

# Kaiser Permanente: A SHORT HISTORY

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“Dr. Garfield was a man of energy and imagination, not constrained by traditional methods and practices. Henry J. Kaiser, his son, Edgar, and the key executives of the Kaiser organizations had an impressive record of innovation and willingness to break with tradition.”

Scott Fleming

*Evolution of the Kaiser Permanente Medical Care Program*

“ . . . This may well have been the most extraordinary experiment in the delivery of health care the world has ever seen.”

Cecil Cutting, MD

Senior Physician Yearly Conference, Monterey, CA, 1991

**Gerry Gaintner, EdD**, was a Kaiser Permanente employee for 15 years, all in the Information Technology department. He found Kaiser Permanente’s history fascinating beginning with his introduction to it by his hiring manager. He believes that a history as eventful and meaningful as Kaiser Permanente’s deserves to be shared with all Kaiser Permanente employees. This short overview history serves as a concise compilation of the history from its start to current times.

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## FOREWORD

The 1990s was a decade of major chaos in American health care delivery. Some predicted Kaiser Permanente would not survive, yet it emerged stronger than ever and remains a model in the 21st Century. How could it survive when others did not? There are complex reasons, but major health care scholars concur that the central one was that it remained true to its core values. However, to continue to succeed requires that its staff understand those values and pass them on from generation to generation, as it has done for almost 70 years.

For this reason, this short history is an important read. There are comprehensive works — and thousands of archival records — for anyone who wants to study Kaiser Permanente's history in great depth. What has been lacking until now, however, is a short history through which any staff member, patient, or citizen can get a solid, introductory lesson about one of the most important health care delivery programs to emerge in the second half of the 20th century. Gerry Gaintner has remedied this by his dedication to, and love for, Kaiser Permanente by writing this book.

Tom Debley  
Emeritus Director  
Kaiser Permanente Heritage Resources

## INTRODUCTION

All large companies and organizations have histories, many of which are fairly interesting. Kaiser Permanente's history is not only interesting, it is significant. Significant because it carries the founding ideas and concepts — and struggles — that underlay the development of the largest and most successful comprehensive prepaid group health care organization in the United States.

The creation of Kaiser Permanente was neither quick nor easy. The fully operating integrated health care organization we know today as Kaiser Permanente arose from a number of sources and events, uncertainties, conflicts, social contexts, professional concerns, determinations, and, needless to say, egos and personalities. Kaiser Permanente grew because of serendipity and circumstances of opportunity, and also because a group of people — both physicians and lay management — believed deeply in a model of health care that those opportunities presented.

Kaiser Permanente is now in the hands of a third generation of leaders, the first being the founders, the second being those who replaced the founders but knew them personally. This makes the recording and recounting of Kaiser Permanente's history even more important, as it is critical to preserving the mission, values, and goals of the Kaiser Permanente Medical Care Program.

It is the intent of this short history to convey, in fairly straightforward telling, the main events that contributed to Kaiser Permanente's history. It should not be considered an academic or interpretive history. Rather, it is hoped that readers, especially Kaiser Permanente employees, will find it informational and, possibly, inspirational, insofar as they may recognize how their current contributions add to this history.

## **PART 1: GETTING TO KAISER PERMANENTE**

### **CHAPTER 1: GETTING THE IDEA**

Kaiser Permanente did not begin with Henry J. Kaiser, nor did it begin with a well-thought-out idea for an integrated, prepaid, group health plan. It began with a young medical school graduate, Sidney R. Garfield, MD, who found himself unable to establish a solo fee-for-service medical practice. It was quite a number of years before what we might recognize as Kaiser Permanente began to take shape. This is the story of how it began.

Even though he always had a strong interest in engineering, Sidney Garfield followed his parents' wishes and attended medical school, graduating from the University of Iowa Medical School in 1928 and completing a residency in general surgery at Los Angeles County General Hospital in July 1933. He planned to set up a standard fee-for-service medical practice as a general surgeon. However, it was not easy to start a practice during the Great Depression, and Garfield soon began to consider other options.

At about the same time, in 1932, work had started on the Colorado River Aqueduct, a large project sponsored by the Metropolitan Water District of Southern California and contracted to a consortium of construction firms. This aqueduct was to bring water more than 200 miles across the Southern California desert from the Colorado River to the Los Angeles basin. The project had 5,000 workers spread across the desert doing heavy construction, and the availability and quality of health care for them was far from adequate.

Hearing about the need for medical care for the aqueduct workers, with a loan from his father and agreement from the Metropolitan

Water District, Garfield built a small, 12-bed field hospital near Desert Center, California: Contractors General Hospital. Garfield's plan was to offer fee-for-service medical care for on-the-job compensable injuries and illnesses, paid through Workers' Compensation insurance. Additionally, he would provide fee-for-service care for nonindustrial needs. He had a small staff of one nurse, a cook, and a handyman/ambulance driver. He handled administrative duties himself.

The workers did come with a variety of illnesses and problems, but making ends meet was not easy. Many patients could not afford to pay for care for off-the-job injuries or illnesses, and seriously injured patients were transferred by insurance companies to physicians and hospitals in the Los Angeles metropolitan area. The insurance companies also discounted the payments on many of the claims submitted by Garfield. The consequence was that both money and interesting medical cases were going to physicians and hospitals in Los Angeles, not to Garfield and his hospital. So within seven months of opening its doors, Contractors General Hospital was on the verge of bankruptcy and Garfield was ready to close it.

The largest insurance company on the project, however, Industrial Indemnity Exchange, was partially owned by Henry J. Kaiser. A. B. Ordway, an executive under Henry Kaiser, was also the Executive Vice President of Industrial Indemnity, and one of his key managers was Harold Hatch, chief planner for Industrial Indemnity. Ordway sent Hatch to inspect the construction sites, and while he was there, Hatch and Garfield discussed the problems of Contractors General Hospital. Neither the insurance company, the contractors, nor the unions wanted to lose local medical care and coverage for their aqueduct workers.

Hatch proposed the following arrangement to Garfield: The portion of the basic insurance premium that went to Contractors General Hospital and Garfield would be set at \$1.50 per worker per month (equal to 5 cents per day) for industrial coverage. Garfield also

proposed a voluntary payroll deduction, through prepayment, of another 5 cents per day for complete nonindustrial coverage, both of which would be prepaid to Contractors General and Garfield.

This plan was accepted, nearly all the 5,000 workers enrolled, and before long Garfield was compensated with the equivalent of about \$500 per day. This enabled him to get out of debt and even make a profit. Eventually, Garfield had two other aqueduct field hospitals across the desert project as well. Equally important to him, the arrangement allowed him to focus on preventive care: better preventive care resulted in fewer cases requiring more costly serious care.

The Colorado River Aqueduct was completed in 1938, and by then Garfield had been able to save a substantial amount of money. His intent was to return to the Los Angeles area and establish his own fee-for-service surgery practice.

But in 1938, the Six Companies, a consortium of contractors led by Henry Kaiser as general chairman, won the contract to build the upper portion of the Grand Coulee Dam on the Columbia River. This dam would become the largest dam project in the world, and the largest single structure ever built. The executive in charge of the Grand Coulee Dam project was Edgar Kaiser, Henry's son.

The local town of Mason City, Washington, the base of operations for the Grand Coulee construction site, had one hospital. The physicians there received part salary and part fee-for-service income. But neither the construction workers nor the union leaders felt they were getting adequate medical care. Also, workers' families and dependents were not receiving decent care, in part because they could not afford the fee-for-service care available.

So Edgar Kaiser contacted Ordway for assistance. Ordway in turn contacted Garfield, who was still in the desert closing down his hospital. He invited Garfield to visit the Coulee construction site.

Garfield was hesitant, since he had already signed on as a senior teaching resident at Los Angeles County Hospital and had his own plans to return to Los Angeles and private practice. But he agreed as a favor to Ordway, since Ordway had been instrumental in arranging the survival of Contractors General Hospital.

When Garfield got to Mason City, he immediately saw advantages to the situation: a localized company town of more than 15,000 people, a 35-bed hospital (not in the best of condition, but useable, and improvable), and the clear need for medical care (a large industrial project). Dam construction was dangerous work. Everyone involved — workers, union leaders, and management — agreed that competent local medical care was fast becoming a high priority.

So Garfield agreed to set up something similar to what he had done in the desert. It gave him the opportunity to do two very personally motivating things: select and hire quality physicians, and staff and refurbish the Mason City Hospital.

Garfield established himself as Sidney R. Garfield, MD and Associates and hired five additional physicians: two general practitioners, one surgeon, one internist, and one obstetrician-gynecologist, plus medical and administrative support staff. Later, a pediatrician was added. Garfield stayed at L. A. County Hospital as a surgery teaching resident, but he flew to Portland and the dam site on a rotational weekend basis to provide relief for the on-site physicians. Otherwise, the medical staff worked seven days a week. Two of the physicians he hired, Cecil Cutting, MD, and J. Wallace Neighbor, MD, later became key figures in the establishment of Kaiser Permanente.

Financially, the Grand Coulee Dam medical care plan was similar to the plan offered for the aqueduct workers: a percentage of workers' compensation for full industrial coverage for on-the-job injuries and illness, plus the opportunity for a voluntary payroll deduction of 50 cents per week per employee for non-industrial coverage.

As with the Aqueduct situation, prepaid coverage was not offered to wives and children. They could get fee-for-service care, but most workers could not afford it, and the consequence was that families either delayed or simply didn't seek treatment, thus increasing subsequent costs for more advanced care. However, union leaders wanted family care provided, so Garfield took this problem to Edgar Kaiser. Without any previous cost and pricing guidance to go on, they agreed to provide prepaid care to families for an additional 50 cents a week per adult, and 25 cents a week per child. The majority of the community accepted the plan, and the group eventually provided care for 15,000 workers and dependents. The result was that everyone thrived: the construction workers and their families, the hospital, the health of the community, the project, and Sidney Garfield and Associates.

The Grand Coulee program created by Garfield and his associates was the first sustained comprehensive, prepaid, hospital-based group practice covering both workers and dependents (though not the first prepaid group practice in the U.S.). Critical to the arrangement was that the physicians controlled the use of the hospital, since they considered it an integral part of the comprehensive component of care. Garfield later referred to the Grand Coulee experience as the "final dress rehearsal" for what became Kaiser Permanente, though he didn't know it at the time.

It might be noted that although a Kaiser company was part of the construction consortium, and Edgar Kaiser was the general manager of the project, Henry Kaiser was not closely involved with the setup and management of the medical care program.

One item of interest, in retrospect, was that the physicians formed a Grant County Medical Society and applied for membership to the American Medical Association (AMA). They were acknowledged informally by the Washington State Medical Association, though they never became fully accredited.

When the Grand Coulee Dam was finished in 1941, the group broke up. During their time together, they had had conversations about developing a prepaid group practice in an established community. They concluded, however, that the time and conditions were not right, based on three main problems:

- 1) Despite their acknowledgement by the Washington State Medical Association, they recognized there might well be potential opposition to this kind of medical care arrangement from the AMA and associated state and county medical chapters.
- 2) There would be a problem gaining and holding membership. A prepaid practice requires a substantial member base. In those days, medical advertising was considered unethical. Furthermore, people — potential members — would have to break established patterns of obtaining medical care, which was not easily done, especially on a massive basis.
- 3) The endeavor would require capital to fund the program, both through its start-up period and in the acquisition of hospital facilities. Even though Sidney Garfield and Associates had acquired some amount of capital, it was far from enough to fund a program such as the one the group had in mind.

So late in 1941, the Garfield group dissolved its practice at Mason City. Garfield joined an Army medical reserve unit after Pearl Harbor was bombed, as did many other physicians at the time. He also remained as a medical resident and teacher (some referred to him as a "super resident") at the Los Angeles County General Hospital/USC School of Medicine. This experience at Los Angeles County Hospital had two profound effects on him: first, he became convinced of the professional value of the collegial work setting with medical peers and associates; and second, he developed an ever-stronger belief in the social value of providing medical care to the underserved in the community.

## CHAPTER 2: FROM THE SHIPYARDS TO PERMANENTE

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As Sidney Garfield made his own transition from the Grand Coulee Dam project, Henry Kaiser, by this time a major figure in the world of large industrial projects, and Todd Shipbuilding Co., of Seattle, created the Todd-California Shipbuilding Corporation to build ships for World War II. Initially, through the U.S. government, they contracted to build ships for Great Britain. But in 1942, after the U.S. entered the War, they began to build ships for the United States.

