By Francis J. Crosson, MD

Permanente Medicine: The Path to a Sustainable Future

Introduction

From time to time—and especially in difficult times—any organization finds it important to take an objective appraisal of its condition: its strengths and weaknesses, its progress in realizing its aspirations, its adaptability to changing circumstances, and its ability to sustain itself. The challenges that Kaiser Permanente (KP) faces today—a financial crisis, a troubled partnership between the Kaiser Foundation Health Plan/Hospitals (KFHP/H) and the Permanente Medical Groups, and a hostile external environment—make such an assessment timely.

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Meeting New Challenges

In fact, the problems we confront today may be as daunting as any we have faced in the last half-century. Not surprisingly, people in our organization are beginning to feel fear, anger, frustration, and even desperation about how to get through the next few years and ensure a secure future for our Program and for our members.

Fortunately, as physicians, we all know what to do when things seem to be getting out of hand. In critical clinical situations, for instance, we fall back on the old mnemonic, ABC: airway, breathing, and circulation. We go to the basics—the fundamentals. I think we need to do that today, too. I think of the same mnemonic—ABC—but I would translate it differently: A would stand for Appreciation of what's happening all around us—the internal and external forces in today's health care environment; B, for Belief in who we are and what we have created—this culture of Permanente that we have built and the practice model we call "Permanente Medicine"; and finally, C, for Commitment to work together as a community of 10,000 Permanente physicians carrying Permanente medicine into the next century as our best hope for long-term sustainability and success.

Let us begin at the beginning by taking a look at some of those internal and external forces we must respond to.

Revenues

The major influence on our revenue has been the power of large purchasers such as the Pacific Business Group on Health (PBGH) and the Health Care Financing Administration (HCFA). In 1995 and 1996, PBGH negotiated premium reductions (9.5% in 1995 and 4.3% in 1996); in 1997, premiums were held steady. In 1998, the increase was only 1%. Nationally, KP's mean rates—already tending to be on the low side—decreased almost 6% in 1995, about 5% in 1996, about 1% in 1997, and began moving back up in 1998, with a 2% increase (Fig. 1). Similar reductions are being made in governmental programs: Although premiums in our Medicare risk program increased about 5% annually between 1990 and 1997, the 1997 Balanced Budget Act reduces those Medicare increases to about 2% annually for the indefinite future.

Competition

Meanwhile, our competitors may be fewer but are also stronger. In 1990, in California, we faced 17 disorganized HMO competitors; by 1996, they had consolidated into just four powerful HMOs.

The future will bring even greater challenges. The pharmaceutical industry, with its vast capital resources, is likely to move into the broader health care market. The telecommunications industry and the banking industry are both considering the prospect of moving into the health care field, which represents one-seventh of the national economy. We might soon see huge conglomerations of disparate industries joining with medical groups to create formidable national competitors. Imagine, for instance, a joint venture health care organization made up of a Microsoft, Schwab, Nations Bank, and a medical group!

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Health Care Costs

Medical inflation is being driven upward by factors that are largely beyond our control, especially the aging of the population, the increasing costs of pharmaceutical agents, and the adoption of new technology. By the year 2000, the leading edge of the huge "baby boom" generation will have reached its mid-50s, and—as we well know—a direct correlation exists between the age of the population and the cost of the health care it requires. Measures such as inpatient hospital days show steep increases from about age 55 on (Fig. 2).

The extent to which technology drives health care costs upward is harder to quantify, because some technologies also decrease costs. However, a 1998 review of the literature on the subject in the journal *Medical Care Research and Review* concluded that "[t]he preponderance of evidence suggests that the development, adoption and diffusion of medical technology are responsible for a large part of the increase in inflation-adjusted health care costs."[1:282] At least one study indicates that technology may account for as much as 70% of overall medical cost inflation.[2]

Prescription drugs have also become a major factor behind medical cost inflation. The HCFA has projected a rise in total drug expenditures from just over $60

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billion in 1996 to about $165 billion in 2007 (Fig. 2). Much of that increase is being driven by direct-to-consumer drug advertising, which increased from about $100 million spent in 1990 to more than $1 billion spent in 1998 (Fig. 3). We all see the effects of this in our practices: an increasing number of patients ask for drugs that may in fact be inappropriate, provide no added value, and are exceptionally expensive.

