physician.

Thus HMO cost reduction goes hand in hand with a general inaccessibility of services. The reason for this is the workings of the profit motive. Whereas for-profit or technically "non-profit," private corporations have always committed themselves to maximizing their income, reducing their expenditures, and using the surplus for expansion. The profit incentive leads private HMO's to limit services by hiring an inadequate number of physicians and other personnel so that patients will be discouraged from seeking care. In this way, expenses go down and surplus goes up.

HMO's, then, take the profit incentive of fee-for-service medicine and turn it on its head. Whereas fee-for-service doctors and hospitals make more money by seeing more patients, performing more operations and hospitalizing people longer, HMO's increase their net income by doing less. Either way the situation can be deleterious to people's health.

Besides the conflict between cost reduction and availability of services, private HMO's oriented primarily toward their surplus income are actually unable to cut costs significantly over the long run. For equivalent services, Kaiser costs less than Blue Cross/Blue Shield, but Kaiser's rate of cost increase is just as great as, or greater, than the national rate of increase. Thus HMO cost reduction is a one-shot affair; if the entire health system switched next year from fee-for-service financing to HMO financing, the costs of care might dip down, but would then inflate as rapidly as ever. Within a few years any cost reduction would be virtually cancelled out.

Again the reason is profit. Each provider and supplier of service—whether the construction company, the manufacturer of the EKG machine, or the doctor—will raise prices as fast as possible in order to make more money.

If HMO's are no long-term answer to cost rises, do they solve the other components of our health crisis? Here the answer is even simpler—they do not. Even
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ing editors.

Finally comes the myth of health mainte-
ance—that it's cheaper for an HMO to
prevent disease than to cure it. In
the short run, that's just not true. Annual Pap
smears, breast exams, blood pressure
checks, glaucoma screening and other
valuable early diagnostic procedures cost
money and require more medical person-
nel. The savings—in reduced numbers of
seriously ill patients—come only many
years later (if then), far beyond the pro-
jections of corporate accountants and
planners. Only with large federal grants
has Kaiser offered multiphasic screening
exams to many of its subscribers, and
with cutbacks in the grants, Kaiser is re-
ducing the screening. In HMO's as within
"mainstream" medicine, acute illness will
always take precedence over preventive
care.

People who believe that HMO's should
be publicly-controlled and service-ori-
ted rather than privately-run and profit-
oriented have two courses of action. They
can try to set up local health plans pub-
licly controlled by the users and em-
employees. Community groups across the
country are planning or even actually es-
tablishing their own HMO's or PHP's. But
the capital requirements needed to start,
and the enormous time and energy spent
on technical proposals, plans and con-
tracts are almost prohibitive. It is the rare
community that will put together a plan
that it really controls without being in-
debted to a lending institution or a group of
doctors. The alternative is a struggle
for areas of power in private HMO's—for
community positions on the board, for em-
ployee meetings in specific clinics and
hospital wards, and for public airing of
planning documents and financial trans-
actions. In either case, HMO's will in-
creasingly be foci of community and
health worker action in the health system.

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CORPORATE MEDICINE:
THE KAISER HEALTH PLAN

"I want to see a thousand of these health centers all over the country," declared Henry J. Kaiser in 1950. Well, it would warm Henry J's gravestone if he knew that today his name is linked with the most important health care reform in a troubled America. The Kaiser-Permanente medical care program operates throughout most of California, up to Portland, out to the Hawaiian Islands, into Denver and east to Cleveland.

Kaiser-Permanente (K-P) has its proponents and its critics. K-P, which is group-practice based, has stopped hospital over-utilization and cut costs, supporters claim. Critics counter that Kaiser provides "assembly-line medicine" and, because it cuts costs, care is mediocre. Many California subscribers think "Kaiser's not good, but it's the best around."

Kaiser certainly differs dramatically from traditional American medical care. People buy insurance from the Kaiser Foundation Health Plan usually through their union or place of employment. But the insurance is good only for care offered at K-P's own hospitals and clinics.

When Kaiser members get sick, they call the nearest Kaiser facility and make an appointment—with their personal physician if they have one, or frequently with whatever specialist seems appropriate. Because appointments are often hard to get, people needing immediate treatment can go to the drop-in-clinic or emergency room. Those desiring a physical check-up are referred to the multiphasic screening unit for a battery of tests with a follow-up doctor visit. Generally Kaiser covers many more medical services than most private insurance, and leaves fewer deductibles and other out-of-pocket payments for the patient. Another important and innovative feature at Kaiser is that doctors are paid on a salaried rather than fee-for-service basis.

While Kaiser administrators and researchers have written extensively about Kaiser's positive achievements, a critical study is needed to sort out the successes from the failures and to address certain questions: Why is a large corporation like Kaiser Industries, traditionally engaged in construction, mining and aerospace, associated with a health plan? Is K-P really non-profit? Does it truly keep down the costs of medical care? And how do its subscribers feel about the care they receive?

Kaiser-Permanente's Beginnings

Kaiser-Permanente sprouted in a field of cement: the colossal dam construction of the ’30s. Hoover, Grand Coulee and Bonneville dams were all built by Kaiser Industries under government contracts.

In 1933, more than 5,000 Kaiser workers were cutting a canal to carry fresh water from the Colorado River's Hoover Dam to Los Angeles. The project spread over 400 square miles of desert, and injuries or sickness meant a 200-mile trip to Los Angeles.
Angeles. Because of the distance, Kaiser built medical facilities in the nearby area. Henry Kaiser made an agreement with Sidney Garfield, an enterprising young doctor in Desert Center, California, to set up a prepaid medical service. Initially, Kaiser paid the Desert Center Hospital and physicians a certain amount to cover industrial injuries. Later, the workers could voluntarily put in a nickel-a-day payroll deduction for general medical services.

When Kaiser moved on to the Grand Coulee Dam project, Garfield followed and continued his prepaid medical plan. For the first time, workers' families were given full medical coverage, wives for seven cents a day and children for twenty-five cents a week.

The Government Helps Out
At the onset of World War II the market for dams slackened, and Henry Kaiser turned to shipbuilding. Again using government contracts, Kaiser organized shipyards in California, Oregon and Washington, employed 200,000 people, and turned out fully 35 percent of all US merchant vessels made during World War II. As a result, Henry J was dubbed by many as “Sir Launchalot.”