The main West Coast shipyard for the Kaiser-Todd group was in Richmond, California. That yard mainly built cargo ships of various kinds: over 1,400 Liberty and Victory cargo ships, small aircraft carriers, troop transports, frigates, tankers, and various other ships. It took 197 days to build the first ship, but by the end of the war, with a workforce of over 90,000 men and women working three full shifts, seven days a week, they built ships in an average of 27 days.

Where did the shipyard get its workers? A national recruiting effort was launched, and within a month of Pearl Harbor they had 30,000 workers, about a quarter of whom were women. Many of the men had been rejected by local draft boards for health reasons. One consequence of this was that the shipyard work force was, in general, not fundamentally healthy (both Garfield and Cecil Cutting later referred to the workers as “a walking pathological museum”).

Since the Richmond shipyard was under civilian ownership and management, no military medical care was provided, though the workers were doing vigorous, difficult, and dangerous work. Also, the size of the workforce grew rapidly and soon became much larger than the local fee-for-service medical community could handle.

The general manager of the Richmond shipyard was Clay Bedford, who had been the chief engineer at Grand Coulee Dam. He

immediately recognized that he had a medical care problem on his hands. Bedford contacted Garfield, only to learn that Garfield and his Army medical reserve unit had been called to active duty and was to leave for India in one month. Bedford’s next step was to meet with Garfield, A. B. Ordway, and Harold Hatch. They concluded that only Garfield had the experience and know-how to quickly organize and manage a large medical care program — much larger even than needed at Grand Coulee Dam.

So Henry Kaiser sent Ordway to Washington, DC, directly to President Roosevelt, with a request to obtain a release for Garfield from his military obligation so he could run the medical care program at the Richmond shipyards. It was granted, Garfield was released, and he relocated to Northern California to start the medical program.

Garfield, still operating as Sidney Garfield and Associates, recruited and hired a medical staff. Two principal staffing hires were Cecil Cutting, as Chief of Staff, and Morris Collen, MD, as Chief of Medicine, both of whom played key roles in the subsequent history of Kaiser Permanente after the war.

Garfield quickly built a 10-bed field hospital near the shipyard (eventually it grew to 75 beds), and he and Cutting contracted for beds and staff privileges at Merritt Hospital in Oakland. With an initial staff of about a dozen physicians and 50 nurses, and with the field hospital and the arrangements at Merritt Hospital, they were able to provide medical care to the Richmond shipyard workforce very soon after getting set up.

As part of the arrangement with Merritt Hospital, Garfield purchased an abandoned hospital in Oakland, the Fabiola Hospital. Garfield had heard of this building, and after he and Henry Kaiser inspected it and agreed it had potential for refurbishing, offered to purchase it from Merritt for \$50,000. (The offer was from Sidney Garfield and Associates, with Garfield still an independent medical provider.)



Kaiser and Garfield then went to the Bank of America, in fact, directly to its founder and president, A. P. Giannini, with whom Kaiser had an established relationship. They obtained a loan of \$250,000 to renovate the hospital and bring it to useable medical condition. It opened with 54 beds in August, 1942, eventually becoming a 300-bed facility.

While Garfield and his staff were getting the shipyard care program set up and running, and while the Fabiola building was being renovated, another very important event was taking place: the founding and structuring of The Permanente Foundation in 1942. Initially proposed by Ray Kay, MD, a medical associate and friend of Garfield's from Southern California, the idea was for a nonprofit foundation rather than a corporation. With such a foundation in place, they could begin saving money so they could create a prepaid group practice in the Los Angeles area after the war. Garfield liked the idea, and he and Bedford took the idea to Henry Kaiser. Kaiser agreed with it, and directed his legal staff to create the foundation. The Permanente Foundation was designated as a charitable trust, and therefore a nonprofit organization, the purpose being to accumulate funds for charitable purposes such as medical research and making medical services available to underserved segments of the population. Thus was founded the initial legal entity on which the subsequent Kaiser Permanente history depended.

“Permanente” was the name of a stream on Henry Kaiser's property on the San Francisco Peninsula that flowed year round, regardless of whether the seasons were wet or dry. For Kaiser and his wife Bess, this stream represented “excellence that would endure,” and they adopted the name of the stream, Rio Permanente, for many of their enterprises, including the health plan and medical care endeavor. The renovated Fabiola Hospital, for example, was renamed the Permanente Foundation Hospital. (Of note: One of the current buildings in the Kaiser Permanente Oakland Medical Center complex is named the Fabiola Building.)

Through a set of legal and financial arrangements, the Permanente Foundation, the Permanente Foundation Hospital, and Sidney Garfield and Associates were then linked so they could provide the kinds of services they envisioned for a group practice medical care plan. Operationally, the health plan, the medical group, and the hospital administration were managed as a single entity, all under the control of Garfield.

Because of the quick growth of the workforce in Richmond and the surrounding area, including workers' families, there was a lack of adequate housing in the nearby communities. Temporary and often semi-primitive worker communities sprang up: shacks, tent cities, and ramshackle living quarters. Race strife, typical of the time, was another problem. Given the nature of the work and employee conditions, there was a high rate of turnover, absenteeism, and alcoholism. Adequate and available medical care became a key factor in reducing these problems.

During the peak production years at the Richmond shipyards, 1942-1943, more than 90,000 workers were receiving comprehensive medical care through the Permanente Foundation program. It was funded similarly to the arrangements in Desert Center and Grand Coulee: prepayment of 17 percent of the workers' compensation premium. In addition, about 90 percent of the workers voluntarily paid 50 cents a week for nonindustrial medical coverage. It was calculated that comprehensive medical care was being provided for approximately 50-60 cents per worker per week.

World War II, of course, required a massive effort, and at the same time Henry Kaiser opened the Richmond shipyard, he opened one on the Columbia River near Portland, Oregon. Edgar Kaiser was the general manager of this operation and, like Bedford in Richmond, knew he needed to set up a medical care program as well. So he invited Garfield to visit their site and establish a program similar to the one in Richmond. A second, separate foundation, the Northern Permanente Foundation, was established in 1942, and one of the

physicians from Grand Coulee, Wallace Neighbor, was released from the Army in 1943 to become its CEO and Medical Director. Near the end of the war, Ernest Saward, MD, who had been Medical Director at the Hanford, Washington, site of the Manhattan Project, joined the staff as Medical Director. Both Neighbor and Saward went on to play key roles in the early development and expansion of Kaiser Permanente.

The shipyard workforce in the Northwest, about 90,000 workers, was split between Portland and Vancouver, Washington, and so the program needed to account for differences in the medical communities in the two states. The medical group in Portland was adamant about not having a Permanente hospital there, but they agreed to allow a prepaid group practice for the duration of the war if the hospital was located in Vancouver. Edgar Kaiser and Garfield agreed to this to maintain relations with the local physician groups. So the Northern Permanente Foundation Hospital was opened in Vancouver in June, 1942, with 75 beds, growing to 300 beds with over 30 physicians on staff by the end of 1944.

In addition to the Permanente programs and facilities in Richmond, Oakland, and Vancouver/Portland, a fourth location was opened at Fontana, in Southern California, site of a newly built Kaiser steel plant that provided steel for the shipyards. There, Garfield, acting as the Kaiser Fontana Hospital Association (not as Sidney Garfield and Associates), opened a small, 60-bed hospital, staffed by eight physicians. The general offering was similar to the other locations for industrial, non-industrial, and family care. Whereas this site was not part of the Permanente Foundation Program started in Northern California, it was nevertheless important for two reasons: it gave the program an anchor in Southern California, and its primary group of members came from the United Steelworkers union, unions being critical to Kaiser Permanente growth in the years shortly after the war.

To recap, then, at the height of World War II there were:

- Two Permanente groups: the Permanente Foundation in Northern California and the Northern Permanente Foundation in Oregon and Washington.
- Four locations with hospitals: the Richmond field hospital (100 beds), the Permanente Hospital (Oakland, 300 beds), the Northern Permanente Hospital (330 beds, in Vancouver), and the Fontana Hospital (60 beds)
- Approximately 100 physicians across all locations
- More than 200,000 workers and dependents across all locations using Permanente medical services.

In January 1944, Garfield published the “First Annual Report of the Permanente Foundation Hospital.” In this report he pondered the future of the Permanente organization and noted these key points:

- Resistance from the medical profession, even though the Permanente Foundation had proved itself in the area of quality of care
- The Permanente model focused on health rather than on sickness
- The three main principles for medical care in postwar America should become prepayment, group practice, and adequate facilities, which became the foundational principles for Kaiser Permanente.

During the war period, caring for shipyard workers in Richmond took all the resources of the medical staff, so coverage was not offered to dependents. However, as the war effort began to decline in 1944 and as workers left the shipyards and the program, the Permanente staff could serve more people. Garfield opened the program to dependents, and a large portion of dependent families who remained in the area took advantage of the opportunity for quality medical care at an affordable cost.

Within a few months after the end of the war the shipyards were closed. Rather than the gradual reduction of workers they had expected, the Richmond shipyard went quickly from 90,000 to

13,000 workers, and from 75 physicians to about a dozen. Reductions at the Portland/Vancouver site were similar.

In both Northern California and the Northwest, only a very small group of Permanente physicians remained committed to the future of the prepaid group practice health plan model and to the dream of opening it to the community at large.

However, the World War II medical program and experience did accomplish these very critical things in anticipation of the future of Kaiser Permanente:

- It demonstrated the viability of the health care model that Garfield and his associates believed was critical to the success of the program they envisioned, and on a much larger scope than they had at Grand Coulee.
- The Permanente Foundation was established so that they had a legal structure in place for future development of the organization.
- The program was established in three locations: Northern California, the Northwest, and Southern California.
- They had a much better idea of what they were up against, both financially and professionally.

Even before the war was over, Dr. Garfield and a core group had begun discussing how to continue the program in a public, peacetime, civilian setting.

### CHAPTER 3: AFTER THE WAR: GROWTH — AND GROWING PAINS

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Shortly after World War II, Permanente membership and physician morale were both at their lowest point. There were fewer than 10,000 enrollees in the Richmond/Oakland area, all voluntarily enrolled, and only 3,000 members each in Vancouver and Fontana. But the remaining physicians were determined to make a transition from a well-supported wartime industrial program to a peacetime public program of medical care. It was not to be an easy transition.

Sidney Garfield and Cecil Cutting decided to approach Eugene Trefethen, a key executive for Henry Kaiser, and one who had been closely involved with the Permanente program along the way. Their request was for assistance in taking the Permanente program public after the war: Was it possible? What was the best way to go about it? They had already formed The Permanente Foundation to own and oversee the hospitals. Now they decided to form the Permanente Health Plan, a nonprofit trust. With this status, the Health Plan was not a corporation, and so would not be engaged in a corporate practice of medicine, which was a concern of the AMA and the local medical societies.

At this point, the structural arrangement of the program was as follows:

- The Permanente Health Plan enrolled members and collected membership dues.
- The Permanente Foundation owned the hospitals and carried all the indebtedness.
- Garfield was the sole proprietor of the Medical Group.
- Sidney Garfield and Associates leased the hospitals from the Foundation.
- All personnel, including the physicians, were employees of Sidney Garfield and Associates.

Everything operated under Garfield's general direction and leadership, with Trefethen as the primary Kaiser executive and non-physician advisor associated with the program.

Looming over all arrangements, discussion, and decisions was Henry Kaiser, who had his own ideas about the direction health care should take, locally as well as nationally. He of course exercised authority wherever he could (he was, after all, "the Boss"), and he often took it upon himself to be the public face of the young organization, defending it against both professional and political foes of prepaid group practice medical care.

With an organizational structure now in place, attention turned to the primary issues confronting the program. At this point, there were three main barriers to success: difficulty in marketing a medical care program of this nature, start-up costs and the need for ongoing operating capital, and opposition from organized medicine.

As far as marketing the program went, medical ethics and customs during the 1940s and 50s precluded advertising. Since group health plans were not well known or understood by the public at that time, how were they to gain new members? Initially, the best growth opportunities came from members who remained with the program after the war and recruited new members, and from potential labor groups. However, if Permanente representatives wanted to contact labor or company groups, they were required to have a letter of inquiry from the requesting group before the Plan representative could approach with enrollment information. Otherwise, the medical societies would accuse them of soliciting business. So all-in-all, post-war growth was slow and difficult, and only the most resolute Permanente physicians stuck with the program.

