



## Permanente—Fifty Years Ago?

***The following three articles were published in the New England Journal of Medicine and California Medicine in 1952 and 1953. The points raised in these articles are not much different than what is discussed today about Kaiser Permanente. The major difference is that we have***

***more than 50 years of distinguished history, giving us much more credibility in today's medical community. I hope you find these two articles interesting reading. I would appreciate your comments.***

***– Scott Rasgon, MD, Section Editor***

### The Permanente Plan's First Ten Years

*N Engl J Med 1952;247:692-3*

With the cost of medical care rising progressively, with insurance plans such as Blue Cross and Blue Shield forced to increase their premiums while their benefits provide for decreasing proportions of the faster rising costs, and with less and less of the worker's income from wages or salaries available for savings, it is a question whether the supplying to considerable segments of the people of some form of prepayment plan for total medical care can be indefinitely postponed. It is therefore incumbent on the medical profession, as well as other interested parties, to continue to study carefully every apparently successful experiment designed to provide complete medical care of the highest quality to large groups of people at a cost that they can afford and that they can budget. One experiment deserving such scrutiny is the Permanente Plan.

In the Tenth Anniversary Issue of the *Permanente Foundation Medical Bulletin*,\* issued in August, 1952, Dr. Sidney R. Garfield traces the development and growth of the Permanente Plan in the Pacific Coast states. It was originally designed to meet the serious dearth of facilities and medical services in the San Francisco Bay area created by the mass dislocation of people into wartime shipbuilding. Actually, it evolved as the result of a decade of earlier attempts by a group of interested and farsighted persons to provide the best hospital and medical care to average workers at a cost that they could afford. According to its director, the plan, as it actually worked out, was the outstanding wartime medical service outside the armed forces; the list of its achievements seems to bear out that estimate.

At the end of the war in 1945, when shipbuilding was discontinued and the workers were dispersed throughout the country, the relatively few who remained served as a nucleus for the continuation of the plan on a community basis. Now, in 1952, the Permanente Plan serves 250,000 members in California, Oregon and Washington, as well as large numbers of patients who are not members. The acceptability of the plan and its popularity are fully attested by the fact that new facilities are now under construction that will provide for an increase in membership to 400,000.

The scheme was designed to eliminate the waste resulting from poorly planned facilities and from the ineffectual coordination both among the physicians themselves and between them and the institutions in which they worked. It was accomplished by a well coordinated group practice operating in well planned medical centers. It is a prepayment plan based on the insurance principle for the provision of a comprehensive medical service. The fee for service was abolished, but all the prepaid funds have been going to physicians and hospitals. It has therefore provided the greatest incentive and laid the foundation for the genuine practice of preventive medicine by making the healthy person an asset and the sick person a liability.

Details of the plan are worthy of study, for, although Dr. Garfield's presentation might be interpreted as being tinged with enthusiasm and self-interest, the facts of its accomplishment are impressive. It has also been a financial success. In the 10 years since the plan was established and while it was developing, participating physicians and professional personnel have been paid \$23,500,000, and over \$10,000,000 has been paid to non-professional personnel and \$1,500,000 to outside physicians and professional people.

The organization consists of the following parts: a foundation that is a charitable trust providing facilities and funds for teaching, training, research and charity; a health plan that enrolls members, collects funds and apportions them among the hospitals, medical groups and administration; hospitals that are nonprofit corporations operating medical centers; and medical groups of independent physicians organized in partnerships, each covering a regional service area. The incomes of the doctors in these groups compare favorably with those of physicians in private practice in the same area.

In closing his report Dr. Garfield makes the following statement of the future and of the aspirations of the Permanente Plan:

We are striving to prove (1) that high quality medical care and hospital service can be rendered to the people at a cost which they can afford; (2) that this can be done to the benefit of all parties concerned—the people, the physicians, the hospitals; (3) last and not least, to prove that all this can be done by *private enterprise* without necessity for government intervention ...

... The great interest displayed by doctors, labor, government and the people in the "Permanente idea" encourages us to believe that the accolade of "mission accomplished" cannot be too far off. The workers at Permanente feel that new horizons are opening up for the coming decade...