Anti-HMO Sentiment

No matter how different we believe we are from the rest of the managed care industry, the anti-HMO sentiment that has swept the country has attached to KP along with every other HMO. This negative sentiment can and has created damage to our reputation; it has diverted our energy and attention; and it has lowered morale among our caregivers and our members. For politicians, this phenomenon has become a *cause du jour* that has led to a growing list of counterproductive laws and other governmental mandates that contribute to more costly health care without in any way improving its quality or accessibility.

Ultimately, "HMO-bashing" in the political arena could lead to fundamental, industrywide legislative changes that could radically alter the basis of employer-provided, prepaid group health care.

Rise of Individual Consumer

We are also witnessing a substantial, accelerating shift in health care purchasing from large employer groups to individual consumers—a shift that results from a change in job-based, defined-benefit health coverage to defined-contribution plans that give employees a limited amount of dollars with which to purchase their own health care. By requiring individual consumers to pay more for their health care, this arrangement—which, incidentally, is supported by the American Medical Association—could undermine the economic basis for group comprehensive coverage and could ultimately restrict access to high-quality health care, causing more Americans to be uninsured and dependent on the fragile health care safety net.

Besides these external forces, some important internal issues are also influencing our future. Perhaps the most important of these influences are the status of our partnership with KFHP/H, the financial condition of KP, and the implications of KP's national strategy, the KP Promise.

Partnership Issues

The history of Permanente's relations with our Health Plan partner over the past decade has not been entirely positive. In fact, most of the 1990s saw a dissolution of trust between Permanente and Health Plan at a national level (and in some cases, at a local level). The problem began to be remedied in 1997 with the creation of The Permanente Federation, which enabled creation of a renewed National Part-

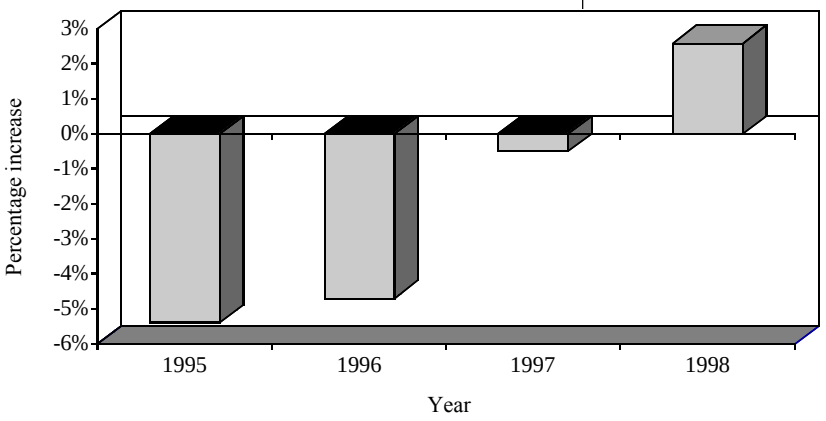

Fig. 1. Percentage increase in KP rates 1995-1998.

Fig. 2. Number of inpatient hospital days per 1000 U.S. population, by years of age.