Financially, the group needed to address key issues. With some foresight, Sidney Garfield and Associates had created a contingency fund during the war to carry them over between the end of the war

and decreased membership, and the time when they would be able to increase membership through post-war growth. This contingency fund was needed to cover salaries and operating expenses, including the maintenance of their hospitals. It did not, however, provide sufficient funds for ongoing capital.

Opposition from organized medicine came from several sources. First, professionally and legally, prepaid group practice was a perceived threat to the standard fee-for-service medical establishment, as well as to the concept of free choice of physicians and medical care. It was, in fact, considered to be unethical, and possibly illegal, by much of the medical community. And with Henry Kaiser's dynamic personal and corporate involvement, there was great concern about the danger of third-party, non-medical, corporate control of the practice of medicine. Also, as before the war, Permanente physicians continued to be rejected from membership in local and state medical societies (especially the Alameda County and San Francisco groups, and the Multnomah County society in Oregon).

The most blatant example of this was the attempt by the Alameda-Contra Costa Medical Society, through the California Board of Medical Examiners, to have Garfield's California medical license suspended in 1946. Eventually, after legal proceedings, the charges were dropped. But it showed the extent to which the medical establishment was willing to go to undercut group health care programs. The program also began to gain some grudging acceptance after Garfield brought delegations of local medical society leadership to visit the Permanente hospitals and inspect the quality of care. But the continuing resistance was debilitating to the Permanente physicians, and it made professional recruiting even more difficult.

Local and national resistance remained for some years. The conflicts with the AMA and local medical establishment were significant. Both Henry Kaiser and the Permanente physicians had long-running

and very pitched confrontations with the medical societies, often in legal proceedings or legislative hearings.

In California in 1953, the Los Angeles County Medical Association, with the support of the California Medical Association, made an all-out editorial effort in their journal to thwart all prepaid group plans and have them declared unethical and leading to socialism. The *Journal of the American Medical Association (JAMA)* joined in the attack as well, bringing the power of the national organization fully into the fray.

In 1954, the conflict came to the fore with an AMA resolution proposing to make a panel of physicians (i.e., a group practice) unethical, because it would not give patients full freedom of choice of physicians. An amendment proposed by a Kaiser Permanente physician providing that freedom of choice was inherent in a patient's selection of a group was subsequently added. Ultimately, the resolution was never acted on, giving at least temporary reprieve to the Permanente position.

The conflict between the AMA and prepaid medical groups, of which Kaiser Permanente was only one, continued for more than 10 years and abated only after a number of legal victories for group care organizations. The AMA's 1959 Larson Commission Report, which acknowledged that voluntary choice of physicians was indeed provided by these plans, was also critical in gaining acceptance of prepaid group plans. The ongoing toll of the conflict with the medical establishment should not be underestimated, but the result was finally grudging acknowledgement of a new, growing, and legitimate model of health care.

Although Garfield was generally in charge of the entire program, a number of other issues were beginning to emerge. One related to Garfield himself, who was a visionary leader but a somewhat disorganized manager. Given the growth and complexity of the entire organization, and with the competing incentives of different

people and groups, Garfield's management style was becoming an impediment to smooth operations.

In addition, there was a perception among the physicians that Garfield was becoming ever more aligned with Henry Kaiser and the Kaiser corporate leadership. Whether true or not, the perception compromised the effectiveness of Garfield as the trusted leader.

Finally, there were growing tensions regarding responsibilities and authority between Henry Kaiser and the physicians. Eventually, the issues around governance would come close to destroying the entire program. But even at this time, in the late 1940s, there was mutual recognition that they needed to be dealt with.

The solution seemed clear: restructure the overall organization to provide a better management framework and to more clearly delineate the various entities of the program. The Permanente Foundation and the Northern Permanente Foundation had been formed as nonprofit organizations, and they owned the hospitals. Also, the Permanente Health Plan had been founded in 1945 as a nonprofit trust, led by lay trustees. With agreement among the groups, the reorganization included the following changes:

- The Permanente Hospitals were incorporated by Henry Kaiser in 1948 as a charitable corporation and detached from the Permanente Foundation. Sidney Garfield and Associates were reimbursed for previous ownership of the hospitals, the Sidney Garfield and Associates group was dissolved, and Garfield stepped down from both ownership and control of the hospitals. The hospitals were now owned and controlled by the Permanente Hospitals, though administration was still primarily in the hands of the physicians.
- Also in 1948, the physicians in Northern California formed The Permanente Medical Group (TPMG) as a for-profit partnership, with seven original partners. TPMG replaced Sidney Garfield

and Associates as the Medical Group providing services to the Health Plan and Hospitals. (In 1982, TPMG became a professional corporation instead of a partnership, led by an Executive Committee rather than by a set of partners.) The formation of TPMG was especially important, as it signified that the physicians were not employees of either Henry Kaiser or the Kaiser Industries.

- Garfield was designated the Executive Director of both the Health Plan and Hospitals, and though he was not a partner, acted as the *de facto* Executive Director of TPMG as well.

With the completion of the restructuring, the three main entities of what would come to be the Kaiser Permanente organization were now in place: the Permanente Health Plan, the Permanente Hospitals (later to become the Kaiser Foundation Health Plan and Kaiser Foundation Hospitals), and The Permanente Medical Group.

Despite internal growing pains, the Permanente Medical Care Program continued to grow for a number of reasons:

**Affordability and predictability:** Through the Permanente program, medical care became affordable, especially for working class people, because it was predictable for members: a steady dues rate, with one location for all services, covering all health care needs.

**Organized labor:** During the war, federal wage controls exempted fringe benefits, so labor unions were able to negotiate favorable terms for health care, including the Permanente Health Plan, which was attractive to many employers.

**Free choice of physicians:** A sticking point with the medical establishment had been that those joining Permanente did not actually have a free choice of physicians. So by this time Permanente had a policy of dual choice firmly in place: any group offering Permanente care must also offer another plan that gave

people full free choice of physicians. No one must be forced to join Permanente and take a Permanente physician; everyone must have another medical care option.

From a post-war low of about 10,000 workers and their families in mid-1945, membership had risen to over 72,000 across all locations by mid-1948. This growth demonstrated that there was sufficient core membership for the program to continue, and to continue following its basic tenets. It also showed that there was a core group of Permanente people who believed in the concept of prepaid group health care and who stuck with it until it could reach a critical mass of membership. This core group included not only the remaining leaders from the WWII Permanente physicians, but also key Kaiser Industries executives and a set of younger, newer physicians who had joined Permanente since the end of the war.

Up to this point, Kaiser Permanente was still primarily located in the East Bay and in the Portland-Vancouver area, with a clinic in San Francisco (opened in 1946) and the Fontana hospital in Southern California. By this time the program's foundation seemed strong enough to support various other undertakings.

Its real growth in San Francisco began when civilian workers at the Hunters Point Naval Shipyard wanted to enroll in the program. So in 1948, Garfield opened a clinic in the Bayshore district of San Francisco, with Cutting moving temporarily from the San Francisco clinic to the Bayshore clinic in 1948, and Wallace Neighbor taking over as Medical Director of the San Francisco clinic.

Slightly farther out, a clinic was opened in 1945 in Vallejo, California, to serve the needs of groups there that had requested Permanente care. On a very personal note, Henry J. Kaiser, Jr., a victim of multiple sclerosis, had been treated in Washington, DC, by Herman Kabat, MD. Henry Kaiser, Sr. was so impressed with the treatment that he asked Garfield to sponsor a Kabat clinic in California. The Kabat-Kaiser Institute for physical therapy and

rehabilitative treatment for serious neurological injuries and diseases was founded in 1948, with locations in Vallejo and Santa Monica, California.

Under the leadership of Ray Kay, and because of the growing membership in Southern California, the Southern California physicians group established their own identity in 1950 as the Southern California Permanente Medical Group (SCPMG). Kay, an outspoken supporter of the Medical Groups, was influential in the subsequent resolution of various issues confronting the program.

In the Northwest, under the leadership of Ernest Saward, and as a response to concerns of the Washington State Medical Association, the physicians established The Permanente Clinic as a Medical Group partnership in 1946. This enabled them to refute the charge that they were employees of The Northern Permanente Foundation, considered to be a lay-managed organization. The Permanente Clinic later became the current Northwest Permanente.

Two key unions joined the Permanente program during this period. The first was the International Longshoremen and Warehousemen Union (ILWU), in 1950. With new clinics in Northern and Southern California, and arrangements with small independent practice groups in some locations, Permanente was able to provide care for nearly 15,000 ILWU workers and dependents from San Diego to Seattle. Following the ILWU, the Retail Clerks Union Local in Los Angeles, which had 30,000 members, joined in 1951.

With the prospects of growth based on the ILWU and the Retail Clerks, the Foundation began plans for a hospital in Southern California, eventually opening the 200-bed Sunset Hospital in 1953 with a woman, Dorothea Daniels, as hospital administrator. Shortly after, in 1954, the San Francisco Hospital opened with 216 beds.

By this time the leadership of the Permanente Program had articulated what became known as the “genetic code” of the Program. The six principles were:

- Prepayment, because it encouraged patients to visit their physicians for earlier treatment of medical conditions and thus contributed to the practice of preventive medicine.
- Group medical practice, which provided a close network of disciplines and capabilities for greater collaboration and continuity in providing health care.
- Adequate and integrated facilities, including both clinics and hospitals, that enabled the efficiency and control of medical care under one roof with aligned financial incentives.
- New economy of medicine, which encouraged a shift in emphasis from medical care for sickness to medical care for health, thereby reducing overall costs of medical care.
- Voluntary enrollment with dual choice, which met the conditions of the medical profession regarding free choice of physicians. [Note the dual choice principle is no longer a requirement in the 21<sup>st</sup> century insurance environment.]
- Physician responsibility in management as well as in medical affairs, enabling shared decision making for all critical issues affecting both the Medical Groups and the Health Plan and Hospitals.

This formula was beginning to prove itself as the Permanente program continued to grow and become recognized as a legitimate medical care alternative. The first five principles were fully acknowledged and well understood. The last, however, was a sticking point that took some years before the nature of the working relationship between physician leadership and Health Plan management was finally worked out.



## CHAPTER 4: RESOLVING PROBLEMS: THE TAHOE AGREEMENT

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In 1952, total membership was nearly 250,000, with 160,000 in Northern California, 67,000 in Southern California, and 17,000 in the Northwest. The three Permanente Medical Groups together included 125 physicians, there were four hospitals with a total capacity of 500 beds, three clinics were in operation, and three new California hospitals were in the planning or building stages (in Los Angeles, San Francisco, and Walnut Creek). In addition, there was an accredited nursing school and accredited intern and residency training programs. All in all, the program had managed not only to survive after the war, but to grow.

But with growth came other issues and problems, primarily with governance and control. And the issues of acceptance by the medical community were still very real, even threatening. It took several more years for all these issues to be fully defined, come to a head, and get resolved.

At the center of everything were Sidney Garfield, visionary physician, and Henry Kaiser, powerful industrial leader and visionary in his own right. Although they could work together, their visions were not always aligned: Henry Kaiser had a grand national vision, Garfield focused on the local and pragmatic. Garfield, by virtue of personality and history, was essentially the single person holding everything together, with Eugene Trefethen of Henry Kaiser's executive staff as his major management liaison.

But as the program grew, management responsibilities became more demanding and their decisions became more complex. Also, conflicts between the physicians and lay administrators (i.e., Kaiser executives) slowly began to escalate. It was becoming clear to everyone that it all had to be resolved or the program would collapse.

The general overriding question was over who was, or who should be, responsible for what parts of the program? Given the nature of the various entities (the nonprofit Health Plan and Hospitals, the for-profit Medical Groups), a number of related and critical issues surfaced:

- Who controlled the finances? And who was responsible for the program's indebtedness?
- Who controlled all matters related to medical care? For example, was hospital planning and design a medical care issue or a construction problem?
- Who controlled or was authorized to set conditions and criteria for new members?
- Who determined geographical and locational growth, especially considering the demographics of potential new members, and particularly if they were large groups (e.g., unions)?
- Who controlled salaries and all other potential expenditures for the professional staff?