... The lifting of barriers to the financing of facilities, as demonstrated by the projected new construction, cannot help but make an impressive demonstration to the physicians and hospitals of the country. The excellence of these new facilities, their innovations, the quality of work being performed, the educational and research programs developed will add in no small measure to pyramiding evidence of worth and soundness.

Certainly, this plan is worthy of careful study by physicians throughout the country as one type of program that may not only erect further defenses against the encroachment of socialized medicine but actually provide more and better medical service, at lower cost, and at the same time maintain the dignity of both doctor and patient.

## Regarding The Permanente Plan

*N Engl J Med* 1953; 248:743-4

A letter published elsewhere in this issue of the *Journal* from Dr. Charles G. Gayden, executive director of Massachusetts Medical Service, calls attention to an editorial in *California Medicine* for January, 1953, written in reply to the editorial "The Permanente Plan's First Ten Years," which appeared in these columns on October 30, 1952. Dr. Hayden suggests the reprinting in full of the *California* article, but since it is long and space is at a premium an attempt will be made instead to present its salient features.

First, however, it may be desirable to reproduce for the reader's convenience those parts of the *Journal's* editorial of last October on which the writer in *California Medicine* seems to place the greatest emphasis:

With the cost of medical care rising progressively, with insurance plans such as Blue Cross and Blue Shield forced to increase their premiums while their benefits provide for decreasing proportions of the faster rising costs, and with less and less of the worker's income from wages or salaries available for savings, it is a question whether the supplying to considerable segments of the people of some form of prepayment plan for total medical care can be indefinitely postponed. It is therefore incumbent on the medical profession, as well as other interested parties, to continue to study carefully every apparently successful experiment designed to provide complete medical care of the highest quality to large groups of people at a cost that they can afford and that they can budget. One experiment deserving such scrutiny is the Permanente Plan.

After a condensed history of the plan, taken from the report of its director, Dr. Sidney R. Garfield, published in the Tenth Anniversary Issue of the *Permanente Foundation Medical Bulletin*, the *Journal* goes on to say:

Details of the plan are worthy of study, for, although Dr. Garfield's presentation might be interpreted as being tinged with enthusiasm and self-interest, the facts of its accomplishment are impressive. It has also been a financial success. In the ten years since the plan was established and while it was developing, participating physicians and professional personnel have been paid \$23,500,000, and over \$10,000,000 has been paid to non-professional personnel and \$1,500,000 to outside physicians and professional people.

After Dr. Garfield's description of the present working of the plan, the *Journal's* editorial closes as follows:

Certainly this plan is worthy of careful study by physicians throughout the country as one type of program that may not only erect further defenses against the encroachment of socialized medicine but actually provide more and better medical service, at lower cost, and at the same time maintain the dignity of both doctor and patient.

The comments of *California Medicine* in reference to the *Journal's* editorial are in part as follows:

In California we have long carried out the "careful study" of closed-panel plans which the editorialist recommends. We have had the advantage of direct observation, so that our conclusions need not be based wholly upon a report of the medical director of such a plan, which the *New England Journal of Medicine* admits "might be interpreted as being tinged with enthusiasm and self-interest..."

Our study shows closed-panel plans destroy the doctor-patient relationship. This destruction begins with the plan salesman, who must convince the prospective buyer it is to his advantage to break his relation with his personal physician. This is necessary because these plans offer no provision for indemnification of the patient who prefers his own doctor to the plan doctors ...

Another destroyer of the doctor-patient relationship is the rapid turnover of Permanente doctors, according to *California Medicine*, which finds also that closed-panel plans rob the patient of his freedom; important, too, in illustrating the unfair competition represented by such plans is the statement that Permanente doctors solicit their patients whereas doctors outside the plan may not do so.

Revealing, too, is the following quotation from *California Medicine's* editorial:

And now, specifically as to Permanente. Who and what is Permanente? In California, when we have difficulty with Permanente, we start with the doctor or doctors then acting as medical directors and end up talking to Mr. Henry Kaiser. We have no technical proof that Permanente is the practice of medicine by a layman. But we inevitably end up talking to—or, more accurately, being talked to and often threatened by—Mr. Kaiser. Our medically trained minds cannot follow Permanente's intricate intercorporate entanglements, rental arrangements, partnership, interorganizational contracts and pooled personnel and purchasing arrangements. But we know that what Mr. Kaiser says will happen in Permanente usually happens.