These shipyards were the basis for the first expansion of the Kaiser medical empire. In order to keep his men healthy, Henry Kaiser built clinics at production sites in Oakland, Richmond, Vancouver and at the Kaiser steel mill in Fontana, California. “The financing of these clinics was provided out of government contracts, since their cost was accepted by the authorities as a bona fide operating expense. After the war the clinics and their equipment were declared surplus war property. The Kaiser Hospital Foundation was established by Kaiser and his wife, Bess, to buy them at 1 percent of cost.” (1)

With the shipyards closed and the Kaiser workforce plummeting, the health plan was opened to the public and renamed the Kaiser-Permanente Plan. (The name Permanente was Bess Kaiser’s idea; Henry’s first cement plant was located on the Permanente Creek.) Thus at government expense, the K-P medical care plan was begun.

Henry Kaiser’s Philosophy
Henry Kaiser’s expansion into the health field wasn’t just “one of his crazy ideas,” as many critics thought. During the New Deal years, the air was filled with federal and state proposals advocating compulsory health insurance. This movement was strongest in California where over a dozen progressive health bills were introduced during the late ‘30’s and ‘40’s.

A strong advocate of private enterprise, Henry Kaiser in 1942 publicly warned, “If the doctors fear socialized medicine, if industry is anxious about the widening powers of the state, why not venture now, boldly, into the activity that will forestall the superplanners in their schemes to direct medical services into the channels of distributive bounty?” (2)

In 1945, Henry Kaiser began a national campaign for his new prototype of health insurance. He modestly proposed that the Federal Housing Agency guarantee 10 percent of local bank loans to non-profit groups that wanted to set up facilities for prepaid hospital care. The AMA called Kaiser’s program “socialized medicine.” Kaiser countered that his prepaid medical projects would operate as “business enterprises motivated by the impelling force of competition.” (3)

But Kaiser did not need any legislation. His visions came true much faster than people expected. By 1955, K-P had over 500,000 subscribers.

Kaiser Is Big Business
Whether Kaiser physicians or subscribers like it or not, Kaiser-Permanente is part of the Kaiser Industries empire and is largely controlled by it. Kaiser Industries consists of about 100 active companies including Kaiser Aluminum and Chemical, Kaiser Steel, Kaiser Cement and Gypsum, Kaiser Engineers and Kaiser Aerospace and Electronics.

Of the 17 persons on the board of directors of the Kaiser Foundation Health Plan and Hospitals, eight represent Kaiser Industries. Most prominent is Henry Kaiser’s son, Edgar, who is chairman of the board of both organizations. Kaiser Industries’ representation on K-P was even stronger a few years ago, but as K-P became more successful and secure in its West Coast position, it began responding to public pressures of the ‘60’s and added non-Kaiser people with little power. As public relations man Dan Scannell quipped, “Now we have a Black, a woman and an Oriental on the board.”

Many people ask why a successful
business would want to get involved with all the problems of health delivery. Dr. Clifford Keene, president of the Hospitals and the Plan, as well as a board member of Kaiser Industries, sums it up in saying, "the unparalleled corporate interest in health and medical affairs . . . arose out of the needs and interests of the Kaiser companies over the past 30 years." (4) We can only speculate what these needs and interests are.

Washing Away Industry's Sins

As California labor consultant Thomas Moore puts it, "the medical program is just so damn self-serving for Kaiser Industries. It washes away the sins of industry." Health care is always a shining star to pin on one's chest. When asked in interviews which of his ventures gives him the most satisfaction, Edgar Kaiser always responds, "the Kaiser Medical Care Program."

Tomorrow the World

The Kaiser medical philosophy has not stopped at the American border, but is expanding throughout the world. Located on the 17th floor of the giant Ordway Building (part of the Kaiser Center) in downtown Oakland, a small staff is quietly spreading the word throughout the Third World under the guise of the Kaiser Foundation International (KFI)—funded by Kaiser Industries.

KFI was originally organized in 1957 as a California non-profit corporation under the name of Kaiser Foundation of Hawaii. According to KFI's literature, its original purposes were to develop charitable, scientific, educational and hospital programs on a local basis. But in 1964, its emphasis had shifted to promoting hospital and health care programs abroad. Reflecting its potential geographical scope, its name was changed to Kaiser Foundation International. Its board of directors include Dr. Clifford H. Keene, president, who is also director of both Kaiser Industries and the Health Plan and Hospitals, and vice-president Dr. James P. Hughes, also a director of Kaiser Industries.

KFI is naturally following in the footsteps of its parent organization, the Kaiser Health Plan and Hospitals. Initially it was active only in those countries (Jamaica, Ghana, etc.) where one or another of the various Kaiser industrial and construction firms had business interests. The Foundation has organized and managed mostly occupational medical services for its employees—especially its foreign workers—located in remote areas. "In Ghana," according to Dr. Hughes, "it was quite clear that our medical mission at the outside would be to take care of the work injuries on the construction of the plant, so that the local government facilities would not be further burdened. . . . Our second consideration was that we had recruited a group of skilled people from around the world to go in and provide the technical know-how that the construction required. We knew that they would not go there, at least happily, without an adequate medical service. So there was no problem at all about identifying for whom we would be responsible at the outset, and to what extent." (Our italics.) (Health Care For Remote Areas, An International Conference, Kaiser Foundation International, 1972, page 21.)

It's all very good for companies to provide health care facilities, but KFI is taking a giant step in developing its brand of medical delivery services for other countries. As a matter of fact, according to Hughes, "the majority of developing countries in which Kaiser Foundation International has worked to date have not been the site of Kaiser industrial or construction projects. . . . The mission that we in Kaiser Foundation International are charged with is to find places around the world where community health care can be improved by applying some of the principles developed in our domestic prepaid health plan."
On Edgar’s conscience may be the fact that Kaiser Steel is one of the big polluters in southern California. Edgar Kaiser contributed sizeably to the campaign against California’s recent ecology measure, Proposition 20. According to the Washington Post (5), Kaiser Aluminum dumps large amounts of mercury-containing waste into the Mississippi River in Louisiana. Controversy erupted in the San Francisco Bay Area over Kaiser Sand and Gravel’s defacing of hilltops in Orinda. Other Kaiser strip mining operations go on in Canada and Australia.

