Cite this article as:
David M. Lawrence
Perspective: Quality Lessons For Public Policy: A Health Plan's View
Health Affairs 16, no.3 (1997):72-76
doi: 10.1377/hlthaff.16.3.72

The online version of this article, along with updated information and services, is available at:
http://content.healthaffairs.org/content/16/3/72.citation

For Reprints, Links & Permissions: http://content.healthaffairs.org/1340_reprints.php

Email Alertings: http://content.healthaffairs.org/subscriptions/etoc.dtl

To Subscribe: https://fulfillment.healthaffairs.org

Not for commercial use or unauthorized distribution
Consumer trust is driven by many factors. Two important ones are how well health care organizations manage quality and the direction and shape of public policy.

The lessons learned by Kaiser Permanente and similar health plans over the past fifty years hold important public policy lessons. They can guide public policymakers seeking to create a climate that enables and encourages—in fact, requires—competitive health plans and health care delivery organizations to improve quality.

Perhaps our most profound lesson is that constructing an environment focused on quality requires a complex set of interactions that fit together like an elaborate jigsaw puzzle. The absence of even a single piece leaves a hole that spoils the big picture. We at Kaiser Permanente have come to understand that the key to creating a quality-focused environment is continued improvement and learning over the long term. There is no end point.

Lessons from our experience in seven areas have particular relevance to a public policy direction that supports the management of quality.

Patient-Driven Care

**Observations.** Physicians and patients, engaging in open and comprehensive discussion about the available science and technology, must jointly determine the type, amount, and setting of care. This shared responsibility moves away from the provider-centered (some would say paternalistic) model of care, which has dominated medicine for decades.

Involving the patient in clinical decision making is, in fact, a critical component of quality improvement efforts. In Colorado, Kaiser Permanente has been successful in involving patients in decision making as a demonstration project for outcomes-based research conducted by John Wennberg.¹ Using an interactive videodisc, the project educates patients on the clinical and lifestyle advantages and disadvantages of two options for treatment of mild to moderate symptoms of prostate disease: prostate surgery or “watchful waiting.” Patients are given the information they need to decide which treatment is best for them.

**Public policy implications.** The doctor/patient decision-making process must be unequivocally protected from the interference of insurers, health plans, and government. Health care organizations should be encouraged to find effective ways to incorporate consumer perspectives in clinical care policy and guideline development, and they need to design ethical processes to support the integrity of clinical and care delivery decisions in difficult end-of-life and heroic-care situations.

Care Coordination

**Observations.** Patients with chronic diseases or serious or life-threatening illnesses may require a variety of specialists and resources. When these are coordinated for the benefit of the patient, both patient satisfaction and clinical outcomes can improve, and

David Lawrence is chief executive officer and chairman of the boards of the Kaiser Foundation Health Plan, Inc., and Kaiser Foundation Hospitals.
resources can be used more effectively.

The only way to deal effectively with the diverse needs of an enrolled population is by coordinating the activities of physicians, other clinicians, and support personnel. This approach has enabled Kaiser Permanente to develop highly successful, personalized treatment and management plans for children with asthma, which include medical evaluation and follow-up, intensive health education for children and their parents, appropriate medications, and use of devices such as peak flow meters. These young persons learn to understand, predict, and control their disease and thus have fewer emergency room visits and hospitalizations due to asthma. These reductions decrease the cost of asthma care, and patients are better served, healthier, and happier.

Public policy implications. Public policy actions should support the coordination of care and oppose activities that erode or discourage it. For example, “any-willing-provider” legislation, which requires health plans to contract with any provider who expresses interest or with all licensed categories of providers, is antithetical to care coordination. Such regulations impair the ability of a health care organization to organize services effectively for the benefit of patients and enrolled populations.

Building And Preserving The Culture Of Medicine

Observations. The delivery of superior care requires an organization of physicians that focuses on consistent care improvement, discovery, and professional renewal. The organization must enable physicians to coordinate the care of patients and discover new and innovative ways to meet patients’ needs.

Physicians must be entrusted with making clinical decisions and managing their professional lives. Leadership of physicians must come from physicians. Patient care must ultimately be the responsibility of health care professionals with both the training and legal responsibility for ensuring appropriate care.

Self-governance can take many forms, from independent medical groups to self-employment contracts. The critical issues are: Who makes clinical decisions—the physician or other clinicians or agencies outside the examination room? And who manages the professionals—the professionals themselves, the contractor, or the institution? Regardless of the form of governance, the relationship between the health plan and physicians must be one of partnership, in which each entity understands and facilitates the other’s accountabilities and expertise, all in the service of health plan members or patients.

Public policy implications. Public policy must ensure that the goal of independent clinical decision making is preserved in all health plan and delivery system arrangements. Physicians’ ability to advocate for their patients and communicate to them all pertinent information on treatment options must be fully protected. We must avoid policy that restricts the ability of health plans and physicians to develop meaningful partnerships or that structures those partnerships in an inflexible way.

Individual And Organizational Learning

Observations. The greatest challenge we face is finding effective models that achieve significant reductions in clinical variation while improving quality overall. Such models should permit physicians and other professionals to review science and their collective experiences, incorporate those findings into their own practices, and improve steadily through constant performance assessment.

Protocols and guidelines developed by “experts” and appropriately structured incentives are necessary but insufficient. We must
be cautious in our reliance on expert systems, as our understanding of what works when and for whom evolves continuously through experience and experimentation. We also must be moderate in our approach to incentives because physicians are largely self-disciplining, the “right” thing is a moving target, and the link between incentives and quality behaviors is tenuous at best.

