One Industry's Involvement in Health Care*

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The title of my remarks is somewhat misleading, because the Kaiser companies are involved in a number of industries. Our founder started his corporate business career as a contractor in 1914, building highways and paving streets in British Columbia, Canada. Therefore, our first experience with medical care arose from the construction business.

Our experiences with medical care have encompassed three basic areas:

First—industrial care; namely, the care of our own employees who were injured on the job.

Second—industrial care, plus health care of workmen and their families on construction projects in remote areas in the United States—and overseas; and later during World War II in overcrowded communities with overburdened medical and hospital resources.

Third—providing a comprehensive medical and hospital service for members of the public.

Each followed the other as a natural outgrowth of our business experiences.

My remarks to you this morning are addressed as an industrialist whose organization—out of necessity—became involved with medical care.

From 1914 to 1927 our experiences in the medical care field were limited to providing industrial medicine. By 1927 we embarked on our first foreign venture. We paved approximately 200 miles of road in central Cuba. There it became necessary to establish what I would classify today as first-aid stations. As I look back on it, they were quite primitive. Even at that time, however, working in a foreign country posed some very unusual medical and management problems.

In those days the Cubans were not accustomed to very good medical attention, particularly the *guayagos*. These were uneducated, unskilled men from the interior of the island who had to be supervised in depth by expatriates. Even in those days the turnover of expatriates was excessively high—if their families did not come with them. Therefore, we had to make arrangements for good medical care for the expatriates and their families. This immediately posed a problem, because the medical attention required for expatriates was considerably above the level that the *guayagos* were used to receiving. It soon became evident that we must furnish the same class of care for all the people. Thus we started learning something about medical care—in construction work in a foreign country.

Then in 1930 we joined a group of contractors, known as the Six Companies, and bid successfully on Hoover Dam which in its early history—depending on which Administration was in office—was known as both Boulder Dam and Hoover Dam.

Las Vegas, Nevada was the nearest town, and it had less than 5,000 people. I remember the little hotel, called the "Sal Sagev"—Las Vegas spelled backwards! And believe me, that was the *only* hotel. Since Hoover Dam would require a minimum of 5,000 workers—and many would be bringing their families—this meant a town of some 15,000 people at the dam site. Obviously, it had to have medical facilities and that meant building a hospital, staffing it, and operating it. We went through all kinds of problems, the most serious of which was that we were living in a very closely knit community, and the spread in incomes between supervisory and hourly personnel was such that it became clear that the hourly workers could not afford adequate medical care for their families.

From Hoover Dam we moved to Bonneville on the Columbia River about forty miles from Portland, Oregon. There were adequate medical facilities and there was a hospital association in Portland that provided a service similar to Blue Cross. We tried that. The medical care for the families was done on a fee-for-service basis, but that wasn't really satisfactory. We were not receiving adequate medical attention. This is not a criticism of the doctors; it was a combination of circumstances: forty miles away from good facilities—and, again, the difference in incomes. But it emphasized to us once more that some other system must be found.

From Bonneville we went to Grand Coulee, ninety miles from Spokane. In the case of these three projects the group of contractors was different, but on

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Bonneville and Grand Coulee the Kaiser Company had the responsibility as a sponsor and project manager.

Our work on Grand Coulee was what was called the "second step." Another group of contractors had built the foundation of Grand Coulee Dam, and our work was to build the superstructure and the powerhouses—a $50 million contract.

The first contractor had a hospital at the site, but there was much criticism of how it had been operated. When we started negotiations on our union contracts, the unions stipulated that the contractor could not operate the hospital as had been done on the previous job. This posed a real problem. Who was going to operate it? And it wasn't a problem for us as contractors alone. When we asked the unions, they too were stumped.

The First Prepaid, Group Practice Industrial Health Care Program

At that time in the Southern California desert where the Metropolitan Water District aqueduct was being built, a young doctor named Sidney Garfield had organized a program to provide medical care through group practice to populations of construction workers. On the California desert job, patients were first charged a fee for service. This system failed, and Dr. Garfield introduced a type of capitation payment—first for industrial care and later for general medical services. There were problems, but the system worked. The workers were much happier, and there was less lost time for illness and from industrial injuries.

Dr. Garfield had heard about Grand Coulee, and he came north to talk with us. He explained the system he had used on the desert and proposed that we try it at Grand Coulee. We presented it to the unions; they approved it; and we initiated the plan that also included the families for full coverage. We remodeled the hospital and upgraded the equipment. We charged seven cents a day for the wives and twenty-five cents a week for each child. Much to our amazement the system was not only self-supporting financially but was enthusiastically received by the workmen and their families.