Another blot on Kaiser Industries’ image is its rating in the top 100 Department of Defense contractors’ list. One of its wholly-owned subsidiaries, Kaiser Aerospace and Electronics Corporation, produces rocket motor nozzles and structural components for aircraft and missile programs and electronic equipment such as aircraft flight display systems. In 1972, Kaiser Aerospace and Electronics had a $3.7 million contract to build electronic equipment for the A-63 fighter-bomber which was used extensively over Vietnam. Kaiser companies also have made bombers, ammunition and built military bases (6).

Kaiser Aluminum and Chemical, in a new partnership with Aetna Life and Casualty Company, is one of the country’s largest real estate and land development corporations. Directed by Edgar Kaiser, Kaiser-Aetna has developments in California, Hawaii, Arizona, Baltimore, Atlanta, Cincinnati, New Orleans and Texas. In 1970 it evicted over 100 poor native Hawaiian families at Kalama Valley. In a Wall Street Journal ad, Kaiser-Aetna boasts, “If we’re not already in your neighborhood, perhaps we will be soon.”

Nor is Kaiser above self-serving illegal deals. The Wall Street Journal (7) reported that 36 officers of Kaiser Steel, including Edgar Kaiser, secretly bought 63,200 shares in a Canadian coal mine. The shares were supposed to be sold only to Canadians. When the mine yielded practically nothing, the Kaiser officers, with inside information, sold their shares at a profit while making reassuring statements about the mine. The Securities and Exchange Commission investigated, and a federal court issued an injunction against Kaiser’s fraudulent activities. A Kaiser public affairs vice-president commented, “Everything we’ve done is open and above board.”

### Kaiser and Taxes

In 1948, Henry Kaiser set up the Kaiser Family Foundation which is entirely distinct from the Kaiser Foundation Health Plan. In doing so, Henry “seemed more interested in providing a vehicle for tax planning and estate management than in execution of a charitable program,” according to a study by the usually staid Twentieth Century Fund (8). In fact, the Kaiser Family Foundation, the 27th largest foundation in the US, plays a key role in the control of Kaiser Industries by members of the Kaiser family.

The Kaiser Family Foundation is now the single largest owner of Kaiser Industries stock, with a controlling share of 32.7 percent. The next largest block of stock, 8.5 percent, is owned by Edgar Kaiser, chairman of the board of Kaiser Industries. Currently, Edgar is also a trustee of the Family Foundation. The Family Foundation’s income from Kaiser Industries’ stock is tax-free. So Edgar can make a large, taxable personal income from his own shares, and keep control over Kaiser Industries through the tax-free Family Foundation shares.

Specifically, the Family Foundation provides capital to the Kaiser Foundation Medical Care program to assist its expansion in California and into new regions of the US (9). The Foundation donated $3.5 million to start a Kaiser-Permanente program in Cleveland, and $2 million for one in Denver. Seed money for the Oregon and Hawaii ventures also came from the Foundation. To insure that control of the Family Foundation never leaves Kaiser hands, all of the trustees of the Family Foundation are past or present members of the boards of both Kaiser Industries and Kaiser-Permanente. (Interestingly, for a while K-P directly owned $2 million of Kaiser Industries stock, but sold its shares in 1970.) The Family Foundation has received most of its stock from bequests in the wills of Kaiser family members—in 1951 after the death of Bess Kaiser, in 1961 after the death of Henry’s youngest son, and in 1967 following the death of Henry himself.

Kaiser Industries also receives a small, but direct benefit from K-P’s continuous hospital and clinic construction. Kaiser Engineers, a wholly-owned subsidiary of Kaiser Industries, designs most of the hospitals and many of the materials used for construction are Kaiser’s. One example comes from Redwood City, California...
where a building inspector explained, "Of course Kaiser Industries builds their hospitals, and they specify in their contracts that it uses their own materials." (10)

Kaiser's Growth

"Growth is a way of life for the Kaiser-Permanente Program," states the K-P 1969 annual report. Most subscribers don't even know that 4 percent of their premium plus a minimum of 15 cents per member per month is budgeted for expansion.

K-P's eagerness to grow is reflected in its over-subscription policy in some regions. The southern California Panorama City Hospital provides a good example. Three years ago, the Lockheed Corporation in Burbank was looking for a health plan for its 8,000 employees. Kaiser initially said that it wasn't equipped to handle that many more people for three years. But not wanting to lose the 3.3 million dollars a year that 8,000 employees would bring in, Kaiser changed its mind when Lockheed began to look elsewhere.

The Lockheed employees were not assigned their own doctors until they were processed through a screening exam. But appointments for the exam took up to six months and even then, the members did not receive a doctor unless they showed an abnormal test. The discrepancy in staffing for the new patient load was not fully rectified for three years. According to one source, the entry of Lockheed employees into Kaiser resulted in other Kaiser members getting lower quality services for their money, the new Lockheed workers getting partial benefits even though they paid full price, and hospital personnel working longer and harder hours with no increase in pay.

Why does K-P expand? One important reason was expressed by a K-P planner: "As long as we keep expanding, our patient population won't get too old. If we remain static, our average patient's age will get older and older and then we'll be in trouble economically. This way every time we get a new union or a new factory, we get only the people who are working now and are in good health; not the retirees and the people who've had to quit because of a disabling disease." (11) This is good "business sense," because the older one gets the more medical services are required. Also at Kaiser, the longer one is a member, the easier it is to know and utilize the system. As one Kaiser nurse explained, "The longer you're at Kaiser the more you realize that you can get immediate care by demanding and shouting either on the phone or in the clinics." Clearly, it is more economical for Kaiser to have a continuous stream of new subscribers who don't know how the system works.

How The Kaiser Health Plan Works

Who Subscribes?

Two and a half million people belong to Kaiser. The Northern and Southern California regions each account for well over a million, with the remaining 300,000 scattered in Oregon, Hawaii, Ohio and Colorado. Yet, as Kaiser's own analysis shows, its membership by no means resembles the general population (12).

Kaiser families had an average income of $11,309 in 1967 and 1968, while data show southern California families averaging incomes of $10,421. Thus Kaiser tends to enroll healthier people avoiding the burden of those who need medical care the most—the chronically ill, elderly and poor. In the words of Kaiser's own economists, "we are younger and relatively under-represented in certain population groupings, for example, the unemployed, the indigent, the wealthy, the self-employed, and people living in rural and other non-metropolitan areas." (14) It should be noted that Kaiser is no different than private insurance companies in skimming lower-risk people from the population; commercial insurers in southern California, for example, have an even younger and healthier population than Kaiser.