So while Garfield and Henry Kaiser, the physician groups, and the Kaiser executives all saw prepaid group medical care as a wonderful social experiment that had indeed proved itself (at least to their satisfaction), the realities of managing the experiment to the general satisfaction of everyone became more and more critical.

Compounding the situation was the complex relationship between Garfield and Kaiser. When Kaiser's first wife, Bess, died, he married the nurse who had cared for her, Alyce Chester. Not long after, Garfield married her sister, Helen Chester, thus making them brothers-in-law. Further, Garfield was Henry Kaiser's personal physician, and they also lived next to each other in Lafayette, California. This relationship, and Garfield's standard deference to Henry Kaiser, made it even more difficult for Garfield to effectively lead both physicians and lay management.

A number of events in 1952 set everyone on the road to open conflict and ultimate resolution. First, Kaiser decided on his own to build a state-of-the-art hospital in Walnut Creek. It would be paid for with funds generated by the Permanente physicians as part of the Permanente Program. However, the physicians — and, interestingly, some of Kaiser’s key executives, including Edgar Kaiser and Trefethen — did not believe a hospital was needed in Walnut Creek. There were simply not enough members in that locale to warrant a full hospital. The physicians were not involved in the planning and design of the hospital (though Garfield himself was heavily involved in the design of the Walnut Creek, San Francisco, and Los Angeles hospitals). They also did not believe their earnings should be used without their involvement and approval. And finally, they were not consulted on the staffing and management of the hospital: Henry Kaiser’s new wife Alyce, a strong administrator in her own right, became the *de facto* head of the hospital and selected the Walnut Creek physicians. So when the completed Walnut Creek facility became a hospital showcase, there remained resentment among the Permanente physicians on a number of counts.

Also in 1952, the Foundation entities changed their organizational names, becoming the Kaiser Foundation Health Plan (still a nonprofit corporation) and the Kaiser Foundation Hospitals (still a charitable trust). The Medical Groups refused to change their names: they would remain “Permanente.” The physicians did not want to be, or even appear to be, employees of Henry Kaiser or the Kaiser Industries. It was very important to the Medical Groups that they retain their independence and demonstrate it by name to the medical community.

Finally, sensing the solidarity of the physicians, Kaiser wanted the Medical Group to break into separate groups, one for each facility. The physicians saw this as a divide-and-conquer strategy, and they refused.

So by 1955, the general stances of the Medical Groups and Kaiser management could be summarized as follows:

- The Medical Groups felt they owned the program and should run the hospitals as medical care facilities, and that the Health Plan was merely an effective agency for enrolling members, setting rates, and collecting prepaid dues and fees.
- The Kaiser management perspective was that the Health Plan and Hospitals were the driving force; the members belonged to the Health Plan, and the Health Plan was therefore the source of money and ongoing program support. Also, indebtedness for the hospitals was carried by the Health Plan and the Foundation, so they were the real owners of the program. All non-clinical activities were, in effect, business activities to be managed by business people, not by physicians.

The long-time arrangement with Garfield at the center of the whole works, with a special relationship both to Henry Kaiser and to the physicians, was not proving suitable for long-term stability. People with legitimate concern for both the program as a whole, and their places and responsibility in it, were questioning the setup and structure. Eventually, as a result of all the issues, Garfield would lose his place of prominence within the program.

A critical, and controversial, management appointment was also made at this time. In 1953, Henry Kaiser and Edgar Kaiser persuaded Clifford Keene, MD, the Medical Director at Kaiser’s Willow Run, Michigan, automobile plant, to accept a somewhat undefined position to complement and support Garfield in managing the organization. Keene took on a number of assignments and responsibilities, but he was resented by the physicians as being a medical person who had joined the Kaiser management team to actually run the entire program. He also faced stiff resistance from the local medical society for the same reason and was denied membership in the local AMA chapter.

Despite often uncomfortable relationships with the physicians, Keene was an accomplished administrator who was ultimately involved with nearly every critical event in this period of the program's history. Early on, his most important role was as a knowledgeable and acceptable face to financial managers and bankers, who were otherwise skeptical of dealing directly with physicians or with the program as a whole.

Meanwhile, Henry Kaiser continued to present himself as the leader of the Permanente Program, including in Washington and in governmental and political affairs, where he was able to exercise influence. This did not always work in his favor. The AMA, for example, fought Henry Kaiser as much as they worked to reject the Permanente physicians and program. And while he strongly believed the Permanente model for health care should be replicated throughout the U.S. (including by other groups not under his control), his ideas in this respect were often interpreted as support for socialized medicine. This was ironic, as both he and Garfield strongly believed that Permanente-type programs would obviate the concern about government control over medicine.

Still, it was difficult, if not impossible, for Kaiser not to be in charge of anything that he was associated with, and his personal, take-charge style became more and more problematic for the physicians. The physicians continued to believe that they knew what was best for the business of medical care and that they were the most capable of running the Permanente Program, which was different by nature from the industrial companies that Kaiser and his executives managed. Eventually, they would come to acknowledge that professional managers had something to offer, though how it would work on a practical, operational basis was still to be determined.

During this period (1952-1954), a number of written statements, documents, proposals, reforms, and agreements were prepared, reviewed, and accepted by both the Kaiser Foundation Board of Trustees and the Medical Groups. All parties and documents

acknowledged the desire to continue the program as being a valuable and fully legitimate way to provide health care to the public. But none of them provided acceptable or lasting solutions to the full satisfaction of either the physicians or the Kaiser executives.

Ray Kay, Executive Director of the Southern California Permanente Medical Group, provided an excellent and fairly objective summary of the situation. First, it was difficult for the physicians to hold parallel responsibilities in both the Foundation entities (Health Plan and Hospitals), which were nonprofit, and the Medical Groups, which were for-profit. Then, if the physicians were limited only to Medical Group membership, they feared they would have no influence in the running of the overall program, which they perceived as fundamentally a medical care enterprise. Finally, the program as it stood provided no security for the physicians, for either continuing employment or retirement, and so they were constantly in danger of losing professional staff, thereby putting the program's overall quality of care at risk.

Given all these things – governance issues, financial issues, personal relationship issues, leadership issues – the program was in a precarious state by 1955.

It shortly became recognized that a confederation arrangement of some sort seemed the best solution for the program. Such an arrangement would enable some level and type of centralized control, especially for the Health Plan and Hospitals (both primarily under the control of the Kaiser organization, which managed the Health Plan and held the indebtedness for the hospitals), alongside some level and type of localized control for medical matters, since the physicians were primarily organized in local groups (Northern California, Southern California, and Northern — later the Northwest).

A document prepared by the joint Medical Groups in April 1955 and delivered to the Kaiser management outlined the basic problems and

goals and proposed a working council to address them. They were: “the obtaining of a mutually satisfactory integration of all management activities, mutually satisfactory representation at policy-making levels, mutually satisfactory methods of monetary distribution and control, and mutually satisfactory methods of selection of all key personnel.”

The working council was formed, comprising members of all groups. Trefethan, a skilled and acceptable leader, was selected as chair. (By some accounts, Trefethen’s style as a leader, negotiator, and facilitator during this period earned him unofficial recognition as “the man who saved Kaiser Permanente.”)

The working council met three times in May and June of 1955. Their primary conclusion was that the best overall resolution to the situation lay in the establishment of a set of contractual agreements between the Medical Groups and the Health Plan that would delineate the nature of the working relationships among the various entities included in the growing “Kaiser Permanente” world.

A fourth, and what became a watershed, meeting was then held, at Henry Kaiser’s invitation, at his estate at Lake Tahoe. What is now referred to as the Tahoe Conference convened on July 12, 1955. Critically, immediately prior to the Tahoe Conference, Garfield was asked to resign all his positions in the organization: from the Health Plan, the Hospitals, and the Medical Groups. To maintain his involvement, Garfield was designated Executive Vice President for Facilities and Planning.

This move, however personally difficult for many people, opened the door for a week of contentious but productive negotiations among the leaders of the various entities. The Tahoe Conference produced what became known informally as the Tahoe Agreement (the actual title was “Decisions of Working Council”). This document, basically a set of principles, was not actually a legal agreement but rather a document containing major points of consensus that would

allow subsequent legal agreements to be formulated. It was only five pages long, but the conference and the document were a pivotal moment in the history of Kaiser Permanente.

Key points of the Tahoe Agreement included directives for the creation of various policy and management teams, as well as for the drafting of contractual and financial agreements. Subsequently, a set of contract proposals known as Medical Service Agreements (MSAs) were drafted by Trefethen’s staff, primarily by Scott Fleming, the Health Plan’s first lawyer. These agreements were eventually ratified by each of the three existing Medical Groups (Northern California, Southern California, and the Northwest). Organizationally, the MSAs continue to provide the underlying and ongoing framework and contractual arrangements for the working relationships among the various Kaiser Permanente entities.

To reach these agreements, major compromises were made on both sides, altogether acknowledging:

- That the Health Plan and the Medical Groups were separate and autonomous organizations.
- That professional management capability was critical to the operation of Kaiser Permanente as a whole.
- That physicians had a legitimate interest in and claim to the setting of overarching program policies.

Briefly, the primary underlying working arrangement that was set, and that continues to this day, is that the Health Plan would contract exclusively with the Medical Groups for services; *vice versa*, the Medical Groups would contract to render services exclusively with the Health Plan; the physicians would have responsibility for direct medical matters and patient care; the Health Plan and Hospitals would be managed by non-physician leaders from those organizations; and that other operating issues, could, and would, be handled by agreements and contracts.

With the conclusion and implementation of the Tahoe Agreement and the Medical Service Agreements, the program had reached a level of stability and maturity from which it could continue. Indeed, one medical historian attributes Kaiser Permanente's long-term success more to the Tahoe Agreement than to anything else. Kaiser Permanente was the result of organizational medical care experiments in the desert, at Grand Coulee Dam, during World War II, and during the post-war period. Many people, with many thoughtful positions, motivations, and goals, had worked for over twenty years to reach this point, never knowing along the way exactly what the outcome would be or when it would be reached. It was clearly the determination of all the leadership people involved that got them through this crisis and put Kaiser Permanente on the road to continuing success.

## **PART 2: GROWTH AND CHANGE**

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### **CHAPTER 5: GAINING CREDIBILITY**

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With the Tahoe Agreement in place and the Medical Service Agreements approved by the existing Medical Groups, Kaiser Permanente was now in a position to work cooperatively on the quality of health care and the growth of the program. In 1955, membership was more than 500,000.

Key people provided leadership continuity, which was critical during this period of transition to the new working arrangement. For the Kaiser Foundation Health Plan and Hospitals (KFHP/H), a single, common Board of Directors was named, with Henry Kaiser as the Chairman and Edgar Kaiser as CEO. Eugene Trefethen and others from the Tahoe conference were also on the new Board of Directors. However, no physicians or representatives from the Medical Groups were included.

For the Medical Groups, Cecil Cutting was named the first Executive Director of The Permanente Medical Group in Northern California in 1957, with Morris Collen as Chairman of the TPMG Executive Committee. Ray Kay continued as the leader for the Southern California Permanente Medical Group, and Ernest Saward for The Permanente Clinic in the Northwest. Together, all these leaders from the Medical Groups and the Health Plan and Hospitals ensured the stability that would enable Kaiser Permanente to move from its post-war period to its new management and governance model.

Also critical to the operation of the newly structured organization was the gradual emergence of what became known as the Central Office. Program leaders began to recognize that they needed central

coordination for a number of things, including the development of cross-organizational policies, a department with authority to respond to requests from outside Kaiser Permanente, and the handling of increasing numbers of administrative and operational responsibilities, including government relations as health care oversight increased under the federal government. This office began informally under the management of Clifford Keene, with the first two key staff members being a lawyer, Scott Fleming, and a medical economist, Arthur Weissman. It grew with the addition of legal and financial staff devoted to the Health Plan and to Kaiser Permanente as a whole. Eventually, the Central Office became what is now referred to as the Program Offices.

Sidney Garfield, no longer a leader of the Medical Groups or a practicing physician, was named to the KFHP/H Boards of Directors. He also held the position of Executive Vice President for Facilities and Planning. So whereas he had relinquished his central role in Kaiser Permanente, he was now in a position to focus on aspects of health care that were perhaps the most personally important to him: visions of improved models of health care, and the design of new and improved care facilities. He remained on the Board of Directors until 1971, another 16 years, also becoming a prominent figure on the national health care scene.

