

# Better Care at Less Cost Without Miracles\*

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Our present system of medical care is not a system at all. The majority of physicians, operating alone as private entrepreneurs, constitute an army of push-cart vendors in an age of supermarkets. Most patients pay by the cumbersome "fee-for-service" or piecework method, which involves separate billing for visits to doctors, shots, x-rays, laboratory tests, surgery, anesthesia, hospital room and board, etc., etc. The American hospital system, as Herman M. and Anne R. Somers of Princeton University said in their book, *Medicare and the Hospitals*, "is largely a figure of speech," the result of a haphazard growth of isolated, uncoordinated institutions.

For a patient simply to *find* medical care can be maddeningly difficult. In poor city neighborhoods and rural areas, the supply is sometimes fatally sparse. The middle-class citizen, living in a region where doctors are statistically abundant, encounters frustrations when he seeks "access"—a suitable entry point into the medical labyrinth, where a competent person can give an accurate diagnosis of his ailment, or relay him to the proper specialist. With more and more doctors working a five-day week, access has become especially difficult on evenings and weekends. Increasingly at those hours, people are forced to resort to the overcrowded, understaffed emergency rooms of hospitals, where admissions have shot up by 250 percent in the past twenty years, and where only a third of the people waiting for attention are true emergency cases. When he is finally in what he hopes are good hands, the patient is incapable of evaluating either the quality or the quantity of the service he receives. In his ignorance he may submit to more care than is necessary—adding both to the personal risk and to the strain on an inflation-prone system. . .

Some eight million Americans now receive medical care under plans that work well, and that are subject to the constraints of the marketplace. These "pre-

paid group practice" plans are not the only model for reform. Further, even these plans have not yet been brought to the degree of efficiency that they may someday reach. Nevertheless, they represent an alternative that more Americans should be able to choose. Their expansion would exert a badly needed competitive discipline upon the rest of the medical system.

The Kaiser Foundation program is by far the largest of the prepaid systems. It has two million members and its own network of hospitals and outpatient clinics in California, Oregon, and Hawaii. The program began in the late 1930's when the late Henry J. Kaiser, then building hydroelectric dams in remote locations, felt obliged to provide medical services for construction workers and their families. After a conventional, fee-for-service payment system proved unpopular, Kaiser substituted a single fee covering all needed services, and the plan was enthusiastically accepted. In response to requests from hundreds of former shipyard workers, Kaiser kept the program going on the West Coast after 1945, and opened it to the general public. Today, employees of the various Kaiser companies and their families constitute only about 3 percent of the membership.

The Kaiser plan has made some notable improvements over the orthodox means of distributing medical care. To begin with, access is easy. Physicians of all major specialties are housed in large clinics in each of the regions covered by the plan. . . . If the patient requires hospitalization, he is sent to one of the Kaiser Foundation's nineteen hospitals, many of which adjoin the outpatient clinics.

Unlike ordinary private "health insurance," which is really sickness insurance designed to reimburse selected medical expenses under the fee-for-service system, the Kaiser program assumes broad responsibility for keeping its members sound of body. The range of services varies according to the employer group or individual member, but a fairly typical plan offered in the San Francisco-Sacramento area currently costs a total of \$35.40 a month for a subscriber with two or more dependents, including the employer's contribution. This covers all professional services in the hospital, in the doctor's office, and in the home, including surgery; all x-ray and laboratory

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## BETTER CARE AT LESS COST WITHOUT MIRACLES

services; all preventive care, including physical examinations; and hospital care for up to 111 days per person in a calendar year. Some nominal charges are made for drugs and for doctors' visits (\$1 per office visit, and up to \$5 for house calls after 5:00 P.M.), and there is a \$60 charge for maternity care. Some items are excluded, notably dental care, psychiatry, and nursing-home care (though some Kaiser plans offer psychiatric and convalescent care, too). For an additional monthly payment of 15 cents, hospitalization can be extended all the way to 365 days.

The more liberal of the Kaiser plans probably cover about three-quarters of a family's insurable medical expenses. The very breadth of the coverage provides two important benefits. On the one hand, no paid-up member need be deterred from seeking medical care for fear of the expense. On the other hand, no built-in bias exists favoring a particular *type* of care, since most types are covered anyway. A patient does not have to be admitted to a hospital for a test or a minor operation, which could be given on an ambulatory basis, solely in order to gain insurance coverage.

The Kaiser plan also provides an incentive for efficiency. The providers of medical care—the doctors and the hospitals—*share* the financial risks of illness with the patient. Members' monthly charges are set for a year, and during that period the program must operate on the revenue generated by these charges. If costs exceed revenues during that period, the Kaiser system must absorb them.