In northern California 76 percent of Kaiser members are in a healthy age group under 45 years, compared to 70 percent of the general population (13). Only 4.2 percent of Kaiser subscribers in northern California are over 65, whereas 9 percent of the general population is in this high risk age. Kaiser will not accept group enrollment that has more than 25 percent of its membership over 60 years. If it weren't for Medicare, Kaiser would have far fewer elderly people.

In northern California 87 percent of members join K-P through a group, with the employer generally paying all or part of the monthly charges. Public employees—federal, state, local, including employees of school districts—constitute
K-P's Business

K-P is a very successful business operation. Although it is legally a non-profit organization, its "excess income" is as high as many profit-making corporations. In 1971, K-P reported a tax-free net income of $12 million. Adjusting that figure for accelerated depreciation, and for corporate income taxes, Fortune claims that the organization's excess income would be 8.8 percent. This is about equal to that of the oil industry (9 percent) and only 0.3 percent below the average return for the Fortune 500 that year, according to Fortune. An indication of Kaiser's financial strength is its ability to borrow from the Bank of America at the prime rate. In January, 1973, Standard and Poor's awarded the Kaiser Plan an "A" bond rating—its first to a private non-profit corporation.

Because of its legal non-profit status, K-P cannot pocket its profits. Much of its excess income is turned back into expansion and high administrative salaries and expenses.

The total revenue of K-P in 1972 was $454 million. Of this amount, $363 million came from members' dues; $44 million from supplemental charges (most of which comes from the pharmacy and the optical laboratories); $37 million from Medicare reimbursement, and $10 million from non-plan, industrial and non-member services.

Expenses for 1972 were $441 million with $234 million going to physicians and their staff; $151 million going to hospital services—including the salaries of all hospital workers; $28 million for outpatient pharmacy and optical services and almost $4 million for other benefits such as ambulance costs and reimbursements of members for out-of-area emergency expenditures; close to $7 million goes to Community Service programs, but almost all of the $7 million is reimbursed under federal research grants and contracts; and $13 million is used to administer the Health Plan.

more than 40 percent of Kaiser's total membership. Non-group enrollment is 13 percent of Kaiser's entire membership. These persons enrolled on an individual basis or converted to individual membership when they left an employer who had Kaiser insurance. According to Kaiser spokesman Robert Zimmerman, the health plan will not accept high-risk individuals who are over 60 or have high blood pressure, diabetes or other chronic conditions. Benefits under individual enrollment are more limited than those provided in groups and the premiums are higher. The health plan may terminate the membership of individual members on 15 days notice. Officials say this is seldom done.

Comprehensive Benefits

Kaiser's benefits are relatively comprehensive compared to other health insurance plans. Generally all subscribers receive hospital services, out-patient care with lab tests and X-rays, drugs, eye exams, physical therapy, ambulance service, emergency care and maternity care (after 10 months of membership). However, different members have different plans, depending on the costs of the monthly premiums. A more expensive plan might include psychiatric service and long term care; a cheaper plan might charge the patient for certain services and limit the number of hospital days.

In southern California, for example, Plan AA costs more per month and provides doctor visits, eye exams, and physical therapy free. Plan BC, with a lower monthly premium, charges $2 per doctor visit, eye exam and physical therapy treatment. Both AA and BC subscribers must pay "reasonable rates" for out-patient drugs. Plan M—for Medicare beneficiaries—is the most comprehensive; Kaiser receives a monthly payment from the federal government plus an additional charge from the member for those services not covered by the government.

Currently the health plan does not cover attempts at "suicide or other intentionally self-inflicted injuries or illnesses (this would include overdosage of pills);
Structure of the

The Kaiser-Permanente medical care program is divided into four components: the Kaiser Foundation Health Plan, Kaiser Foundation Hospitals, Permanente Medical Groups and Permanente Services Incorporated. All four are decentralized into six regions.

The Kaiser Foundation Health Plan
This "non-profit" corporation acts like an insurance company. The main difference between it and Blue Cross is that people insured by the Health Plan must (except in emergencies) use their insurance only at Kaiser hospitals with Permanente Medical Groups. So the Health Plan not only enrolls subscribers, it also arranges for their health services through contracts with the hospitals and medical groups.

The Kaiser Foundation Hospitals
The hospitals, also "non-profit", are run by the same board of directors as the Health Plan; in fact, these two components have almost amalgamated into one entity. Kaiser has over 20 hospitals, and the Health Plan contracts with non-Kaiser hospitals in Cleveland, Denver and San Diego where the program has relatively few subscribers.

The Permanente Medical Groups (PMG's)
The PMG's are groups of physicians, one in each of the six geographical regions. Legally they are profit-making organizations, though the profits go to the physicians themselves rather than to outside stockholders. The PMG's are separate from the Health Plan and Hospitals partly because of state laws that prohibit physicians from working under a lay employer, and partly in order to maintain the non-profit, tax-exempt status of the Health Plan and Hospitals. Structurally, the PMG's each have their own board of directors (sometimes called executive committee).

The Health Plan pays the PMG's on a capitation basis, that is to say, the PMG receives a fixed amount of money per member per month. In operation

...drug addiction; alcoholism; conditions covered by Workmen's Compensation; military-service connected conditions; custodial, domiciliary or convalescent care; cosmetic surgery; corrective appliances and artificial aids; extensive neuromuscular rehabilitation and conditions resulting from a major disaster or epidemic." Also, if a member is injured or taken ill while temporarily more than 30 miles from a Kaiser hospital, Kaiser will pay for treatment in any hospital. Kaiser claims it will pay up to an aggregate maximum of $3,000 for emergency services and ambulance. There have been reported cases of emergencies, where Kaiser has not paid because it didn't deem certain injuries or illnesses as emergencies. Subscribers suffering emergencies within the 30 mile zone must go to Kaiser or pay their own way.