Here, then, in our opinion, is the pattern for lay practice, control and direction of a profession. We need not argue the public interest factors in this condition. They have long since been decided and repeatedly reaffirmed by the courts. How many profit-minded laymen will see in the "Permanente idea" the opportunity to "reverse the usual economics of medicine" for themselves? And what will they do with it? Whom will they exploit? And to whom will they be answerable?

There is always risk of creating misunderstanding in lifting passages from their context and using them as representative of the intent of their writer. In this case, however, the attempt has been made to present, in limited space, *California Medicine's* greatest objections to the Permanente Plan.

The *New England Journal of Medicine* holds no brief for the Permanente Plan, which, despite its name, may be thoroughly



discredited ten years from now, nor has it the slightest inclination to quarrel with *California Medicine* for opposing it. It continues to advocate the open-minded study of any plan of medical practice that may contribute the greatest good to the greatest number of persons and permit the equitable distribution of medical care to advance in as straight lines as possible. This, it may be hoped, is the long-term view held by all physicians, despite their concern over the defects that may be apparent in

any immediate situation. And in this way, by the gradual improvement and extension of voluntary plans, the socialization of medicine may be avoided.

The statement in *California Medicine* that the *Journal's* editorial "cites closed-panel medical plans in general, and the 'Permanente idea' in particular as 'worthy of careful study by physicians ...'" remains unclear, since closed-panel medical plans in general were not mentioned.

### A Defense Against Socialized Medicine?

*California Med 1953;78:66-7*

A recent editorial in the *New England Journal of Medicine* cites closed panel medical plans in general, and the "Permanente idea" in particular, as "worthy of careful study by physicians throughout the country as one type of program that may not only erect further defenses against the encroachment of socialized medicine, but actually provide more and better medical service, at lower cost, and at the same time maintain the dignity of both doctor and patient."

In California, we have long carried out the "careful study" of closed panel plans which the editorialist recommends. We have had the advantage of direct observation, so that our conclusions need not be based wholly upon a report of the medical director of such a plan, which the *New England Journal* admits "might be interpreted as being tinged with enthusiasm and self-interest..."

Our study shows closed-panel plans destroy the doctor-patient relationship. This destruction begins with the plan salesman, who must convince the prospective buyer it is to his advantage to break his relations with his personal physician. This is necessary because these plans offer no provision for indemnification of the patient who prefers his own doctor to the plan doctors. Then, having become a member of the plan, the patient finds many barriers to the establishment of the desired personal physician-patient relationship. We have just received a letter from a patient which is only a variation on the familiar theme. She went to the plan doctor in her area, who sent her to the nearest Permanente plant (Oakland) to complete spontaneous abortion. There her treatment was handled by three successive doctors, none of whom she saw more than once. So, she will drop the plan, she says, and return to her personal physician, who will see her through any illness.

Another destroyer of the doctor-patient relationship is the turnover of Permanente doctors. There are at least 35 former Permanente doctors now in private practice in the East Bay area alone. What percentage went elsewhere, we do not know. This parade of doctors into and out of a closed-panel plan in itself precludes sufficient continuity to establish and maintain the kind of relationship between doctor and patient necessary to the total medical care needs of the whole patient.

We find also that closed panel plans rob the patient of his freedom. He may not dismiss his plan physician and select another of his choice outside the plan without loss of protection for which he has paid. Under the Permanente plan, for the same reason, he cannot change hospitals. The subscriber contracts today for whatever quality of service may be available from the plan at an indeterminate future date—the date of his future illness. And he is

"stuck" with whatever quality of service is then given to him. The patient thus becomes the captive of the plan. One California closed-panel plan recently changed ownership; its patients were "bought and sold." The subscriber who is dissatisfied with the service, or who at the time he is ill would feel confidence only in a physician who is not a captive of the plan, does have a choice. He may take the unsatisfactory service, or he may write off his health plan dues as an ill-advised investment and pay the total cost of his care to the doctor of his choice. Many choose the latter.