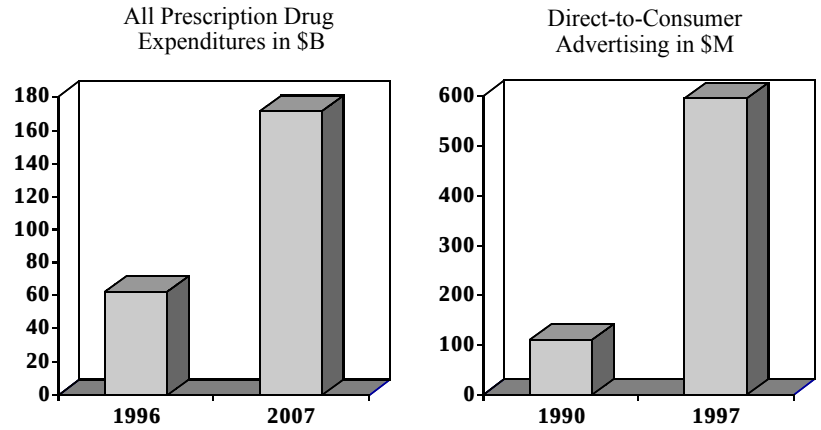

Fig. 3. Factors contributing to increase in drug costs.

nership Agreement that has reestablished the principle of mutual exclusivity between the Health Plan and the Medical Groups. The National Partnership Agreement also established the KP Partnership Group, a joint body at the national level, to determine KP's national strategy for the future.

Financial Crossroads

Despite recent improvements in the structure of the partnership, we have seen deterioration of our ability to produce sufficient net income to fund the capital projects required for a successful future. In the mid-1990s, KP was generating revenues of about $600 to $800 million a year, but in 1995, that amount fell to about $500 million; by 1997, we had lost almost $270 million, and we will have lost about as much in 1998 as well. Those losses are critical because our capital expenditure needs—the funds we need to finance our information technology infrastructure, new facilities, and other requirements—will be about $2 billion dollars a year. In addition to depreciation, therefore, we will need to generate about $200 to $500 million in net income each year just to keep the organization financially stable and to make the appropriate technological investments needed to care for our patients.

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In fact, decisions about capital spending are only one aspect of a complex matrix of decisions that the organization must make. These decisions must be made both nationally and locally, and they must be made cooperatively between the Health Plan and its Permanente partner—whether individual Medical Group or The Permanente Federation. The future of the organization depends on how we resolve the question of exactly where these decisions get made—nationally or locally, and by the Health Plan or Permanente.

This past fall, a process for developing a "roadmap" for the future got underway at the national level between the Health Plan leaders and the leaders of Permanente. We call this plan the "Path to Recovery, 2001," and it is intended to help resolve the question of how the necessary decisions about our future are made. A preliminary agreement (Memorandum of Understanding) was signed on January 7, 1999 by Drs. Crosson and Lawrence.

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The KP Promise

In addition, we are striving to shape our own future through a jointly developed national strategy known as the KP Promise, a strategy which fundamentally defines what kind of organization we want to be in the future. For all of us, this strategy has three important implications. First, it shifts the focus in the health care value equation from simply providing low-cost, quality health care to providing a high level of service that still remains competitive and affordable. That focus will be the basis for our competitive future. Second, fulfilling the KP Promise will depend in part on developing state-of-the-art clinical information technology. And third, fulfilling the KP Promise will depend on our ability to maintain and strengthen the unique delivery system that we call Permanente Medicine.

Defining Permanente Medicine

We might best define Permanente Medicine as consisting of structural principles (the principles underlying the structure of our organization) and performance principles (the principles underlying our performance in delivering health care). Let's look at each briefly.

The structural principles underlying our organization consist of group responsibility, self-governance, and self-management.

Group responsibility.

As Permanente physicians, each of us has a professional responsibility to each patient, one at a time. That responsibility is the Hippocratic tradition. As Permanente Medical Group physicians, however, we add to that responsibility an additional element: accountability to an entire group of members for quality of care, service, and appropriate use of the resources which those members have entrusted to us.

Self-Governance.

We manage this dual responsibility through self-governance, which means we conduct our internal affairs through a democratic process of representative, elected group leadership and decision-making, with due process and fairness to all.

Self-Management.