In northern California, new benefits will be added, effective January 1, 1974. They are: care for intentionally self-inflicted injury (this apparently is included because at point of entry, it is difficult to diagnose whether certain injuries or medical conditions are self-inflicted); intensive care for TB patients in specialized hospitals (there is a low incidence of TB among Kaiser subscribers); emergency coverage up to $3,000 occurring anywhere in the world (including 80 percent coverage up to $50,000 and 365 days in the hospital).

Low-Income Care
By dabbling in small projects for low-income people and publicizing these projects far beyond their worth, Kaiser is trying to change its middle-class image. The best-known effort is the Portland OEO program for 1,200 low-income families. Similar tiny programs were opened in southern California and Hawaii. Kaiser is
K-P Medical Program

this basically means that physicians are salaried.

Salaries of Kaiser physicians are competitive with the medical marketplace. Beginning salaries range from $20,400 to $24,000 with fringe benefits up to an additional 25 percent. The average salary is around $40,000 plus substantial fringe benefits. According to PMG physicians, some specialists make $70,000 to $100,000. Each year besides cost-of-living increases, merit raises are doled out by department heads and the physicians-in-chief.

For the first two years a doctor at Kaiser is an employee of the PMG, after which the physician is eligible to become a so-called "participant." After another year, the physician is eligible for partnership. The difference between a partner and a non-partner appears to be primarily financial. Once a partner, the doctor can share in all the profits of the group. Voting privileges are also acquired. Approximately two-thirds of Kaiser's more than 2,000 physicians are partners.

Doctors' profits at Kaiser are variously termed the "contingency contractual payment," "divisible surplus," "bonus" or "incentive compensation." What this means is that after the budget for the entire medical care program (hospitals and PMG's) is prepared, an additional 5 percent is tacked on and made part of the final budget. Then, four or five times a year, any budgeted money left over is distributed equally between the PMG's and the Health Plan/Hospitals. The PMG money goes to the physician partners as a bonus, and usually runs from $7,000 to $9,000 in addition to their salaries.

Permanente Services Incorporated (PSI)

The profit-making Permanente Services corporations—one for each region—perform administrative and pharmacy services for the Hospitals and PMG's. PSI functions include accounting, payroll, employee relations, planning and construction management, and the operation of pharmacies for the hospitals and clinics. The profits of PSI go to its stockholders, the Kaiser Foundation Health Plan and Hospitals. PSI appears to be separate from the Health Plan and Hospitals for legal and tax reasons.

rightfully proud of the fact that the poor were cared for on an equal basis with regular Kaiser subscribers. Of course, Kaiser received ample funds for its projects; in addition to paying the premiums, OEO provides money for patient transportation, home care, staff training and other social and outreach services. You can bet that these extras will disappear with OEO.

Without investing a penny of its own, Kaiser found through its OEO programs that it could serve small numbers of poor people without a marked increase in costs per patient (15). This information is extremely useful in deciding on further integration of low-income Medicaid patients into Kaiser facilities and calculating reimbursement rates from Medicaid programs.

In an experiment with a prepaid Medi-Cal (California's Medicaid program) contract, Kaiser's southern California Fontana facility signed up 1,200 Medi-Cal patients in 1972. This contract may not last. Under a new conflict of interest law, no organization can receive Medi-Cal contracts if any of its officers are state employees, legislators or commissioners. K-P may prefer access to important government groups than to serve low-income patients.

Charity Begins At Home

A very small number of the medically indigent—people without insurance, Medicare or Medicaid—get into Kaiser. On the average, according to a Health Plan representative, only 1 percent of any one hospital's inpatients are non-Plan subscribers and have no insurance coverage. They are financed by the individual facility's Medical Social Assistance Account.

In the past the percentage of charitable cases was much higher. The 1961 K-P Annual Report dedicated a page to charitable care nobly stating, "The Com-
Community Service Program places special emphasis on charitable care. This charitable care program is designed to assist persons or families the social service workers describe as 'medically indigent.' They become 'medically indigent' in the face of heavy hospital or medical bills. Any clergyman, community welfare agency representative, doctor or nurse may refer these 'medically indigent' cases to Kaiser Foundation Hospitals.

Today Kaiser is far less generous with community services and rarely talks about the individual medically indigent. The community service funds allotted for "charity, research and education" are largely funneled to physicians for individual research projects. This arrangement enables Kaiser to create a "university atmosphere" for many of the "academically inclined" doctors. As one San Francisco doctor said, "research money is our sanity money. It gives us a half day or so to be away from patient care."

Quality of Care

The most important aspects of medical care are most difficult to measure. Only a few studies of Kaiser's quality of care have been done. Most useful are (1) a 1972 study by Milton Roemer and others on comparative utilization rates, costs, attitudes of patients, and quality of care under three major types of health insurance plans (Blue Cross/Blue Shield, private insurance company and Kaiser) (16), (2) an examination by Nolan, Schwartz and Simonian of social class differences in the utilization of pediatric services at the Oakland Kaiser clinic (17), and (3) the California Council for Health Plan Alternatives (a union-sponsored organization) and the Medical Committee for Human Rights 1973 mail questionnaire study of consumer satisfaction among 10,000 members of the Northern California Carpenters Union who subscribed to the Kaiser Plan. (Because only 24 percent replied to the questionnaire (18), this study must be viewed only as an indication of consumer feelings.)

The findings of these studies will be discussed below in analyzing whether K-P meets its own standards for quality care. Dr. Clifford Keene, as President of the Kaiser Foundation Health Plan and Hospitals, has stated,

"the criteria for judging quality in medical care are the degree to which it is available, acceptable, comprehensive, continuous, and documented; and the extent to which adequate therapy is based on an accurate diagnosis rather than symptomatology. I would add the criterion of dignity—the dignity accorded the recipient of services, and the dignity of style of the providers of services." (19)

Availability

Almost everyone agrees that the US suffers from a shortage of doctors. But no one is sure just what the proper ratio of physicians to patients should be for optimal care. Kaiser views one physician per 1,000 members as the ideal, but does not achieve its goal. In fact, Kaiser's physician-to-members ratio is lower than the physician/patient population ratio of the states in which Kaiser is located. The ratio of para-medical personnel to patients is also lower at Kaiser, which employs an estimated two persons per patient compared with 2.8 nationally in "short-term hospitals."