When Grand Coulee was nearing completion, World War II was imminent. The Maritime Commission began a shipbuilding program a few months in advance of Pearl Harbor. It immediately became clear that the shipyards for which we had management responsibility and which were to be located in the San Francisco Bay Area, specifically, Richmond, and in the Portland, Oregon-Vancouver, Washington area, would eventually require over 100,000 workmen in each yard. It was likewise clear that these communities could not absorb that additional medical load. So we built hospitals and clinics, and we put into effect basically the same plan that we used at Grand Coulee.

There was one difference. Since there were other doctors and hospitals in each of those areas, the plan was voluntary. In other words, shipyard workers did not *have* to belong to the plan; it was optional. The plan worked—and it worked successfully. Before War's end it served some 90,000 workers and their families in the Richmond, California area and about the same number in the Portland-Vancouver area.

The First Voluntary, Community Group Practice Program

Then came the end of the war. We could have closed the hospitals and disbanded the physicians; but many of our former shipyard workers who had now returned to peacetime occupations liked the program. We had hundreds of individual requests to continue it, as well as a demand from the unions.

I should make it clear that, starting with the operations at Grand Coulee, the medical plans were operated on a non-profit basis; and we contracted with the doctors to provide medical service.

It was at this point in the history of our medical operations that my father made a most important decision. I think most of us around him assumed that, with the closing of the shipyards, we would terminate the health plan operation. But, when we had the requests from the individuals and the unions, my father said: "Well, why shouldn't we open the plan to the public and see if it works? It's been tested under all sorts of conditions—in war-time and peace-time, in depression and prosperity, in remote desert areas and in large cities. We know the basic incentives are good. Let's go!"

Many people have asked us why we took on this responsibility, since it aroused much criticism, resistance by organized medicine, and a heavy commitment of time and effort by management from our industrial companies. For my father the reasons were partially personal. His mother, my grandmother, died in his arms when he was a boy of sixteen. He always believed that the family's lack of money kept her from the medical care that might have saved her life. Later my grandfather went blind, though his sight might have been saved if the family had had the money for proper care. And my mother had a major operation on our kitchen table. These events left my father with a desire he expressed many times: to do something so that people could afford the costs of medical and hospital care.

The other factor was our conviction that we had helped develop one workable solution to health care problems. The plan had demonstrated that it is possible within our free enterprise system to organize medical care on a private, financially self-sustaining basis so that the consumer is satisfied and the physician is professionally gratified by his role. We believed

then—and do now—that this approach is one that should be encouraged and extended.

Present Organization of the Kaiser Foundation Medical Care Program

In the twenty-four years since our program was opened to the public it has matured measurably. Today it is the largest practice prepayment plan in the United States, operating in six regions: Northern California, Southern California, Portland, Oregon, Hawaii, and most recently Cleveland, Ohio and Denver, Colorado. The program provides comprehensive, prepaid medical hospital care for two million members on a direct-service basis through nineteen hospitals, two extended-care facilities, and fifty-two clinics. Medical service is provided by an autonomous group of physicians in each region. Hospital service is provided by the Kaiser Foundation Hospitals and through arrangements with a number of independent community hospitals.

Our Health Plan membership is made up of federal, state, and local government employees—such as postal workers, university faculty and employees, members of health and welfare funds, including retail clerks, culinary workers, teamsters, longshoremen, and industrial unions. Less than four percent of our members are employees of Kaiser industrial companies.

Wherever I travel these days, people ask me about the medical program. How does it work? I tell them that we have not developed any panacea for medical problems. We've made mistakes and we are still learning. We've discovered several basic lessons that work —for us.

Most importantly, we have developed workable arrangements with participating physicians. They—and only they—hold full responsibility for the professional care provided within our program. Each group of physicians operates as an independent, autonomous medical group. The medical groups, the hospitals, the health plan, and business management are all directly involved in the planning decisions. Certainly problems and disagreements arise in our relations with the medical groups. But they have always been worked out, because both parties—the physicians and Kaiser management—are dedicated to the program and believe in its principal features.