But any reduction in operating costs below management's projections swells a bonus fund that is shared by doctors and hospitals. Doctors are not paid on a fee-for-service basis, but receive a relatively stable annual income. When they render excessive treatment, they waste their own time and risk a reduction in their bonus, which, coming atop generous regular incomes, can be sizable. In 1968 the eligible doctors in Kaiser's northern California region each collected a bonus of \$7,900. Since they also received regular incomes that ranged from \$20,000 to \$53,000, they probably fared better, on the average, than solo practitioners in the area. And because working hours are fairly regular in group practice, with members taking turns working nights and weekends according to schedules set in advance, the doctors probably lead a more pleasant life.

Even though there is no limit to the number of times a member can see a doctor, members of the Kaiser plan make slightly *fewer* visits to doctors than the public in general. But the most dramatic savings are in hospitalization. One 1965 study, comparing Kaiser members in northern California with the population of California as a whole, showed that the average Kaiser member spent only 69 percent as much

time in a hospital. Still, the Kaiser plan has been affected by the wage inflation common to the health industry. Its nurses won a 40 percent wage increase in 1966, and its hospital workers came under the federal minimum wage law in 1967. As a result, premiums in northern California have risen about 50 percent since 1960, slightly more than the rise in the nationwide index of medical care during this period. But Kaiser's health services still cost from one-fourth to one-third less than the same package of services would cost outside the system.

The Kaiser plan operates in the black. Counting depreciation and some other items, the program generated a total cash flow of \$17,200,000 in 1968 on revenues of \$216 million, enough to provide funds for expansion. Except for one recent federal grant under the Hill-Burton hospital program, the Kaiser Foundation has financed all of its expansion from its own revenues and from borrowings. Unlike most voluntary hospitals, the Kaiser hospitals have never had to fall back on rich trustees or public fund-raising programs to cover deficits or obtain funds for expansion.

Kaiser's experience refutes the widely held belief that if medical services are "free," or virtually free, the public will stampede to them. Neither does the evidence indicate that Kaiser has gone to the opposite extreme, cutting corners and denying needed medical care. This criticism is often voiced by doctors opposed to prepaid group practice, along with the familiar charge that group practice precludes the free choice of "family" physician, and that it renders care in an impersonal, "assembly-line" manner, which lowers the quality of medical services.

In fact, the Kaiser program makes possible an educated choice of a family physician, because the patient in a large clinic is in a position to compare doctors. The atmosphere at one Kaiser clinic, in suburban Walnut Creek, California, is a good deal less suggestive of an assembly line than the typical jammed office of a solo practitioner; the place has more the relaxed ambience of a resort inn. A study team from the Johnson Administration's National Advisory Commission on Health Manpower gave the Kaiser program a thorough going-over in 1967, and found the quality of services to be high. One factor raising quality, according to Dr. Wallace H. Cook, the sun-tanned physician in chief of the Walnut Creek Center, is that doctors devote themselves to "absolutely pure medicine here." They have nothing to do with the billing, and they do not have to worry about the financial impact of the type of care that they prescribe on the patient, since virtually all phases of medical care are prepaid.

"Peer review," that much-evoked but little-practiced procedure for uncovering medical incompetence, is inherent in a group operation. "We constantly look over each other's charts," says Cook. An incompe-

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tent doctor can quickly lose the respect of his colleagues. In solo practice, doctors obviously can never lose their jobs no matter how incompetent they are; with only a few exceptions, licensed doctors are in business for life regardless of performance. At Kaiser, however, even doctors who have attained relatively secure "partner" status, which comes after a three-year probationary period, can be discharged. Not long ago a surgeon too inclined to use the knife was let go.

Another advantage that Kaiser physicians enjoy over their counterparts in solo practice is access to good health records. Generally, health records are in a medieval state, with incomplete data on each individual scattered in every doctor's office and hospital that he has ever visited. Most Kaiser members' medical histories are readily retrievable, and in a growing number of cases are stored on computer tapes. The eventual goal is to give each member a lifetime electronic medical file, based in part on the periodic, multiphasic testing with which the Kaiser Foundation is now experimenting on a large scale.

Probably the greatest spur to maintaining the quality of medical services is the fact that Kaiser does not have a monopoly over health care in the areas it serves. Once a year each group, and each individual within a group, has the chance to drop out of the program if he wishes. If enrollment figures are any guide, the consumers couldn't be happier. Membership has grown threefold in the last ten years, and the Kaiser Foundation is expanding about as fast as its financial resources will permit, currently at a rate of 200,000 persons a year. . . .

By almost any measure, then, the Kaiser program represents a quantum leap ahead of the prevailing pattern of health care in the U.S.