<table>
<thead>
<tr>
<th>Doctors per 100,000 Population—1969 (20)</th>
<th>State Ratio</th>
<th>K-P Ratio</th>
<th>Percent Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern California</td>
<td>161</td>
<td>102</td>
<td>-58</td>
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<tr>
<td>Southern California</td>
<td>161</td>
<td>90</td>
<td>-48</td>
</tr>
<tr>
<td>Hawaii</td>
<td>133</td>
<td>83</td>
<td>-38</td>
</tr>
<tr>
<td>Oregon</td>
<td>128</td>
<td>67</td>
<td>-49</td>
</tr>
</tbody>
</table>

Understaffing causes limited access for Kaiser subscribers. The usual complaint among Kaiser subscribers is waiting on the phone to make an appointment, waiting until an appointment is available, and waiting at drop-in and emergency clinics. Thirty percent of the CCHPA/MCHR respondents wait over one month for an appointment, and 27 percent wait from one to two hours to see a doctor at a drop-in clinic.

Another problem facing many subscribers is that they live too far from the nearest Kaiser facility. Among patients sampled at the Oakland pediatric drop-In clinic, Nolan et al found 22 percent of patients making daytime visits and 53 percent of those making evening visits had a transportation problem (21).

Lack of access causes many subscribers to seek, and pay extra, for care outside Kaiser's facilities. 55 percent of those who answered the CCHPA/MCHR questionnaire have used non-Kaiser medical services since joining K-P. 78 percent of these
Kaiser Plays The Numbers Game

Kaiser's philosophy is one of efficiency and cost-savings, and all personnel are guided by it. Physicians and clerks alike are pressured to perform to their limits; patients and workers suffer as a result.

The telephone appointment procedure is the crucial entry point into the Kaiser system. All calls for appointments are handled at a circular central appointment desk around which sit a number of clerks. In the center of the desk is a huge electrically controlled lazy-Susan filled with all the physicians' individual schedules so that each clerk can handle any appointment for any patient to any physician.

This all appears rather efficient. So why do subscribers chronically complain about long telephone waits of up to an hour? The answer lies in Kaiser's "numbers game."

In northern California, Kaiser's administration has decided that each appointment clerk should be able to handle 25 calls an hour or an average of five and a half to six physicians' calls. The clerks find this impossible to do. Doing their best, each clerk handles about 150 calls a day. The clerks not only care for the patients' needs, but also shuffle calls to other departments. It is almost as if Kaiser deliberately wishes to make access difficult.

If the appointment procedure is sometimes a problem for patients, it is also no joy for the appointment desk clerks. The supervisors of the appointment clerks, who realize that the administration's goals are unrealistic, attempt to do their best. Each supervisor has a panel with automatic counters and red lights which flash on and off. The panel shows how many calls have been taken every hour by each worker, how many have been lost ("lost" calls are patients who hang up in dismay), and how many are waiting at any particular moment.

Roemer and his colleagues found that 12 percent of the services used by subscribers in a 12-month period took place outside the Kaiser facilities. However, there is no report on the number of subscribers involved. Certainly far more than 12 percent of the subscribers used these outside services.

The Kaiser Plan has its own statistics which show even higher outside utilization. A K-P consumer satisfaction study prepared by the Field Research Company found that 44 percent of a southern California sample replied affirmatively that non-Kaiser physicians and non-Kaiser medical services had been used (22). Kaiser officials discount this figure, stating that the survey did not ask whether the services were referrals by Kaiser physicians or whether these outside visits were covered by another health insurance plan carried by the other spouse. Kaiser's explanations are not convincing. The statistics of outside use are relatively high and if a majority of them are due to referrals, then Kaiser is actually admitting that its services are inadequate. Furthermore, the CCHPA study just cited above contradicts Kaiser's statement that members who use outside care are covered by other insurance plans.

When broken down by income, Roemer's study showed that families earning under $11,000 seek more out-of-plan care than do families earning over that amount, especially for maternity care. The researchers suggest that lower income families may go out of Kaiser more often "because of some dissatisfactions or . . . because they have not learned to 'work the system' efficiently . . ." (23).

It is difficult for any Kaiser subscriber to "work the system," but the general problems of Kaiser come down hardest on people who have previously never been given the opportunity to navigate the health system. Kaiser's out-patient services are organized with a white, middle-class bias. Blue collar families utilize K-P services considerably less than do white collar families. Roemer showed that in a three month period, members of blue collar families made only 662 doctor visits per 1,000 subscribers, but for white collar families the rate is 954 per 1,000 (24).

Utilization also differs considerably between whites and non-whites. Nolan reports that "more than half the visits made people must pay for these outside services."
by white children were to the appointment clinics, but only one-third of the visits made by Negro children were to the appointment clinics. Slightly more white patients came for health supervision (school examinations) than for acute conditions among Negroes, for every preventive visit there were two for acute conditions." (25)

Acceptability
Kaiser members like the prepayment method of financing health care more than commercial plan holders like the fee-for-service system. But prepayment does not necessarily result in equal use of services by families or in equal sharing of costs. Non-utilization is actually an indirect way of subsidizing the care received by the users of services. If there is a greater degree of non-utilization, as the Nolan and Roemer studies show, by lower income groups enrolled at Kaiser then they are subsidizing the upper income groups who use the services more extensively (26).

Attitudes toward medical care received at Kaiser are less positive than attitudes towards Kaiser's financing. K-P's own study, conducted by the Field Research Company, comes up with some startling figures: "In both past and present surveys," according to Greer Williams, "only half of the members interviewed were satisfied with procedures in K-P clinics, such as getting appointments, promptness of service, and so on." (27)

Comprehensiveness
Kaiser's benefits and coverage are comprehensive when compared with other insurance plans, although dental care is not covered and psychiatric services are limited. Kaiser covers a greater proportion of medical care costs than do other plans, but the coverage is by no means totally comprehensive. Studies show that Kaiser pays between 43 and 76 percent of total medical care costs (28).

Continuity of Care
Kaiser operates a dual ambulatory system of care: a patient can take the appointment route or the drop-in route. The drop-in clinic is not integrated into the rest of the system. Patients go there primarily because they don't know how to use the appointment system or because they don't feel they can wait the days, weeks, or, for some specialties, even months to get an appointment. Frequent-ly, these clinics (and especially night clinics) are staffed by moonlighting doctors.

