

Kaiser Permanente revisited – Can European health care systems learn?

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Summary: European health care systems are facing the challenge of macroeconomic constraints and a rise in patients with chronic conditions demanding a continuum of services. The US managed care organisation, Kaiser Permanente, has been highlighted as a successful model of integrated, cost effective care. This claim has been disputed, but the evidence base to guide European policymakers and health system planners is limited. This article presents an overview of the organisational structure and developments within Kaiser Permanente to inform this debate. Research initiatives that are still needed to critically investigate the usefulness of the Kaiser Permanente model for Europe are discussed.

Keywords: Integrated health care delivery, Self Care, Disease Management, Chronic Conditions, USA

In recent years the US managed care organisation Kaiser Permanente (KP) has started to influence mindsets and policy development within many European health care systems. Delegations from twenty-six countries, including thirteen from Europe have visited the organisation.¹ The reason for this interest is that KP has been highlighted as a successful model of integrated cost effective care.²⁻⁴ In their influential article in the British Medical Journal (BMJ), Feachem *et al.* compared the costs and performance of the English NHS with those of KP in California. They concluded that KP provided much better value, largely by using only one third of the acute bed days used in the NHS. This was explained by better integration throughout the system, efficient management of hospital use, the benefits

of competition and greater investment in information technology.²

Taken at face value, the benefits of the KP model are substantial. However, the claim was subsequently disputed and several serious criticisms were levelled at the methods used.^{5,6} Seventy-five letters were sent to the BMJ.⁷ Forty-six tried to dismantle the authors' analysis, while twenty-seven letters supported the paper, but many added that the superiority of KP could be explained by the extra resources at its disposal.⁷ To investigate further Ham *et al.* carried out a more detailed study of the KP model.³ Their findings were again in favour of KP, with much lower hospital admission rates and overall length of stay than the NHS. Existing studies therefore indicate that there are important lessons to be learned from the KP model; the evidence base, however, is not conclusive.

To inform ongoing policy debate and facilitate competent learning processes, this

paper presents an overview of the organisational structure of Kaiser Permanente Northern California (KPNC), recent developments within the system, and highlights points of interest for European health care systems. Finally, we briefly discuss the necessity for research initiatives that critically investigate the usefulness and transferability of the KP model to Europe. This is done in recognition of the need for high level policy making to be based on evidence instead of convincing rhetoric and supposition.

The Kaiser Permanente health care model

KP is an integrated managed care organisation founded in 1945 by the industrialist Henry J Kaiser and the physician Sidney R Garfield. It operates in the USA where health care is largely provided by a mix of private insurance companies, as well as through government programmes

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* Medicaid is the United States health care programme for individuals and families with low incomes and resources.

** Medicare is a health insurance programme administered by the United States government, covering people who are either aged 65 and over, or who meet other special criteria.

including Medicaid* and Medicare**. Thus KP operates in a competitive market across eight regional areas and is the largest not-for-profit managed care organisation in the United States, with 8.2 million members.⁸

Structure of KPNC

There has been a particular focus in debate on the KPNC, the largest of the eight regional entities.

This is a consortium of three separate but interdependent groups: the Kaiser Foundation Health Plan and Kaiser Foundation Hospitals are integrated with independent physician group practices called Permanente Medical Groups. The health plan is the insurance component of the organisation, while the hospitals and medical groups provide all clinical services.⁷ To the public these hospitals and general practitioner type facilities are seen as one organisation, commonly referred to as Kaiser.

Integrated patient pathways

Within KPNC a range of health services are provided, including hospital admissions, ambulatory, preventive, sub-acute, accident and emergency care, as well as optometry, rehabilitation and home health care. Coverage provided by KPNC depends on an individual's chosen health plan, ranging from low coverage health plans with relatively high co-payments to plans providing extensive coverage but minimal co-payments.^{2,9} Some European health care systems cover dental services and both long term psychiatric or nursing care to a greater extent than KPNC.

“there is a strong emphasis on primary care and preventive services, including screening programmes”

A typical patient in need of primary care will in the KPNC be treated and cared for solely within an out-patient medical centre. The medical centre will have a range of primary care facilities available, including paediatricians, internal medicine physicians, geriatricians, other specialists, nurse practitioners, nurses, health educators, administrative personnel, a pharmacy and an emergency department. Physicians also have access to in-house

Table 1. Financial structure of Kaiser Permanente

Source of finance	Member dues (71%) Medicare (22.3%) Co-payments, deductibles, fees and other (6.7%)
Financial intermediary	Kaiser Foundation Health Plan between purchaser and provider
Service provision	Not-for-profit Kaiser Foundation Hospital For-profit Permanente Medical Groups
Low income and unemployed	3.5% of Kaiser members are from California's Medicaid programme Medi-Cal Kaiser provides care to uninsured people who account for 5% of admissions to the community hospitals Medicare members can choose to obtain health care from KP
Payment of physicians	Physicians are paid a salary, including 5%–10% in financial incentives
Payment of hospitals	Contracting with the Kaiser Foundation Health Plan

Sources: Feachem RG, Sekhri NK, White KL²; Kaiser Permanente¹¹

laboratory facilities and other advanced medical equipment.