From the beginning, Garfield recognized the importance of continuing education for the medical staff and the benefits of conducting and publishing research. With the mass of people at the shipyards during the war, many in poor health (pneumonia, syphilis, and innumerable other disorders), there was an excellent opportunity for research. The *Permanente Foundation Medical Bulletin*, a peer-reviewed journal, began publication in 1943, with Morris Collen as editor. The *Bulletin*, published through 1953, also gave Garfield a venue to showcase the professional qualities and capabilities of the Permanente staff. The *Bulletin* was praised in the *New England Journal of Medicine* in 1944. Permanente physicians also published

in other professional journals, and their work was acknowledged as being of a high standard.

In 1951, another Permanente publication, *The Educational Proceedings of the Permanente Hospitals*, appeared. It had a two-year life before combining with the *Bulletin* to become *The Kaiser Foundation Medical Journal*. *The Journal*, after four years, ceased publication in 1958.

In 1997, *The Permanente Journal*, developing from *The Northwest Permanente Journal of Clinical Practice*, debuted. This ongoing quarterly journal is a national peer-reviewed medical journal published by The Permanente Press under the auspices of The Permanente Federation.

Research grew primarily on an informal basis after the war, but to support increased interest in research among staff physicians, Keene established the Kaiser Foundation Research Institute (KFRI) in 1958. KFRI continues to this day as the Kaiser Permanente office for coordinating research grants from outside organizations (especially from the federal government), and also oversees clinical trials compliance and quality and human subjects protection.

The Permanente Foundation School of Nursing, renamed to Kaiser Foundation School of Nursing in 1953, was founded in 1947 to help address a post-war shortage of nurses. The director was Dorothea Daniels, RN, a strong nursing administrator with an equally strong belief in nursing education. Up until 1965, students graduated with RN diplomas, but beginning in 1965 the school began awarding academic degrees at the AA level, the first such program in California. In the early 1970s, with a growing number of community colleges and even four-year colleges entering the nursing education arena, the Kaiser Foundation School of Nursing attempted unsuccessfully to affiliate itself with a four-year degree program. The last class of nurses graduated in 1976 and the program was shut

down, having graduated a total of 1,064 nurses over its 30-year existence.

An important event that brought relief to the leadership was the begrudging acceptance of Kaiser Permanente by the American Medical Association. In 1959, the AMA received the final report of the Commission on Medical Care Plans (sometimes referred to as the Larson Report, after its chairman). This commission was formed to examine the nature of group medical practice within the American health care industry. The report, produced after more than a year of study, supported the basic concept of freedom of choice of physician by patients, a sticking point with both local and national AMA leaders. But it also acknowledged the right of the patient to choose a *system* of care, which included prepaid group practices. The report was accepted by the AMA, and over time the Kaiser Permanente program and physicians became generally accepted by both the national and local medical organizations.

By this time, the Kaiser Permanente program was gaining increased national attention. Cutting, Keene, and other leaders were being invited to speak at medical schools and conferences (including the AMA), to write for medical care publications about the program (including the prestigious *New England Journal of Medicine*), and to testify at Congressional hearings and White House conferences. Proof of Kaiser Permanente's increased prominence was a profile of Kaiser Permanente in *Time* magazine in September, 1962. Highlighted by photographs of Garfield, Henry Kaiser, and the then-new Panorama City hospital, the article identified Kaiser Permanente as the largest private prepaid medical care plan in the country and outlined its basic health care plan and services.

In 1960, the Health Plan and Medical Groups published the first Annual Report. Its focus was "What is the Kaiser Foundation Medical Care Program?" The report outlined the main components of the organization and explained the basic principles on which the

program operates: group practice, preventive medical care, integrated medical facilities, and voluntary enrollment.

Also in 1960, a key meeting occurred when the combined leadership of the Health Plan and the Medical Groups convened the Monterey Management Conference. Attendees included nearly 100 management and medical leaders for presentations and panels from both Kaiser Permanente leaders and staff and experts from outside Kaiser Permanente. Although some of the conference necessarily looked back at the development of Kaiser Permanente, the main focus was looking ahead at the next ten years. Topics included population trends; wages, fringe benefits, and labor supply; hospital construction and administration; characteristics of health insurance and prepayment plans; and group practice and preventive medical care.

Addressing the Monterey conference, and showing his awareness of potential capabilities of the new large computers then being built, Garfield envisioned a time when members' full medical histories and current treatments were held as computer records. To support this idea, Garfield sent Collen, whose undergraduate degree was in electrical engineering, to the first national congress on medical electronics, also held in 1960. On his return, Collen predicted that "the computer will probably have the greatest technological impact on medical science since the invention of the microscope."

Nearly a decade before this, in 1951, the multiphasic health screening program had been started with the ILWU. In this program, all union members were given full and extensive general examinations, and their health status and histories were recorded. Initially they were recorded on paper and maintained in files. But Collen saw this program as a perfect project for capturing health data on computers. Thus the multiphasic testing data became the first large-scale project in Kaiser Permanente to use the capabilities of the computer. With this program, Collen also started the Medical Methods Research department, which was the forerunner of both

later Information Technology departments and various Medical Groups research divisions.

In 1965, Cutting, speaking to the American Association for the Advancement of Science, predicted that "Out of this program will come a new medical program for the future ... All histories and findings would be recorded by computers and made available to the physician wherever members go for medical care." Then, in an article published in *Scientific American* in 1970, Garfield placed the computer center, not the hospital or the physician, at the heart of the health care delivery system. The computer was already on its way to becoming a key component of the Kaiser Permanente model for delivery of health care.

In 1960, the first of three federal acts that were critically important to Kaiser Permanente was passed: the Federal Employees Health Benefits Act. The others were the Medicare and Medicaid amendments to the Social Security Act (1965) and the Health Maintenance Organization (HMO) Act (1973).

The Federal Employees Health Benefits Act was passed to provide a framework and guidelines for federal employees to receive health care coverage. As it was initially conceived, the Act would not have permitted prepaid group programs to be offered. However, Avram Yedidia and Arthur Weismann, two medical economists on the Health Plan staff, were able to meet with Sen. Richard Neuberger of Oregon, the chair of the Senate subcommittee, who was himself a member of the Kaiser Foundation Health Plan in Portland. They persuaded him that a plan that offered basic and complete coverage in addition to major medical would be a valuable addition to the bill.

As a result of subsequent modifications to the legislation, Kaiser Permanente qualified as a legitimate carrier and provider, and thus was able to be offered as a benefit program for federal employees in areas where it had a presence.



This act had several important consequences for Kaiser Permanente. First, it affirmed the principle of dual and multiple choice. That is, the government offered its employees more than one choice for health provider, which by now was a keystone of Kaiser Permanente's membership enrollment strategy. Second, it acknowledged the validity of prepaid plans. Both of these were critical to Kaiser Permanente's ability to compete against fee-for-service physicians and plans. Third, the fact that the federal government acknowledged and offered Kaiser Permanente to its employees provided a level of legitimacy that Kaiser Permanente had not had previously. Finally, and financially important, Kaiser Permanente was able to retain all its federal employee members in California, plus enroll additional federal employees as well.

The fact that the federal government now officially recognized and offered Kaiser Permanente as a health care option encouraged other government levels (state, county, municipal) to also offer Kaiser Permanente as a health insurance option. The California State Employees Retirement Board, along with the California Employees Association, began pushing for Kaiser Permanente medical care in the Sacramento area, as did municipal employees in Sacramento and other communities.

As another consequence of this Act, and after much discussion between the Health Plan and TPMG, the decision was made together to expand to Sacramento, where there was a huge market of government employees. The expansion included the purchase of an existing hospital. With operations in Sacramento beginning in 1965, Kaiser Permanente in Northern California had now made its first expansion outside the immediate Bay Area.

Yedidia and Weissman remained important members of the Health Plan staff for many years, especially helping to set up enrollment plans and options and advising on general economic matters critical to Kaiser Permanente's place in the health insurance and health care industries.

In 1965, the second of the major federal acts important to Kaiser Permanente was passed: the Medicare and Medicaid amendments to the Social Security Act, part of President Johnson's Great Society set of programs. As with the Federal Employees Health Benefits Act, there were critical benefits to Kaiser Permanente from the Medicare/Medicaid Act.

Initially, like other providers, Kaiser Permanente was paid on a fee-for-service basis, and a method of payment was specifically designed to accommodate the unique billing structure of Kaiser Permanente. Although workable, Medicare payments did not take advantage of the types of incentives that made an integrated program like Kaiser Permanente effective. Eventually, in 1985, Medicare regulations were modified to allow a prepaid, capitated method of payment, which Kaiser Permanente then took advantage of.

The second, and perhaps more important, benefit of Medicare to Kaiser Permanente was the fact that so many members eventually qualified for Medicare, and thus payment for their care was provided through these programs. Initially (1966) only about 4 percent of Kaiser Permanente's revenue came from Medicare, but it grew rapidly after that. By the early 2000s, about 30 percent of Kaiser Permanente's revenue (from about 10 percent of its members) came from the Medicare program. The Medicare program thus guaranteed a substantial amount of membership and revenue for Kaiser Permanente.

In 1973, the third of the major federal acts that affected Kaiser Permanente was passed: The Health Maintenance Organization (HMO) Act. In initial draft form, the HMO Act was to a large extent modeled after the Kaiser Permanente Medical Care Program, since by that time a number of congressional leaders were quite familiar with both the nature and success of Kaiser Permanente. Also, Kaiser Permanente staff were heavily involved in proposing details for the legislation.

Ironically, the act required a cost method of payment to HMOs, which was inconsistent with Kaiser Permanente's method of determining reimbursement. Consequently, Kaiser Permanente chose not to qualify as an HMO. However, when amendments to the act proposed by Kaiser Permanente and the Group Health Association of America were passed by Congress, all Regions became qualified HMOs in 1977.

As with the other two major federal acts, the HMO act provided key benefits to Kaiser Permanente. The first was that, as with the other acts, it gave additional legitimacy to Kaiser Permanente and enhanced its ability to compete with other health benefits carriers.

The other primary benefit to Kaiser Permanente was the HMO provision that any employer with more than 25 employees was mandated to offer an HMO health care option if one was available in the area. What this meant was not that Kaiser Permanente had to be offered (no specific HMO provider was required to be offered), but rather that Kaiser Permanente, as an HMO, *could* be offered, thereby expanding the potential market for Kaiser Permanente in its membership areas.

## CHAPTER 6: GROWTH AND EXPANSION — PART 1

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While the Program began seeing steady growth in California in the 1950s, the idea of expansion beyond the Bay Area, Los Angeles proper, and the Portland area was not a priority. The first attempt at real expansion came from Henry Kaiser himself, after he retired in 1956 from management of Kaiser Industries, though not from the Boards of the Kaiser Foundation Health Plan and Hospitals. He moved to Hawaii and was determined to start a group health plan program there. Even though another hospital was not needed in Honolulu, he built one anyway in 1958. He also hired physicians, five of whom were selected to form the leadership of a Medical Group, the Pacific Medical Associates. Some additional support was provided by TPMG, but by-and-large it was a Henry Kaiser project.

However, enrollment in the Kaiser Permanente program in Hawaii was substantially less than expected, and far lower than needed to make the program economically viable. Also, despite Kaiser's enthusiasm and personal intent, the medical staff did not fully understand or appreciate the model and tenets of prepaid group care. The Hawaii program did not get off to a promising start.

So in 1960, Kaiser brought Clifford Keene, Eugene Trefethen, and Ernest Seward to the island to review the program. As a result of their observations and Keene's leadership, a number of changes were made, starting with the firing of the physician partners and the naming of Seward as interim leader. Under Seward's guidance, most of the physicians stayed with the program, and Philip Chu, MD, was named leader of the new Hawaii Permanente Medical Group (HPMG). The program grew slowly but steadily, and as he grew older, Henry Kaiser's personal influence over the program gradually diminished, until the Hawaii program more closely resembled that of the California Regions in terms of organization and governance.

Experienced Kaiser Permanente managers had, in effect, saved the Hawaii program.