Drop-in clinics serve as pressure valves on an understaffed, overworked system. Without them Kaiser would have to hire more full-time physicians and ancillary staff; drop-in physicians are frequently part-time employees, not partners in the group practices.

One reason care at Kaiser is discontinuous is because specialty care is emphasized, and is the core of the Kaiser design. Only half of Kaiser's physicians are classifiable as primary care physicians (general practitioners, internists, pediatricians). The others are specialists or super-specialists to whom patients are referred for illnesses which often could be treated by a primary care physician.

Although many Kaiser members are victims of discontinuous care, Black patients fall overwhelmingly into this category. Nolan found that 48 percent of all white pediatric patients visited the drop-in clinic, while 67 percent of all Black patients received care there. Furthermore, 18 percent fewer Black patients have a regular pediatrician than do white patients (29). The CCHPA/MCHR study suggests that an even larger proportion of the total Kaiser population is without a family physician. That study found 51 percent of respondents without a personal physician, of whom 71 percent expressed a desire to have one.

What are Kaiser physicians' reactions to the lack of continuity? An intra-hospital critique at the Santa Clara facility includes physicians' complaints of fractionated care due to overuse of the specialty clinics and poor screening techniques. They added that patients are scheduled to see a different doctor at each visit, even for routine appointment follow-up. Moreover, they claimed, scheduling did not leave them enough time to see their patients adequately. Some physicians discourage "difficult" patients from returning or "punt" them from one doctor to another.

A major issue the physicians continue to wrestle with is the emphasis of Kaiser management on quantity rather than quality of care. As one physician explained, "The system bases many things on numbers without qualifying these numbers. The problem is pressure from the administration which engenders a crazy paranoid way about numbers."

Every month a data sheet with the
count of patients seen in each department and facility in the Northern California region is distributed to physicians-in-chief and department heads. Some doctors have been told by their department heads they were not seeing enough patients and shouldn’t take educational leaves.

Some doctors feel their schedules are so rushed and inflexible as to preclude delivering adequate, humane care. The schedules are also nerve-wracking to many physicians, and, as one doctor put it, "they have an ultimately eroding effect on a physician’s sense of responsibility for the patient."

**Democracy at Kaiser**

**Membership Participation**

As far back as 1957, Henry Kaiser summed up K-P policy stating, "You don’t ask your corner grocer to share his ownership with people who buy at the store." Sixteen years later, K-P’s attitude on membership participation remains the same. There are no member representatives or representatives of subscriber groups on the national board of directors. In the late 1960's the unions attempted to get on the board; Kaiser flatly refused them.

Thomas Moore, former executive director of the California Council on Health Plan Alternatives, testified in 1971 before the Senate Subcommittee on Health, that, after two years of complaining about Kaiser’s inadequate patient grievance procedures, K-P finally proposed some changes. Kaiser agreed to set up a grievance committee "as long as every patient bringing a grievance deposited $150 to cover the cost of arbitration. . . ." "To us," explained Moore, "it is absurd to put such a heavy burden on a man who is making a complaint so that he can’t afford to make it." (30)

**Physician Participation**

K-P always emphasizes the democratic nature of the medical groups (See Box, Page 10) and their autonomy from the health plan. Kaiser considers it a "fundamental principle that the physicians must be involved in responsibility for administrative and operational decisions that affect the quality of care they provide."

Structurally the medical groups each have their own executive committee. Kaiser states it in its literature that “there is constant input from the partners, both formal and informal. . . . Key decisions are made not just by the board of directors but by the board and the full membership.” (31) Interviews with physicians in the Northern California region about the decision-making process reveal a very different picture.

One Kaiser doctor characterized the executive committee as "an autocracy which makes decisions in the guise of 'quality of care.'" Similarly a second physician called them "self-serving, power hungry men with coteries of syncophants who are building personal empires." And a third Kaiser doctor described them as "an oligarchy ruled with an iron fist that makes decisions by fiat." Every day in one Kaiser physician’s practice, a scheduling situation would arise in which “decisions were coming down from the top that interfered with how care was delivered.” (32)

Within the last two years, with the attrition rate increasing significantly, the physicians whose “opinions were neither sought nor listened to” were so dissatisfied that members of the executive committee were forced to tour the hospitals and tokenly restructure their committee.

Today the committee’s board, although it has changed from its original composition of self-appointed lifetime members, is still not elected by or accountable to the full membership of the group. Now the committee consists of at least three old-timers whose power positions are unshakeable, plus the physician-in-chief from each hospital, and one representative from each clinic who is elected every two years by the partners of that facility. Only those representatives from groups of 25 doctors or more who have their own hospital are allowed to vote. (The physicians at the Sunnyvale Clinic and the South San Francisco Clinic, for example, are not voting members.) The company clique is still there; the physicians-in-chief are appointed by the executive committee and elected representatives are always outnumbered.

**Worker Participation**

If things are difficult for doctors, one can imagine the situation of hospital workers. Like all hospitals, Kaiser workers are not involved in any decision-making. The bulk of the workers at Northern California Kaiser, including LVN’s (LPN’s), pharmacists, technicians, dishwashers, housekeepers, etc., are members of Local 250 of the AFL-CIO, the Hospital and In-
This fall Local 250 is negotiating a new contract with K-P. There are three areas that the union considers important: The first is wages. The union wants salary increases that will cover Bay Area cost-of-living increases. The second is health benefits. Kaiser gives its own workers Plan D coverage, which is not the most comprehensive. The union wants Plan SS, a better package. The third concern is that of working conditions. Some of the specific working conditions the union would like to see included, according to one union representative, are on-the-job training, career mobility, and lighter work loads. It should come as no surprise that the union considers this last issue to be the most difficult to negotiate with Kaiser.

**Utilization and Costs**

Many people praise and promote Kaiser for relative economies of costs and utilization of hospital services. Studies generally support the contention that economies exist at Kaiser although the data are not entirely consistent.