The self-governance process allows us to self-manage the delivery of health care: Unlike many of our HMO competitors, when any Permanente physician decides how to treat an individual patient, that physician makes that decision on the basis of his or her best judgment and without being required to go through a Health Plan approval process. This independence preserves professionalism and is a hallmark of Permanente Medicine.

Added to these structural principles are three performance principles underlying our organization: high-quality medical care, a partner relationship between KP and our patients, and sound management of KP resources.

High-Quality Medicine.

First and foremost, Permanente Medicine can be accurately characterized as evidence-based, up-to-date, integrated between hospital care and outpa-

tient care, preventive, and based on the latest research generated both within KP and outside.

Permanente/Patient Relationship.

Permanente Medicine also emphasizes the doctor's or health team's relationship with the patient—a relationship based on partnership in managing the patient's care, a promise of lifetime continuity of care by specialists and primary care providers, and the promise of culturally appropriate care.

Resource Management.

Finally, Permanente Medicine emphasizes appropriate resource management, because affordability of health care is one of the most important factors that we as physicians must preserve for our members. We therefore must run our offices efficiently and manage our use of hospital beds, referrals and claims, and pharmacy resources in a manner that delivers high-quality care to patients but does not waste members' resources.

Facing Our Weaknesses

Why do we think these principles constitute the basis for a sustainable future? Because, simply, they represent the delivery model that can manage the cost and quality of health care better than any other model.

"But if we're so great, how come we're not rich?" you may ask. Perhaps the reason is that we do have some important weaknesses, and the Permanente side of KP must address those weaknesses.

First, we are very capital-intensive because of our integrated structure (ie, we own many of our own hospitals and other facilities). Second, the cost of primary care is high in some parts of the Program. And third, many parts of the Program have had problems with service performance as perceived by our members.

Conclusions

Can we solve these problems while preserving what it means to practice Permanente Medicine?

I think we can. To address our high cost structure, we must redesign primary care to deliver consistent, high-quality care and service, and every Medical Group is already working on that redesign. We can also address these problems through the use of information technology that allows us to construct decision-support systems for Best Practices: practices that produce the best clinical outcomes at the lowest costs. As members become increasingly able to use the Internet, we must leverage that technology to deliver member service and to reduce the cost of collecting and transferring information to and from members. We also must improve the personal communication skills that we use with members—the art-of-medicine skills that are so important to members' satisfaction when they leave the doctor's office.

In fact, from the member's perspective, our task is really pretty simple: We ought to answer the phone, meet members' needs, and treat them with dignity and empathy. That's it. If we do those three things, it hardly matters what else we do; we will be successful. If we fail to do those three things, however, it will not matter what else we do; we will not be successful.

Of course, we must do other things too. We must maintain affordability, which will necessitate our understanding how to build Medical Groups that are based on less expensive capital demands and delivery models. We also must properly do our basic business (eg, improving our contracting and referral processes). We must compensate ourselves effectively and ethically, for which we must understand how to use salary and incentive payments to encourage appropriate practices without compromising our professional ethics. We must also hold ourselves mutually accountable for our performance; we simply cannot have any Permanente physicians or Medical Groups that cannot perform adequately in terms of efficiency and quality of care and service.

I think back more than half a century ago, when Dr. Sidney Garfield and a handful of other visionaries built the foundations of what we now call Permanente Medicine out of the social chaos and economic dislocation of the Depression and World War II. As Permanente Medicine moved from the "fringes" to the "mainstream" and then to a leadership position in American health care, this brand of medical practice has served us, our members, and the entire country by using an ethical approach to high-quality, physician-directed, affordable health care.

In the current period of rapid and uncertain change and discontinuity, we have a similar opportunity to influence the future and to ensure our own sustainability. We can exert this influence by adapting and refining those time-tested principles of Permanente Medicine to carry them into a new era. ❖

This article was adapted from Dr. Crosson's keynote address to the Inter-Regional Medical Directors Conference on Oct. 5 in Los Angeles.

References

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