In 1961, TPMG, acting alone, explored the possibility of expanding the program to San Diego. The TPMG group still believed that they were the main agents of providing health care, and they were determined to demonstrate that they could run their own entire program. They selected San Diego as their target area, with Morris Collen taking the assignment of heading the program there. They purchased a hospital and began additional preparations to set up their own group practice, thus leapfrogging SCPMG in southern California.

But as might be expected, there was almost immediate reaction to this plan, from several parties. First, Henry Kaiser himself, though in Honolulu, objected strenuously, as he felt the move was a direct attempt at competition. Then there was concern from the executives and Board of the Health Plan/Hospitals, especially about potential conflicts of interest and possible destabilization of the existing program and arrangements. Finally, SCPMG, led by Ray Kay, was concerned about a plan being set up in an area that might be considered a prime expansion target for the Southern California region.

A number of meetings were held among TPMG leaders, Health Plan executives, and SCPMG leaders. Finally, Henry Kaiser himself asked Cecil Cutting to abandon the San Diego plan or he would fully disassociate the Health Plan from TPMG. With this threat, Cutting agreed to drop the San Diego venture. TPMG sold the hospital (for a profit), and they agreed to remain a Northern California organization.

The main lesson from the Hawaii and San Diego experiences was the recognition, once again, of the need for close cooperation and a strong working relationship between physicians and the Health Plan and Hospital management and staff. Although they had come to this general understanding previously after years of work, they now

recognized it was absolutely essential even for expansion or in the formation of a new Region.

These two expansion episodes foreshadowed what became the central overall focus for the Program from the 1960s through the 1980s: growth and expansion. What would become the criteria for expansion to other areas, including outside California? How would they handle growth in the current Regions, especially the two large California Regions?

The option of expanding to San Diego arose again in 1966 when SCPMG and the Health Plan were approached by the San Diego Community Health Plan, a prepaid group plan that was having financial difficulties. Ray Kay, the Executive Director of SCPMG, encouraged taking over the San Diego organization and implementing the Kaiser Permanente culture and processes. The SCPMG Board of Directors did not at first agree with the move, citing the difficulties they were having staffing and growing the program in the Los Angeles area, as well as the financial risk of assuming control of a failing organization.

After the SCPMG Board visited San Diego to review the situation in person, however, both the SCPMG Board and the Health Plan Board agreed to the acquisition. As with other expansions, the Health Plan and the Medical Group sent experienced Kaiser Permanente administrators and medical leaders to take over the program. Some of the original San Diego physicians were retained; some left. The resulting Medical Group was strong, and, with stronger administrative leadership in place, the San Diego operation became financially successful within its first year. Ironically, the San Diego operation that was acquired included the hospital that TPMG had purchased, and sold, several years earlier.

By the mid-1960s, in addition to expansion issues, the Health Plan and the Medical Groups were getting requests for consultation and advice from other group practice organizations, as well as from

organizations requesting that Kaiser Permanente seriously consider taking over responsibility for providing their health care or rescuing their current health plans. However, there was no central or mutually agreed-upon office or person to respond to these requests, and no policy on which to base considerations and responses.

Given the situation and the opportunities, Keene scheduled a meeting in May 1967, at the Del Monte Lodge in Monterey County. Now known as the Del Monte Conference, it included leaders from all the Kaiser Permanente groups, and its primary outcome was a decision to form a committee to deal with issues and matters of cross-organizational importance. It was further agreed that this group would be neither a policy-making committee nor an executive or administrative body. Rather, it was to be a joint review and recommending body for the entire Kaiser Permanente program. The committee was to include the Medical Director and Regional Manager from each Region, plus a set of leaders from the central office staff. Initially, its membership was 14 people, supported by staff as needed. At an August, 1968, meeting in Santa Barbara, California, the group formally assumed the name of the Kaiser-Permanente Committee.

As new Regions were added to Kaiser Permanente, leaders from those regions joined the committee. It met two or three times a year, with agendas covering all pressing and long-term issues confronting the Program. The committee continued its general advisory role well into the 1990s, with its recommendations typically accepted by the respective organizational entities.

Subsequent opportunities for expansion, in Detroit and Cleveland, forced the leadership of the Health Plan and Medical Groups to consider whether they wanted to expand, and if so, what the criteria would be for successful expansion. Given the interest and requests for assistance in other geographic locales, a first order of business of the Kaiser-Permanente Committee was to establish criteria to be considered in any expansion request. The criteria agreed on were

population, legality, physicians, hospitals, impact, competition, and capital. Later, ‘special circumstances’ was added to the list. All subsequent expansion opportunities were then examined against this list. Some, as noted below, were successful, and others were not.

In the early 1960s, Walter Reuther, head of the United Auto Workers (UAW), had approached Edgar Kaiser about the possibility of Kaiser Permanente taking over health care for that union. Their care had been provided primarily by the Community Health Association in Detroit, an organization sponsored by the UAW. Reuther continued to press Kaiser Permanente for assistance (this request was actually the primary driver of the Del Monte meeting). Further, it was the first request for actual assistance from another locale and organization. However, at the Del Monte and Santa Barbara meetings, after discussion of the request, it was decided not to pursue the UAW offer. The Kaiser Permanente leadership was just not ready to make that kind of commitment and on that scale. A contributing reason was that the Detroit area as a whole was dependent primarily on only one industry, which made it a potential high risk financial situation in case there was ever a significant downturn in the automotive industry.

At about the same time, Kaiser Permanente had been approached about an affiliation with the Community Health Foundation (CHF) of Cleveland, Ohio. CHF had opened in 1964 with support from local unions and with counseling and advice from Kaiser Permanente leaders, especially Saward from the Northwest Region and Avram Yedidia. Consequently, their basic model was similar in many respects to that of Kaiser Permanente.

Although membership had grown, within a few years CHF was struggling, in large part because of a poor hospital arrangement. In 1967, and with Saward’s and Keene’s support, CHF and Kaiser Permanente began merger discussions. There were advantages to the opportunity, including the possibility of demonstrating the feasibility of the Kaiser Permanente model outside California.

Although there was far from unanimous agreement by Kaiser Permanente leadership, discussions were kept open, partly based on the set of expansion criteria, eventually resulting in the merger and the formation of the Kaiser Community Health Foundation. Cutting and Saward were voted to the Executive Committee, and an Ohio Permanente Medical Group (OPMG) was formed. Also, TPMG was designated as the sponsor of the Cleveland venture. In 1969, the Ohio Region opened as a Kaiser Permanente sponsored plan.

In contrast to the Ohio expansion, in which Kaiser Permanente was invited to help rescue a program, a Denver opportunity in the mid-1960s was a Kaiser Permanente-initiated venture. Interest in Kaiser Permanente had previously been expressed by the United Mine Workers and their medical leadership, especially based on UMW experience with the Kabat-Kaiser Institute for rehabilitative Medicine and an unaffiliated Kaiser Industries hospital in Dragerton, Utah. But it was not until 1967 and the meetings of the Kaiser-Permanente Committee that expansion to Colorado became a fully valid possibility.

About a year’s study of the Denver situation in 1968 preceded the decision to open a Region in Colorado. Kaiser Permanente executives and representatives met with university groups who had done studies on prepaid group health care in Colorado, as well as with labor, community, and physician leaders to assess the potential and risk of such a venture. Using their own expansion criteria as a basis for evaluation, both the Health Plan and the Medical Groups agreed to establish a new Region.

In parallel with the TPMG sponsorship of the Ohio Region, SCPMG and the Southern California Region were invited to sponsor the enterprise in Colorado. A management group was sent to set up operations, including acquiring clinic space, making arrangements for hospital beds and privileges, setting up all administrative and operational processes, and hiring staff. Working out of a motel room

in Denver, they were able to get things set up in less than six months, and the Colorado Region opened for business in July, 1969. As in Ohio, a new Colorado Permanente Medical Group (CPMG) was formed.

Kaiser Permanente was also approached several times in the 1960s about taking on all the health care for the United Mine Workers in Appalachia, under the United Mine Workers Benefit Fund. In this case, the situation was basically many isolated hospitals and clinics throughout the area, which would make it difficult to implement an efficient program based on the fundamental Kaiser Permanente tenets. Eventually, after close study, Kaiser Permanente decided against the UMW expansion opportunity.

With the opening of the Regions in Ohio and Colorado, Kaiser Permanente now had six regions: two in California, one in the Northwest, one in Hawaii, and the two new Regions. And even though the Kaiser Permanente leadership had agreed upon expansion criteria and had successfully moved into the Cleveland and Denver areas, there was no more expansion for nearly ten years.

Unfortunately, Henry Kaiser did not live to see the growth and the coming success of Kaiser Permanente. Kaiser died in 1967, at the age of 85, from generally failing health after having been a supremely energetic individual and industrialist for all his life. In 1990, for his work and philosophies related to labor, the workers, and the trade unions, he was inducted into the U.S. Department of Labor Hall of Fame. His own belief was that the primary accomplishment he would ultimately be remembered for would be the Kaiser Foundation Medical Care Program.

## CHAPTER 7: GROWTH AND EXPANSION — PART 2

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During the late 1960s and 1970s, some 30-plus years after many of the leaders began working together at Grand Coulee Dam, changes in the leadership of the Health Plan and the Medical Groups began to occur. With Henry Kaiser's death in 1967, Edgar Kaiser was named Chairman of the Health Plan/Hospitals Board of Directors, and Clifford Keene was named President. A year later, Keene was also named CEO of Kaiser Foundation Health Plan and Hospitals.

In 1974, James A. Vohs was named President and Chief Administrative Officer, replacing Keene, though Keene remained on the Board. Vohs's appointment to these positions was the first at this level from outside the founding group. A year later, Keene retired from the Board, though Edgar Kaiser remained as Chairman of the Board and CEO. In 1980, he retired also, along with Eugene Trefethen, long-time Vice-Chairman of the Board. James Vohs was appointed Chairman, retaining also the titles of Chief Executive Officer and President. Edgar Kaiser passed away in 1981, having been associated with Sidney Garfield and Kaiser Permanente's history from the time of Grand Coulee Dam, in 1938, nearly 50 years.

Within the Medical Groups, Ray Kay, the founding and only Executive Director of SCPMG, retired in 1969. Ernest Saward, who led Northwest Permanente, retired in 1970. And in 1976 Cecil Cutting stepped down as the leader of TPMG. Cutting, perhaps Garfield's longest and most trusted associate, died in 2008. Morris Collen, another of the early leaders and a fierce fighter for the place of the physicians and the Medical Groups within Kaiser Permanente, remained on the TPMG Executive Committee and as Director of the Medical Methods Research Department until he retired in 1979, though he remains active with the TPMG Division of Research on an emeritus basis.

The Kaiser-Permanente Committee also continued to provide general direction, and in 1970 reviewed its charter and work to date. It determined that its primary functions were to deal with policy issues, expansion considerations, consultation requests, cross-regional matters, and other issues toward the improvement of the total program. As a 1976 report on the "Scope, role, and major functions of the Kaiser-Permanente Committee" states, "It is also the role of the Committee to foster total Program cohesiveness and to enhance both interregional relations and relations between the Regions and Central Staff." For the next 20-plus years, this committee was the guiding deliberative and recommending body for major issues and considerations facing Kaiser Permanente. It had no formal authority, but its recommendations were invariably accepted and implemented by the Kaiser Permanente organizations, separately and collectively.

By 1971, the Kaiser Permanente Medical Care Program had achieved enough stature that there was national interest in it from a large variety of groups, including academic medical institutions. A three-day symposium was held, sponsored jointly by the Kaiser Permanente Medical Care Program, the Commonwealth Fund, and the Association of American Medical Colleges. Focusing on the nature, structure, and administration of Kaiser Permanente, the program hosted over 250 participants representing over 100 medical schools and hospitals. This was a significant acknowledgement of the high regard that Kaiser Permanente had earned. The Program had finally and fully arrived as a major and legitimate health care model and system.

The symposium's proceedings were gathered and published under the title *The Kaiser-Permanente Medical Care Program: One Valid Solution to the Problem of Health Care Delivery in the United States*. The phrase "one valid solution" was a useful admission that Kaiser Permanente leadership did not have nationwide expansion goals. Over the course of the symposium, Kaiser Permanente was able to demonstrate that it provided a cooperative and economically

successful arrangement for both medical and management leadership outside governmental control.