Four comparative studies are relevant

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**Who’s Who on the Board**

Edgar Kaiser—Chairman, Director of all Kaiser companies and subsidiaries.
Clifford H. Keene, M.D.—Board of Directors, Kaiser Industries.
E. E. Trefethan, Jr.—Officer on many Kaiser companies and President of Henry J. Kaiser Family Foundation.
James A. Vohs—Employed by various Kaiser affiliated organizations; member of the Secretary of Health, Education and Welfare’s Task Force on Medicaid and Related Programs, 1968-70.
Mary I. Bunting, M.D.—Ex-President of Radcliffe College; Commissioner with Atomic Energy Commission.
Robert J. Glazer, M.D.—President of Kaiser Family Foundation; ex-Vice President of Commonwealth Fund; ex-Dean of School of Medicine, Stanford University.
Arthur J. Goldberg—General Counsel for AFL-CIO and United Steelworkers of America; ex-Secretary, U.S. Department of Labor; ex-Associate Justice of U.S. Supreme Court.
William Grant—Colorado National Bank; Chairman Democratic State Central Committee, 1965-69; ex-President of Metropolitan TV Company; ex-Chairman of the Board, Sangre de Cristo Broadcasting Company, Denver.
William Hewlett—Chief Executive Officer and Director of Hewlett-Packard Corporation; Director, Chase Manhattan Bank and the Overseas Development Corp.; Trustee of the Rand Corporation; Member of the President’s General Advisory Committee on Foreign Assistance, 1965-68; Trustee, Stanford University.
Roy E. Hughes—Board of Directors of many Kaiser Industries Corporations.
Henry M. Kaiser—Edgar’s brother; Kaiser Glass and Fiber Corporation.
William Marks—Board of Directors of many Kaiser companies.
Quigg Newton—President, Commonwealth Fund; Mayor, City and County of Denver, 1947-55; with Ford Foundation, 1955-56; President of University of Colorado, 1956-63; National Advisory Mental Health Council, National Institutes of Health, 1964-68.
Ralph T. Yamaguchi—Assistant Public Prosecutor, City and County of Honolulu, 1937-39; Special Deputy Attorney General of Hawaii, 1938-39; Director, Hawaiian Telephone Company.
to this discussion: (1) Roemer, et al., Health Insurance Effects, 1972 (33); (2) The Federal Employees Health Benefits Program, 1971 (34); (3) The Report of the Medical and Hospital Advisory Council to the Board of Administration of the California State Employees’ Retirement System (35); and (4) Family Medical Care Under Three Types of Health Insurance, Columbia University (36).

Utilization

Kaiser members have lower hospitalization rates compared with other groups when measured by total days of hospital care per 1,000 members per year. Kaiser's rate is lower in comparison with various commercial insurance plans and certain "individual-practice type plans" such as the San Joaquin Foundation for Medical Care, and about half that of Blue Cross/Blue Shield (37). Two factors, the rate of admissions and length of stay per admission, are responsible for Kaiser's lower hospitalization rates.

Kaiser also has a much lower rate of hospital admissions for in-hospital surgical procedures, about one-half that of Blue Shield. Specifically, the rate is substantially lower for tonsillectomies, "female surgeries," appendectomies, and all bladder surgery (38).

Some authors suggest that one reason hospitalization is lower at Kaiser than other plans is because more procedures are handled on an outpatient basis. However, studies show Kaiser's rate of ambulatory utilization does not differ greatly from the rate in other plans (39).

In the average, Kaiser members do pay for the same benefits than members of other health insurance plans (40). Although Kaiser is generally cheaper than other health insurance plans, it certainly is not the answer to inflation. Kaiser’s costs have inflated faster than the national average (the Consumer Price Index for Medical Care or "CPI"). For the ten year period 1960-70, the average medical care costs at Kaiser (premium and supplemental charges) increased approximately twice as fast as the national average (CPI). Yearly comparisons for this period show that Kaiser’s costs increased more rapidly than the CPI in every year except 1964 and 1965 (42). Were all medical care delivered through Kaiser-like plans, health care costs would continue their inflationary spiral.

Cost Reduction and Patient Control

In this society, medical services are like other commodities whose sale reaps profits. Producers/providers at once control the supply and create the demand for the product. Unnecessary goods such as too many specialists, drugs and surgery are foisted upon people while actual needs may go unmet. It is within this context that Kaiser’s costs and utilization data must be considered.

In prepaid group practices such as Kaiser, the traditional financial incentives are reversed so that profit or savings for physicians and hospitals alike can be achieved through minimizing, rather than maximizing, utilization of services. Given that there is unnecessary hospitalization and excessive surgery in "mainstream" medicine, Kaiser’s lower hospital utilization and surgery rates are commendable. How does Kaiser achieve its lower utilization rates?

The National Advisory Commission on Health Manpower, for example, rejects poor medical care, denial of services or relatively good health of members as explanations of Kaiser’s cost-savings. The Commission also rejects as explanations both innovations in the practice of medicine and economies of scale. They conclude that pressuring the physicians to be cost-conscious and "avoiding waste" result in savings.

If the Commission is correct and control of physicians is a major source of the economies of Kaiser, several Kaiser doctors indicate that the methods and degree of pressure have an ultimately deleterious effect on the quality of care because of their negative effects on the physician (see quality of care section).
Furthermore, contrary to the Commission's conclusions, it appears there are systematic mechanisms in the Kaiser system other than pressure on physicians which discourage utilization. Roemer and his colleagues discussed the deterring effects of barriers created by the system's bureaucracy. And as a Comprehensive Health Planning official said, "Kaiser uses several recognized methods for deterring utilization: copayments, long telephone waits, inadequate waiting room size, shutting down hours of operation, requiring a series of tasks to obtain a prescription, and long waits for lab results." (43)

In terms of costs to members, Kaiser could economize in two ways. One is to reduce the "profits," for example, by slowing expansion and eliminating the physicians' huge bonuses. The other is to reduce the delivery of services. Kaiser is traveling the second route, one which can be followed only so far before quality of care is jeopardized. As a private business, K-P will never take the first route.

Whether corporate HMO's develop in a significant way will depend on whether profits are made. If Kaiser is any indication, the profits will be substantial. However, problems in the delivery of health care will remain. Others, such as overhospitalization and excessive surgery may risk over-correction. With incentives for the extreme it is not unlikely for many people to go un-hospitalized who should be in hospitals.

As seekers of health care, we will continue to pay the costs: monetary, physical and psychological. Budding HMO's will fight-out their survival in the arena of competition and the small weaker ones will fail because of the huge initial capital investments. Ultimately health care will be delivered full force into the age of corporate capitalism.

—Judy Carnoy, Lee Coffee and Linda Koo. Lee and Linda were summer interns at the San Francisco office.

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