Deepening our understanding of science and testing alternative incentives are the easy parts. Creating the culture, the support, and the motivation that continuously promote learning and improvement is more difficult.

**Public policy implications.**
Public policy should support research that improves our understanding of evidence-based medicine. Efforts by physician groups to develop and disseminate “best practices” should be supported. Although there is more we need to know to better care for patients and populations, the primary challenge is to change behavior among health care professionals, especially physicians. Publicly funded efforts to build stronger science are appropriate to this task; forcing clinicians to practice according to mandated guidelines or protocols is not. Such mandates freeze improvements in the care delivery process and restrict patient/physician treatment options.

**Research and Information**

**Observations.** Quality depends on information—about patients, the populations served, the care given, the choices a clinician must make, outcomes, processes of care, and costs. Information can be in the form of satisfaction surveys, demographic data, outcomes tracking, and clinical research. Research in all of these areas must be an integral part of the health care delivery system, not just an adjunct to it. Focusing research on the concerns of the members and communities that health plans serve creates a process that results in wide-reaching improvements in quality of care and a better understanding of community and population needs.

A clinical example of Kaiser Permanente’s efforts to improve the health of the broader community is its support for investigation of vaginal birth after cesarean section (VBAC). The growing incidence of cesarean sections in the 1980s was a point of concern for patients, payers, physicians, and policymakers. Physicians were reluctant to recommend VBAC, despite previous studies indicating the procedure’s safety. Kaiser Permanente investigator Bruce Flamm and others built on this previous research. They examined—and demonstrated—the safety of VBAC in several large-scale studies.

This information had a significant effect on the clinical practice of obstetrics nationally. The rate of VBAC rose from 2.2 percent in 1970 to 20.4 percent in 1990, after the findings of the first study were reported. By 1993 the rate had increased to 25.4 percent. Thus, tens of thousands of women each year are able to avoid unnecessary surgery and possible complications that cesarean section entails.

**Public policy implications.** Public policy should focus on supporting the investments required to build the information systems to support and further quality improvement. Public support for research and development in the creation of public databases may be appropriate, and public policy efforts should be directed to integrating the different measurement and accountability standards springing up throughout the health care industry. In addition, nonprofit integrated health plans should be encouraged to support clinical and health services research.

**Incentives**

**Observations.** At Kaiser Permanente, we believe in creating incentives that link payment to outcomes. For health plan executives, we...
do this by using Health Plan Employer Data and Information Set (HEDIS) measures and National Committee for Quality Assurance (NCQA) accreditation as part of their performance evaluation. Some of the Permanente medical groups have adopted a similar philosophy but may use other measures.

We reject incentives that reward physicians for constraining resources or for meeting specific hospital utilization targets because this diverts them from the primary goals of managing quality. For the same reasons, we believe that capitation payment to individual or small groups of physicians should not occur in the absence of significant safeguards to protect patients.

**Public policy implications.** Public policy should support physician incentive arrangements that link payment to outcomes and explicit measures of quality, such as HEDIS. It should put limits on payment systems that encourage individual physicians to alter their clinical decisions in response to utilization or financial targets.

We believe that incentives that encourage patients and families to take advantage of and appropriately use all of the services available to them are also important to quality. Financial barriers to access, while they may present the illusion of controlling short-term costs, are unethical and inappropriate. They can delay needed care and cause harm to patients. The final irony is that such policies eventually result in increased long-term costs for the health plans that use them, which cancels out any short-term benefit.

**Accountability**

**Observations.** We at Kaiser Permanente strongly believe in holding each other accountable for quality within the organization. The Kaiser Permanente Health Plan holds the Permanente medical groups accountable, whose physicians in turn hold each other accountable.

A key component of this level of accountability is the generation and dissemination of meaningful, comparative health plan performance data. Kaiser Permanente has been a leader in public disclosure of this kind of information. Public information projects in which we have participated include HEDIS coalition initiatives in California, northeast Texas, and New England; the NCQA report-card project; the Pacific Business Group on Health’s (PBGH’s) health plan performance measurement initiative; direct public release of HEDIS and other performance data to purchasers, members, and consumers; and Health Pages evaluations in Colorado and southern California. In northern California, quality analysts used HEDIS as a starting point, rather than an end point, and developed their own “report card,” which exceeds HEDIS in detail and rigor of measurement.\(^6\) Kaiser Permanente also has begun a dialogue with providers and consumer organizations regarding appropriate standards for health plans. Our initial effort was an agreement with the American College of Emergency Physicians on the coverage of emergency care.\(^7\)

**Public policy implications.** Public policy should build upon the efforts of the NCQA and other accrediting organizations in their development of standards and measures for improvement, quality, and satisfaction. It is important to bring together the perspectives of consumers, payers, providers, and health plans in developing a system of accountability that measures performance, encourages quality improvement, and increases the ability of consumers and purchasers to make well-informed health care choices. Similarly, public policy should support nonprofit health care organizations that assume accountability in agreed-upon areas of public concern, such as access, education, and research.

**Conclusion**

Quality ties into everything we do as a health care organization—providing care, reducing costs, achieving optimal outcomes, and meeting our members’ needs. As an industry, we require strong, clearly defined public policy to support our quality initiatives. Crafted wisely, such policy can create an environment...
that will not just require, but actively stimulate and inspire, organizations to emphasize and target quality in all of their efforts, which will lead to better outcomes, more satisfied members, and lower long-term costs.

NOTES