All during this period, growth continued in California. In the 1950s, hospitals went up in Los Angeles (Sunset, 1953), Fontana (1955), Oakland (1956), South Bay/Harbor City (1956), San Francisco (1959), and Panorama City (1959). In the 1960s, hospitals and medical office buildings were built or opened in Northern California in Hayward (1962), Sacramento (1965), Redwood City (1968), and Santa Clara (1969), and in Southern California in Bellflower (1965). Clearly Kaiser Permanente was growing in its home state.

In the 1970s, a new tower went up at the Oakland hospital (1970), and in a huge spurt of construction, hospitals and clinics were built in San Diego (1972), Vallejo (1974), West Los Angeles (1974), Sunnyside, Oregon (1975), South San Francisco (1975), San Jose (1976), San Rafael (1977), and Anaheim (1979). By the end of the 1970s, Kaiser Permanente had nearly a dozen hospitals and medical centers each in Northern and Southern California, as well as numerous clinic and hospital facilities in Hawaii and Oregon.

The 1980s brought more: In 1985 alone four new or renovated facilities opened up: Walnut Creek, South Sacramento, Woodland Hills, and Moanalua (Hawaii). Following these were a major South San Francisco addition (1986) and the Riverside Medical Center (1988).

Over the course of the next several years, and using the criteria established in 1968 at the Santa Barbara meeting, Kaiser Permanente began a slow expansion into a number of other states and into areas of California outside the immediate San Francisco Bay and Los Angeles areas.

Interest in expansion outside California resumed in 1977 when the Kaiser Foundation Health Plan, working with the Permanente Medical Groups, joined with The Prudential Insurance Company of

America to consider opening a group practice HMO in the Dallas/Fort Worth area. After a year of discussions with local medical and hospital leaders and major local employers, the organizations formed the Kaiser/Prudential Health Plan. A Permanente Medical Association of Texas was created for the physicians, and arrangements were made for beds in local community hospitals.

The Kaiser/Prudential Health Plan opened for business in Dallas in 1979, with management being provided by the Kaiser Foundation Health Plan and Hospitals from California. However, in 1982, Prudential bowed out of the program to concentrate on its own Texas group practice plan, and Kaiser Permanente took over in full, renaming it the Kaiser Foundation Health Plan of Texas. The Texas Region subsequently also opened offices in Fort Worth in 1985. This was the only case of all the expansion opportunities that was done as a joint effort with another major partner.

In 1980, the Georgetown University Community Health Plan (GUCHP) approached Kaiser Permanente about assuming responsibility for its program in the Washington, DC, area. Although generally successful, the program needed support for longer term growth. Kaiser Permanente was especially interested because it was important to the Kaiser Permanente leadership that a group prepayment health care program could demonstrate its success in the area of the nation's capital, where so many governmental decisions were made concerning health plans and health care.

Kaiser Permanente Advisory Services had been providing occasional assistance to GUCHP for some time and so was familiar with the quality of the program and its place in the community. With their recommendation, a transition team that included both physicians and management was formed. The physicians remained and formed the Capital Area Permanente Medical Group, but the top level of Health Plan management was replaced. The new Region assumed the name of Kaiser-Georgetown Community Health Plan. It was renamed the



Mid-Atlantic States Region in 1985, serving members in Washington, DC, Virginia, and Maryland, including the Baltimore area.

Expansion into New England was next. In 1982, Vohs, Kaiser's CEO, received a call from the insurance commissioner of Connecticut: there was a prepaid group Health Plan in financial trouble—the North Central Connecticut HMO. After studying the situation and applying the expansion criteria, Kaiser Permanente decided to acquire the Health Plan, renaming it the Connecticut Region. Then, in 1985, Kaiser Permanente also acquired the Westchester Community Health Plan in White Plains, NY. Together, they formed the Kaiser Foundation Health Plan of the Northeast, with over 30,000 members. As with the Mid-Atlantic States Region, this was another opportunity to demonstrate on the East Coast the efficacy of a prepaid group Health Plan.

By this time, the leadership of Kaiser Permanente had determined a strategy to move more broadly outside California and its existing Regions, most of which had been gained through the acquisition of existing Health Plans, and several of which were struggling and needed both the financial and management expertise of a larger organization such as Kaiser Permanente.

This was true as well of Kaiser Permanente's move into the Midwest. A nonprofit group practice prepayment plan, Kansas City Health Care, loosely associated with the University of Kansas Medical Center, was facing increased competition from other local groups. So it, too, turned to Kaiser Permanente for capital and management resources. A transition to Kaiser Permanente ownership was completed in August 1985. Later, in 1994, the Kansas City area was brought under general control of the Colorado Region.

In Southeastern United States, several opportunities were examined, and the leadership finally decided on two target areas: the Raleigh-

Durham-Chapel Hill area of North Carolina, and the Atlanta, Georgia area. In both cases the organizations were started from scratch. Kaiser Permanente sent both management executives and physicians to research, plan, organize, and start the programs. The organizations contracted with local community hospitals, while establishing their own outpatient clinic facilities. The North Carolina Region opened in January 1985, and the Georgia Region opened in October of the same year.

In California, Kaiser Permanente had previously expanded to Sacramento (1965) and San Diego (1966). But the vast Central Valley was not covered, and its population was growing. Also, there were many state and federal employees in the Valley, so it was a prime target area for expansion and membership. In the 1980s, Kaiser Permanente opened operations in the main metropolitan areas in the Valley: in Stockton and Fresno in 1986 (both part of the Northern California Region), and in Bakersfield in 1988 (part of the Southern California Region).

Whereas the Stockton location was essentially a satellite of Sacramento and staffed with Kaiser Permanente physicians from Sacramento, the Fresno and Bakersfield programs were opened with a mix of Kaiser Permanente and locally contracted physicians. In both cases, the programs have grown enough that each area is now fully supported by Kaiser Permanente physicians in several local medical office buildings. For inpatient care, a hospital was opened in Fresno in 1995, while Bakersfield still contracts with local community hospitals for privileges and services. New hospitals were opened in Manteca (outside Stockton) in 2004 and in Merced in 2008.

Although national Kaiser Permanente expansion had essentially stopped in the mid-1980s, the general idea of expansion had not been completely dropped. Since that time, there have been only two attempts at expansion. The first occurred in 1996, when Kaiser Permanente acquired Community Health Plan, in Albany, NY. This

location and group was added to the Northeast Region, which already had members in Connecticut, western Massachusetts, and the White Plains area of New York. Unfortunately, the Region's communities were somewhat spread out, making it difficult to create a cohesive Region with sufficient members to make it economically viable.

Then, with a goal of increasing its market share in the northwest as a whole, Kaiser Permanente entered into an agreement in 1997 with Group Health Cooperative of Puget Sound, which was in financial difficulty. Because of their status as a member-owned cooperative, an actual merger was not possible, so the arrangement was designated an "affiliation" and named Kaiser/Group Health, with its medical group becoming Group Health Permanente. The goal was to share common administrative functions and directions and to provide mutual care delivery benefits. For a number of reasons, the arrangement did not work out as intended, and the Group Health organizations are now fully separate with their original names.

Finally, in a reversal of expansion, Kaiser Permanente sold off four of its Regions in the late 1990s. Primarily for economic reasons, Kaiser Permanente divested the Texas Region in 1998, the North Carolina and Northeast Regions in 1999, and Kansas City in 2001. Remaining were the two California Regions and six Regions outside California: Hawaii, Northwest, Colorado, Ohio, Mid-Atlantic States, and Georgia. Kaiser Permanente has not actively pursued regional expansion since that time.

When Garfield had moved out of the primary leadership role of both the Health Plan and the Medical Groups in the 1950s, he was no longer at the center of the entire organization and all its issues. He was free to focus on what might have been his more fervent interest: what could he do to directly improve the quality and delivery of health care?

Two areas demonstrate his continuing efforts: hospital design and "total health care." As a student, Garfield was initially interested in studying architecture and engineering. With the weight of program management off his shoulders, he could focus on what became his second major interest: hospital design. In actuality, this had started with his design and construction of the Contractors General Hospital at Desert Center, his subsequent gutting and renovation of the Mason City Hospital for the workers on Grand Coulee Dam, the resurrection of the defunct Fabiola Hospital in Oakland, and the design and building of Bess Kaiser Hospital in Portland, Oregon from scratch.

Now he was able to concentrate on it fully, contributing ideas and leadership to the designs of many Kaiser Permanente hospitals. Garfield's continued design innovations were regularly noted in articles on hospital architecture and in conversations and meetings with hospital architects across the country.

But his vision was not limited to the structures themselves. In an address to the Monterey Conference in 1960, he challenged the Kaiser Permanente community to reframe their thinking: "I suggest a radical new idea – that we stop building hospitals and clinics for sick people. Let's concentrate on a brand new type of facility... Let us conceive a building for health – designed, streamlined, and geared to serve our healthy members." Even then, Garfield was advocating what has become a long-standing theme of the Kaiser Permanente model: a focus on health rather than on illness.

Garfield's final project was the three-year Total Health Care pilot project, an effort to collect, computerize, and use health data on all Kaiser Permanente members. Basically, the project was a plan to integrate and streamline preventive care, wellness, medical record tracking, and access to both primary and secondary care with team-based approaches to care, all with the objective of optimizing each member's individual health. Kicked off in 1981, it resulted in massive amounts of data in support of the concept, with a final report published in 1987. Although Kaiser Permanente care today does not

explicitly follow the approach and format outlined in the Total Health Care Project, most of the ideas embodied and supported by the project have been incorporated in various other ways throughout the Program. The emphasis on “total health” implied by this project remains a continuing theme in the Kaiser Permanente vision and is seen in a number of current programs.

Sadly, Garfield missed the conclusion of the project and its report, as well as the new Region expansions in the 1980s. He died on December 29, 1984, at the age of 78, having been the visionary physician of the nonprofit prepaid group medical care model since 1933. He served on the Board of Directors of the Kaiser Foundation Health Plan and Hospitals from 1960 until 1971, where he remained a determined advocate of improvement in health care. Colleen recalled that whenever Kaiser Permanente or its staff or leaders produced notable results or improvements, Garfield’s response was always, “That’s great, but we have to do better.”

Although Garfield was known throughout the health care industry for his efforts and vision, his life work was more formally and publicly recognized when the Group Health Association of America gave him its Distinguished Service Award in 1969. In 1971, he was awarded the Lyndon Baines Johnson Award for Humanitarian Services, presented by Lady Bird Johnson.

In 1986, the University of Southern California, where he had been on the medical school faculty in the 1940s, honored him by announcing the Sidney R. Garfield Chair in the Health Sciences. It was initially funded by the Henry J. Kaiser Foundation and was to be held by a medical scientist whose focus would be on preventive medicine and health policy studies.

Garfield did not invent or discover any of the underlying principles of Kaiser Permanente. His major contribution was figuring out how to put them together to make it all work. His vision and determination brought both dedicated support from his Kaiser

Permanente colleagues and fierce opposition from the medical establishment. By the time of his death, his work was widely acknowledged as a superior and eminently viable model of health care.

## CHAPTER 8: INTO THE 21<sup>ST</sup> CENTURY

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Histories of ongoing organizations must end somewhere, and 1990 is an appropriate place to close this history of Kaiser Permanente. Events since then deserve the broader context of time and perspective to fully appreciate and understand them. A number of specific and significant events, however, have occurred between 1990 and this writing that are worth noting briefly here.

Due to increasing industry competition and the recession of the early 1990s, Kaiser Permanente lost members for the first time in its history, in 1992 and 1993. Membership rebounded in 1994 and continued to expand through the 1990s. To support new growth areas, new hospitals and medical centers were opened in Santa Rosa, Vallejo, Fresno, Baldwin Park, Richmond, and Fremont.

In 1991, James Vohs retired and David M. Lawrence, MD, was selected Chairman and Chief Executive Officer of the Kaiser Foundation Health Plan and Hospitals. Lawrence had been both a Permanente and Health Plan executive since 1981, stepping into his new role from being Regional Manager of Northern California and, previously, Regional Manager of Colorado.

One major change in Health Plan management under Lawrence began during the 1990s: the movement and consolidation of responsibility and authority for the Health Plan and Hospitals from the regions to the Program Offices in Oakland. This enabled the Health Plan to bring a more cohesive approach both to Health Plan products, services, and strategy, and to shared organizational services such as human resources, finance, legal, and information technology.