A dangerous element in closed panel plans will be immediately obvious to every student of the force of incentive in human relations. This is a particularly important factor when incentive concerns a contract for a service that is so difficult of evaluation and measurement as medical care.

The *Permanente Foundation Medical Bulletin*, cited by the *New England* editorialist, talks about incentive thus: "...This results in a reversal of the usual economics of medicine. The well person becomes an asset to the hospital and doctor—the sick person a liability, thus heralding the preventive medicine of the future." The preventive medicine of Permanente so far is truly for the future; we have found no evidence of present achievement. But we agree that the closed-panel plan makes the sick person a liability to both hospital and doctor. The incentive, then, is to withhold treatment, to use short cuts, or to cheapen it, which is the reverse of the incentive of the doctor in private practice.

The only kind of medical economics that guarantees protection of the patient's interests is that which gives incentive to the doctor to prescribe and treat as much as the patient needs. Few people—even doctors—forever violate their own interests.

And now, specifically as to Permanente. Who and what *is* Permanente? In California, when we have difficulty with Permanente, we start with the doctor or doctors then acting as medical directors and end up talking to Mr. Henry Kaiser. We have no technical proof that Permanente is the practice of medicine by a layman. But we inevitably end up talking to—or, more accurately, being talked to and often threatened by—Mr. Kaiser. Our medically trained minds cannot follow Permanente's intricate intercorporate entanglements, rental arrangements, partnerships, interorganizational contracts and pooled personnel and purchasing arrangements. But we know that what Mr. Kaiser says will happen in Permanente usually happens.

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Typical of the mechanistic "efficiency," of the unprofessional approach of Permanente to medicine, is its solicitation of patients. We assume it is unnecessary to quote or interpret the Principles of Medical Ethics of the American Medical Association to our readers. Patients in every group sold by Permanente are solicited, with the full knowledge of "Permanente" but not with the full knowledge of all of the *doctors* of Permanente. Many members of these employed groups are currently under the treatment of other doctors. Our studies of Permanente reveal that either the ethical prohibition of solicitation of patients by any doctor is wrong, or all Permanente doctors are unprofessional and unethical. Doctors outside Permanente may not solicit patients; Permanente doctors solicit their patients.

Much is made of the financial success of Permanente. Captive doctors, seeing and treating many patients, is one reason. Interns and residents treat some—how many we do not know. Another reason for financial success is that many subscribers who enroll do so reluctantly, as minority members of employed groups. These persons continue to go to their private physicians, keeping Permanente insurance in the background for catastrophes. It is difficult to find a private physician in the East Bay "stronghold" of Permanente who does not have Permanente plan members who continue—even for major operations—with their personal physicians. Each such visit, each such treatment paid for by the patient, is a contribution to Permanente's spectacular financial success.

If the values of the art and science of medicine can be measured by an industrialist's standards of production and efficiency and profit, Permanente is an unqualified success. But medicine has other standards.

The Boston editorialist believes that closed panel plans may provide "more and better medical care." It has not yet been produced by these plans. "Lower cost"? Yes, in premium. "Maintain the dignity of doctor and patient"? Former Permanente doctors have regained their dignity in private practice and lose no opportunity to dispute that claim.

As to the patient's dignity: the closed-panel plan tells him he can't select his own doctor. Permanente can do it better, despite its doctor turn-over record. The patient is assigned to a doctor, is told by the plan what treatment he gets, by whom and where. He is *not* free to exercise his own judgment and choice. Can this maintain his dignity?

Our confidence in the good judgment of the American people is such that we are not deeply concerned about the future of closed-panel plans. The "Permanente idea" is *not* new. The history of nearly every medical society will reveal the same problem under the name of "Lodge practice," with inevitably the same result as we predict for the closed-panel plan. The people will make the final determination. Our studies show they want their personal physicians, whose incentive is to serve them and not some third party—union leader, government agency, lodge master or industrialist.

So, we too would join the *New England Journal of Medicine* in counseling study of closed-panel plans. The more thinking and study, the more experience doctors and patients have with closed-panel plans, the more each will realize that it is pointless to "erect further defenses against the encroachment of socialized medicine" if those defenses consist mainly of instituting the worst dangers of socialized medicine. ❖