The professional and organizational independence of the Permanent physicians is preserved by continuing a contractual relationship in each region between the Health Plan and the medical group. The basic compensation to the Medical Group for serving Health Plan members is negotiated annually as a per capita payment, so much per member per month. For these payments the medical group takes full responsibility for organizing and providing medical services for all Health Plan members. How the doctors share that compensation is their responsibility, just as the provision of professional care is their responsibility. I believe this relationship is the basic strength of our program.

When the physician knows that he need not be concerned about his patient's ability to pay for modern medical care, he is relieved of personal concerns for imposing a financial hardship on his patients. Similarly, when the prepaid benefits are broadly comprehensive for both in-patient and out-patient services, and when the physicians are paid on a basis other than individual fees for individual services, the incentives for appropriate utilization of services are greatly enhanced.

For example, there is no necessity to hospitalize a patient for extensive diagnostic tests—and to occupy a hospital bed unnecessarily—when those tests can be done on an out-patient basis and covered under prepaid benefits.

Our financial arrangement with these medical groups also stresses the element of preventive care. Many facets of this aspect of medicine and their significance to total health care are, I realize, still being examined and debated within your profession. Nevertheless, when physicians are paid on a capitation basis, rather than fees for services rendered, the doctor's professional incentives for early diagnosis and for practicing the principles of preventive care are reinforced by an economic incentive.

Membership in our Health Plan is on a voluntary basis. We insist that any group that contracts with us offer its members the choice of at least one other essentially different type of prepayment plan—such as those offered by Blue Cross or commercial programs. The same type of choice is offered to our own employees.

During the past two years visitors from more than thirty medical schools have come to look us over and to ask us about our experiences with prepaid group practice. They are keenly interested in us, because we have a system—a system designed to provide comprehensive health care to a large and diverse population on a financially self-sustaining basis.

Health Plan/Population Interactions

Anything that affects our membership affects us, and we must anticipate and be ready for change. To illustrate, we recently embarked on a four-year facilities program. It is our third since 1962 and will cost some $79 million, of which nearly sixty percent is borrowed from a group of banks and insurance companies. The question of when and where these new facilities should be built is answered through a complicated planning process that projects us into 1972—when the current facilities program is scheduled for completion. Servicing the debts on these facilities takes us even further into the future. Our

lenders had to be convinced that the program would be able to generate enough revenue to make debt retirement payments into the 1970's and 1980's. In those terms our planners are already living in 1988.

Therefore, we must continually appraise and define our population, present and prospective Health Plan members, in terms significant to the economics of medical practice, such as age, family content, and geographical distribution. The participating physicians must attempt to evaluate the significant advances in the science and technology of medicine to see how our program can incorporate them for the benefit of our Health Plan members and for the economy of our operations. We must try to gauge the future availability—and cost—of physicians and paramedical personnel.

We must also attempt to evaluate the impact of present and prospective government-financed health programs and health care legislation. This raises the major question facing the medical care industry in the United States: how to provide adequate medical care to *all* segments of our population.

Relation to Health Care in America in the 1970's

Nearly nine out of every ten Americans under the age of sixty-five are covered by voluntary health insurance plans. There is clear-cut evidence that trends in voluntary health insurance are toward broader coverage of services—toward more comprehensive benefits.

Thus, for the great bulk of Americans, voluntary health insurance is the clear choice among alternative methods of payment for personal health care services. There are many advantages to this voluntary system. It provides a concept of real choice for the consumer; it encourages competition; and it is flexible enough to permit experimentation with new ideas.

Leaving aside for a moment the indigent and medically indigent, there are some identifiable segments of the population whose health care services cannot be adequately covered by voluntary health insurance. The aged represent one such category.

Today, of course, virtually all persons sixty-five and over are covered by Medicare, with many millions also covered by supplemental health insurance, such as that offered by our Health Plan.

I would favor extending Medicare-type coverage to that segment of the population classified as "totally disabled." Like the aged, they represent a significantly higher cost group for personal health services than the nation as a whole. We support the concept that, where voluntary health insurance is inadequate, it is appropriate for the federal government to play a significant role in the financing mechanism.

Organizing and financing comprehensive health care for the indigent and the medically indigent is another problem—one that appears more complex than the issue of the aged or disabled. The resolution of this problem requires accelerated experimentation with different approaches.

A promising development, in my opinion, is the involvement of medical schools in organizing health care services in poverty areas. Whether these projects be Neighborhood Health Centers under the auspices of the Office of Economic Opportunity or some other innovation, they demonstrate the kind of experimentation that is necessary.