In 1994, to meet industry competition, Kaiser Permanente established Kaiser Permanente Insurance Company (KPIC), an indemnity insurance company that provided state insurance-licensed

product capabilities to complement standard Kaiser Permanente HMO products and to better position Kaiser Permanente in the more competitive marketplace of the 1990s.

In 1996, the Kaiser Permanente Committee, which had become unwieldy with the addition of so many new regions, was discontinued. The Kaiser Permanente Program Group, a smaller group, was created in 1997 to take its place. This group now serves as the joint meeting forum for discussion of Program-wide strategies, policies, and processes, subject to approvals of the Boards of the Health Plan/Hospitals and the Medical Groups respectively.

Two major organizational changes occurred in the late 1990s. The first was the formation of The Permanente Federation in early 1997, with Jay Crosson, MD, selected as its first Executive Director. The Federation arrangement, with participation of all the regional Medical Groups, enabled the individual Medical Groups to retain primary autonomy and authority, while ceding certain areas of national responsibility to the Federation leadership for specific operational purposes.

Also in 1997 the new Labor Management Partnership (LMP) went into effect. For many years non-stop bargaining with over 25 unions had presented difficulties to both the Health Plan and the unions. An agreement to address the situation was negotiated in 1996-97 and was ratified by the Health Plan and Hospitals Board and by 8 international unions, 26 local unions, the AFL-CIO, and 62,000 Kaiser Permanente employees. Subsequently, the parties successfully concluded national negotiations in 2000, 2005, and 2010. Kaiser Permanente's LMP has been recognized as one of the largest and most successful in the United States.

In 2002, David Lawrence retired, and George Halvorson was named the fifth Chairman and CEO of Kaiser Foundation Health Plan and Hospitals – the first from outside the Kaiser Permanente community. Previously President and CEO of HealthPartners, an integrated HMO

in Minneapolis, Minnesota, Halvorson brought a well-established national reputation as a spokesperson for the reform of health care in the United States.

Another leadership change occurred in 2008, when Jay Crosson stepped down and Jack Cochran, MD, from the Colorado Permanente Medical Group, became the new Executive Director of The Permanente Federation.

No new hospitals had been built by Kaiser Permanente since 1995. But beginning in 2000, new or upgraded hospitals and medical centers were completed in Roseville, Santa Clara, Antioch, West Los Angeles, Sunnyside (Clackamas, OR, near Portland), Modesto, Orange County/Irvine, Panorama City, Moreno Valley, Roseville (Women and Children's Center), Downey, Vacaville, Los Angeles, Santa Rosa, Vallejo, Ontario Vineyard, and South Sacramento. Additional new or replacement facilities planned for the next few years include Westside (Portland), Fontana, Anaheim, Oakland, Hayward, and Redwood City.

More evidence of the growing stature of the Kaiser Permanente program was a study published in 2002 in the *British Medical Journal*: "Getting more for their dollar: a comparison of the NHS [National Health Service of Great Britain] with California's Kaiser Permanente." Kaiser Permanente was selected for this study because it was the only American health plan large enough and comparable enough to the NHS for a comparison. With a number of documented explanations, the authors concluded that Kaiser Permanente members experienced more comprehensive and convenient primary care services and more rapid access to specialist services and hospital admissions than the British National Health Service.

The Sidney R. Garfield Health Care Innovation Center, a large, warehouse-size facility, opened in 2006. The Garfield Center is a living laboratory space where ideas are tested and solutions are developed in hands-on, simulated clinical environments. The Center

contains, or can create, live nursing stations, patient rooms, clinical rooms, and other physical and technological environments.

In 1997, the Care Management Institute (CMI) was formed, with a focus on the broad implementation of documented medical care best practices for the improvement of quality of care and outcomes for Kaiser Permanente members.

The 2000s also brought new efforts on quality-of-care goals and programs, supported and encouraged by both the Medical Groups and the Health Plan and Hospitals. All regions of Kaiser Permanente now receive exceptionally high quality ratings, rankings, and awards annually from groups such as the National Committee on Quality Assurance (NCQA), the Healthcare Effectiveness Data and Information Set (HEDIS), the California Office of the Patient Advocate's Healthcare Quality Report Card, J. D. Power and Associates, the American Cancer Society, the American Diabetes Association, the American Heart Association, the Health Information and Management Systems Society, and many others.

Kaiser Permanente has always promoted the concept of "total health." Sidney Garfield's Total Health Care project of the 1980s was the first to emphasize it on a program level. The emphasis can be seen in a number of other programs initiated more recently.

The hugely successful Kaiser Permanente branding campaign, rolled out in 2004, emphasizes health rather than health care: "We stand for total health." Informally known as the "Thrive" campaign, it has served to better position Kaiser Permanente both in the public eye and in the increasingly competitive health care industry.

The Health Plan's "Total Health and Productivity" is a program offered by the Kaiser Permanente Health Plan through employers that includes products that reward employees who take the initiative to take care of themselves and improve their own health.

In 2007, to improve the image and quality of its hospitals and medical buildings, Kaiser Permanente's National Facilities Services began implementing its "Total Health Environment" for all new and remodeled facilities. Its emphasis was on creating more helpful, people-friendly environments that better support safe, quality care in innovative, cost-effective, and eco-conscious buildings.

One of George Halvorson's key goals as the new CEO was the implementation of an electronic medical record (EMR) system. KP HealthConnect, Kaiser Permanente's EMR system, now known as an electronic health record (EHR), began to be deployed throughout all Regions and facilities in 2004, replacing all existing Kaiser Permanente EMR systems. As of 2010, it was the largest non-governmental online medical record system in the world, containing health care data on all Kaiser Permanente members and making that data available to all Kaiser Permanente care providers.

Another computer-based success was the launch of My Health Manager, Kaiser Permanente's online Personal Health Record linked to KP HealthConnect. My Health Manager gives members the tools and health information to manage their health wherever they are, whenever is most convenient: "Real-time health care." By the end of 2010 more than 3 million members were using My Health Manager to e-mail their physicians, view test results, refill prescriptions, schedule appointments, and improve their health through online-supported programs.

Kaiser Permanente has long been a strong and vocal advocate of health care for all. The areas of charitable care and diversity demonstrate this. Beginning with its Charitable Care program in 1940, the Regions of Kaiser Permanente have continuously provided substantial amounts of local community benefit and support. In 2002, to better coordinate the many programs and spending, the Health Plan Board of Directors brought the regional efforts together under a single national Community Benefit Department.

Today, this department focuses on four core areas: care and coverage for low-income people, safety net partnerships, community health initiatives, and developing and disseminating knowledge. Altogether, the programs reach and serve over a half-million people each year, including basically free health coverage for over 100,000 people in difficult financial circumstances. By the end of the first decade of the 2000s, Kaiser Permanente had total annual community benefit expenditures of well over \$1 billion.

Likewise, Kaiser Permanente has a long and honorable history in the area of diversity, both for its staff and its members. From its start, Kaiser Permanente leadership allowed no discrimination in the delivery of care in its clinics and hospitals, and the Permanente physicians as well supported integration of their professional staffs. Kaiser Permanente has received numerous awards for its diverse workforce and the wide diversity of the population it serves.

The concern for health care for all is also evident in Kaiser Permanente's involvement in national health care reform. Kaiser Permanente supports three main principles for health care reform:

- Universal coverage through market reforms
- Delivery system reforms through payment reforms
- Community/public health and prevention reforms.

Kaiser Permanente maintains an active presence in health care reform efforts. Halvorson, Cochran, and other Kaiser Permanente leaders have been heavily involved in national health care reform, making presentations at Congressional committee hearings and appearances as keynote speakers, regular presenters, or attendees at major national and international health care conferences.

Kaiser Permanente has come a long way from its desert origins in 1933 and its organizational beginnings after World War II. Now one of the largest and most respected health care organizations in the world, Kaiser Permanente's wonderful and amazing history demonstrates its vision and values – and its story continues.

## AUTHOR'S COMMENTS

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In working on this short history of Kaiser Permanente, I have had access to a lot of historical material. I also had the privilege of talking with many current and past Kaiser Permanente leaders. But perhaps most rewarding is that the history has given me the time and opportunity to ponder Kaiser Permanente: what it is and why it works. I have come to believe that to really understand Kaiser Permanente, it is absolutely critical to understand and appreciate three very fundamental things.

First are the underlying principles of Kaiser Permanente health care: prepayment, group medical practice, integrated facilities, new economy of medicine, and voluntary enrollment. Together they form the model for health care that Kaiser Permanente has adhered to since its early years.

These core values have remained foundational to Kaiser Permanente. Kaiser Permanente's success as a model of prepaid group practice health care is fully and fundamentally based on these principles, and over its history the Kaiser Permanente leadership has time and again emphasized and defended them against those who would criticize Kaiser Permanente's ability to provide excellent care.

The second concept critical to Kaiser Permanente is the nature and structure of the working relationships between the Health Plan and the Medical Groups. Solving the issues of who's in charge, and who's in charge of what, took enormous energy and attention. It was initially addressed at the Tahoe Conference and worked out in detail through the Medical Service Agreements. Without the organizational, operational, and administrative frameworks in place, it would not be possible for Kaiser Permanente to live up to its core values for delivery of health care.

Organizationally, what these agreements laid out was a plan for cooperative management teams at all leadership levels, with parallel levels of leaders from both organizations, Health Plan/Hospitals and the Medical Groups, at the national, regional, service area, and hospital levels. No one group or leader would be dominant at any level; all levels are led on a cooperative basis.

What is so important to recognize and understand about this arrangement is that it is simultaneously very strong and very fragile, but ultimately it is fully acknowledged and accepted by all parties. While the principles above provide the foundation for medical care, it is the nature and structure of the working relationships that actually make Kaiser Permanente work.

The third thing is of a different type. It is this: The people who founded and led Kaiser Permanente had an absolutely strong and deep belief in the model of health care it represents. It was very important to the original leaders, both the physicians and the Kaiser Permanente executives, that they resolve critical issues and prove that the model could work. George Link, attorney and secretary of the sometimes contentious Tahoe Conference, summarized this well later in an oral history when he stated that "all of these people — and I say all of them — were men of good will. They *wanted* to make this thing work."

Our leaders since then have maintained and expressed similar feelings of belief in Kaiser Permanente. Their dedication is evidenced by the very wide recognition Kaiser Permanente has achieved for its promotion of health and its delivery of health care.

When Kaiser Permanente is at its best, there is no care delivery system in the world that is as good.

## SOME INTERESTING NOTES

- The site of Contractors General Hospital in the Mojave Desert is in the California Register of Historical Landmarks, no. 992, 1992.
- Fabiola: A wealthy Roman widow credited with founding the first Christian hospital in Western Europe, c. 380 AD. According to a letter from Saint Jerome, she established her hospital “to gather in the sick from the streets and to nurse the wretched sufferers, wasted with poverty and disease.” (Kaiser Permanente Medical Care Program Annual Report, 1966)
- Rosie the Riveter and Wanda the Welder were fictional characters devised to encourage recruitment of women for factory and other work during World War II.
- Kaiser Permanente was never a part of Kaiser Industries. It was developed and led completely outside the Kaiser Industries organization.
- The Henry J. Kaiser Family Foundation is not a part of Kaiser Permanente. It is a fully separate nonprofit, private operating foundation focusing on major health care issues facing the United States.
- The brand name of “Kaiser-Permanente” (including the hyphen) was used for the first time in 1968. The following year found the use of the phrase Kaiser-Permanente Program, and in 1971, the full phrase Kaiser-Permanente Medical Care Program (KPMCP) was first used in the Kaiser-Permanente annual report. It wasn’t until 1979, though, that the full Kaiser Permanente Medical Care Program name was used on the cover of the annual report, with the hyphen included in the name until 1984.

## MEMBERSHIP BY DECADE

|      |           |
|------|-----------|
| 1950 | 154,000   |
| 1960 | 806,644   |
| 1970 | 2,166,305 |
| 1980 | 3,921,772 |
| 1990 | 6,150,283 |
| 2000 | 8,072,357 |
| 2010 | 8,631,579 |



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- Kaiser Permanente Medical Care Oral History Project. Regional Oral History Office. University of California, Berkeley, CA.
- *Inside Kaiser Permanente: History*. Kaiser Permanente internal Web site. Timelines, narratives, pictorial history, history archive.
- And especially, the Kaiser Permanente Heritage Resources Group. The Ordway. Oakland, CA.