Patients can be admitted to hospital where necessary. Subsequent care and some rehabilitation will be administered outside the hospital at a skilled nursing facility (SNIF). KPNC enters into contracts with these independent SNIFs. Integrated patient pathways are facilitated by a team based approach and by multi speciality medical centres. Information exchange across providers is made possible by the operational electronic health record 'KP Health-Connect'. This also allows for multiple patient panel management and two-way patient contact.⁸ Furthermore, KP Health Connect has been an important driver in quality improvement by creating competition between providers inside KPNC through the benchmarking of performance outcomes.

Financial resources

The financial structure of KPNC sets the framework for the integrated delivery of care. The health plan and hospitals operate under state and federal not-for-profit tax status, while the medical groups operate as for-profit partnerships or professional corporations in their respective regions.¹⁰

In 2004 member dues accounted for 71% of KP revenues, with Medicare making up

a further 22.3% and co-payment, deductibles, fees and other revenues 6.7%.¹¹ These are paid to the Kaiser Foundation Health Plan which contracts with the for-profit Permanente Medical Groups and the Kaiser Foundation Hospitals that run medical centres in California, Oregon and Hawaii and outpatient facilities throughout KP regions. Table 1 provides an overview of the financial structure of Kaiser Permanente, NC.

Focus on primary care and disease management

Due to its history of being a support facility for an industrial production line, the KP system focused on keeping workers healthy and treating the early signs of ill health. Its prepaid, fixed budget design aroused fierce opposition from county, state, and national medical societies. Consequently, Kaiser doctors were barred from existing facilities, thus KP had to build its own hospitals, this becoming a self-contained delivery system with its own full-time doctors, nurses, and other staff.

KP has continued to recruit clinicians who value prevention, provide a whole systems approach to health care and embrace team-based treatment.⁴ This is reflected within the organisation by a strong emphasis on primary care and preventive services,

Box 1: Research to assess the transferability of the Kaiser Permanente approach

Cross country comparisons are important as a driver for change but highly complex to undertake. An initiative is now underway to disseminate the results of empirical work comparing the Danish health care system with that of Kaiser Permanente Northern California.

The initiative has been established by an international research network involving both Danish and US researchers. The network is assessing the general transferability of the KP model and focuses in particular on chronic care management, self management support programmes and care coordination strategies. Findings will be broadly disseminated to policy makers and health system planners.

The research initiative is funded by the Rockwool Foundation.

including screening programmes for a range of diseases. The electronic health record in KP supports this preventive approach, making it possible to reach out to patients due for follow-up examinations. These, for instance, might include individuals having difficulty in managing their conditions, as well as those overdue for a mammogram, cholesterol check or Pap smear. This outreach work is undertaken by Medical Assistants that contact KP members using the telephone or secure messaging (confidential email).

During recent decades KP has also implemented Disease Management (DM) programmes for coronary artery disease, heart failure, diabetes and asthma. DM programmes include clinical guidelines, patient self-management education, disease registries, proactive outreach, reminders, multidisciplinary care teams and performance feedback to providers. The components are integrated in a comprehensive effort to help clinicians plan and deliver care to help patients play an active and informed role in caring for themselves.¹² To strengthen quality and the ongoing development and implementation of evidence based clinical guidelines, KP established the Care Management Institute (CMI) in 1998.

Another initiative to ensure high quality cost-effective care is risk stratification of patients with chronic conditions, along three levels according to the severity of their disease. The philosophy behind these DM programmes is that they will result in

both higher quality and lower cost treatment of chronic conditions.

This idea that DM programmes can reduce health care costs by improving quality has been called into question. An investigation in KPNC revealed that actual cost savings were elusive but that the programme might have sizable potential savings, since costs might increase at a greater rate without the use of DM programmes. The continuous use of this approach to the treatment of chronic conditions thus requires that organisational structures have the political will and capital to invest in DM programmes even though it might take many years for the benefits of these programmes to be realised.¹²

“increased investment alone will not provide health services that are most beneficial to the overall health of the European population”

Conclusion

One key message from the ongoing debate over KP is that policymakers, health system planners and medical practitioners are increasingly realising that increased investment alone will not provide health services that are most beneficial to the overall health of the European population. Fundamental changes in the way that services are organised and managed will also be necessary, as will be a shift in the balance of priorities between primary and specialised hospital care.

To direct policy efforts and assist health system planners in the potential reorganisation of European health systems, we need to strengthen the evidence base through detailed research comparing KP and similar organisations with the broad spectrum of European health care systems. Such research may enlighten us as to whether the KP approach is efficient compared to existing European practices. One example of such comparative work is presented in Box 1. Data sources and techniques for such comparative studies must be refined; more in depth analysis of the potential to transfer selected programmes and system elements to different European settings must be encouraged.

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