A relevant example is also provided by our Oregon Region which gives comprehensive health care to about 130,000 people in urban Portland. Two years ago, we began a Comprehensive Neighborhood Health Services Project in that city, funded by the Office of Economic Opportunity, whereby we undertook to provide very extensive health care services to 1,200 indigent or low-income families who elected to obtain their care from our program. We did this by integrating them into our system. They use the same hospital and the same clinics as any of our other members. They have the same kind of membership cards. They receive the same services—and wait in the same reception areas—as anyone else. The overall success of this program—now expanded to 1,500 families—indicates the importance of organizing comprehensive health care services as well as providing for payment for such services.

There are also significant forward strides being made by a few states in their Medicaid programs. Successes in these programs have been spotty, however, and point to the need for substantial improvements. We should be considering, for example: (*a*) implementation of minimum national standards for Medicaid; (*b*) achieving those national standards with full federal financing of the Medicaid program; and (*c*) finding alternatives to the fundamental concept of the Medicaid program because the program has basic deficiencies.

President Nixon's welfare proposals may provide the key to one alternative—if they include provision for funds that groups of indigents could use to purchase medical care on a prepayment basis.

Personally, I have some philosophical difficulties with income maintenance and subsidy programs, because of the disincentives attached to them. But inequities exist in our society—inequities which are morally wrong, which endanger our domestic unity, and which threaten the very strengths on which our country was built. Therefore, in my opinion, these new approaches are not only justified but imperative as our nation strives to solve its pressing domestic problems.

In seeking other possible solutions, it might be well to revive some of the earlier proposals that have been made at the federal and state levels and which

would have earmarked governmental *variable* subsidies to the indigent and medically indigent, permitting them to enroll in voluntary health insurance programs. These proposals go back as far as the Taft Bill and the Flanders-Ives Bill of the early 1950's.

Because voluntary health insurance does have the virtue of granting free choice to the consumer, while encouraging competition among the providers of service, we believe all types of such coverage should be extended and improved wherever possible. But when voluntary health insurance simply cannot meet the needs of segments of the population, we believe that government participation is not only appropriate but, of necessity, becomes the only resort. Such participation can—with ingenuity and imagination—be organized to support the aspects of consumer choice and competition which represent the advantages of the voluntary system.

Current Challenges

This broad, pluralistic approach to major health care issues does not provide adequate answers to several basic questions. We believe the future of our pluralistic system may well depend on how well it meets these difficult challenges.

For example, all of us know the statistic cited previously—that nearly nine out of every ten Americans under the age of sixty-five are covered by voluntary health insurance—obscures a key difficulty; namely, many millions of Americans are covered by substantially inadequate levels of benefits.

Millions of American families with employed persons have only marginal incomes which are constantly threatened by the possibility of serious illness. It is our challenge to find ways to make comprehensive health care coverage available to these families.

We also have seen demonstrated the direct association between the major new governmental programs, such as Medicare and Medicaid, and the rapidly escalating costs of medical care. This demonstrated link should make us pause before we accept any simplistic notion that, should government take over the health care industry, the escalation of medical care costs will somehow be moderated or controlled. Yet, the challenge of containing medical care inflation, as with inflation in all aspects of our economy, clearly must be met.

Just enumerating our nation's health care needs is a sobering task, but we believe that the pinpointing of problems is a necessary and positive step toward their solution. It is through the good will and efforts of groups such as your own, interested not only in the health care industry but in the welfare of the American people, that we will make the improvements necessary to meet the health care needs of our population.

One of the most interesting efforts in seeking solutions to these problems in the health care industry is being pursued by Walter Reuther. His Committee for National Health Insurance will undoubtedly stimulate new thinking which is vitally needed.

There is a gap between the demand for better health care and the capability of the present American health care industry to meet that demand. The pressure to close this gap should not be viewed as a threat to this industry, but as a tremendously stimulating challenge to medical education, to physicians, to concerned citizens like Walter Reuther who represent large numbers of consumers, to hospital administrators, to businessmen, and to the consumers themselves. Government, at all levels, can help us to close the gap by eliminating the numerous artificial restrictions and restraints that bar more effective health care organization and by encouraging those programs prepared to assume responsibility for better organization of health care resources in order to meet the needs of the American people.

I have been privileged to speak with you today. I do not say that our plan is the only way, but it is a good way. Its incentives are right. The thing that concerns me also concerns my friend, Walter Reuther—namely, that more plans like ours should be in operation across the country.

I believe that by working together in a constructive coalescence we can—and will—meet the challenges within our free and pluralistic system.