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Cite this article as:
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doi: 10.1377/hlthaff.21.1.39

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Interview

Integrating Care: A Talk With Kaiser Permanente’s David Lawrence

How Kaiser continues, after nearly sixty years, to lead the way toward team-based, integrated delivery of health care.

by Jeff Goldsmith

State Of The Managed Care Industry

Goldsmith: Managed care is supposed to be “over,” and yet the Kaiser Permanente system continues to grow. What’s wrong with this picture?

Lawrence: What is over is the effort to invade medical care delivery by the payers, which was doomed from the start. The amazing thing to me is the speed with which those companies that called themselves managed care companies have retreated. They probably moved more quickly than the Taliban leaving Kabul. I think that the idea of using economic leverage as a means to change health care delivery was really a doomed strategy. There was a period in the mid-1990s of moderate prices or flat prices. But after that we saw a reemergence of the physician power base coupled with the consumer backlash. As the physicians fanned that backlash, it forced the insurers into a retreat. They moved back to the classic indemnity-like products. Some are still selling an insurance product called HMO (health maintenance organization), but that’s basically a set of comprehensive benefits and restricted access.

What’s interesting is that the organizations that had joined financing and delivery in their genetic code—like Kaiser Permanente ourselves and a few others—have been wrestling with how one organizes integrated care delivery for as long as we’ve been around. And we didn’t stray very far from that. We had some bad experiments during the 1990s. But we’ve essentially stayed with the same model for forty years, and it’s worked for us.

Goldsmith: A lot of organizations tried to create integrated enterprises and failed spectacularly during the past ten years. What went wrong?

Lawrence: Yes, many tried to emulate us in the 1980s; in the 1990s not so many. Aetna tried with their own delivery system, Prudential tried with their own delivery system, and CIGNA tried one, too.

Goldsmith: What about the large hospital systems?

Lawrence: Hospital systems tried as well. But the balance of power was different for them than it was in some of the older integrated systems. When hospitals tried to get into this effort, a power struggle erupted over who was going to control the delivery system. Hospitals were in the delivery business, as were physicians. And we know from Paul Starr’s book (The Social Transformation of American Medicine, 1982) and others that that’s been a battleground all through the twentieth century. It was unlikely that the hospitals could win.

Hospitals ended up not dealing with some of the basic things that have to happen for an integrated system to work right. Take, for ex-
ample, organized medical groups. There weren’t any to speak of. We haven’t seen much change in the number of doctors who are operating in organized medical groups over the past quarter-century. I think that the numbers show that some 80–85 percent of physicians are practicing either alone or in groups of fewer than ten. One of the things the hospitals missed in their efforts was the need to invest heavily in building the physicians’ organizational capacity into groups. Most didn’t do that.

Goldsmith: Was it possible, given the culture and politics of their medical staffs?

Lawrence: Well, if you go back to the way physicians were trained, with such a heavy emphasis on professional autonomy, the answer is that it’s not possible, or at least it’s extremely difficult. We benefit from the fact that physicians who come to us (and to Mayo and the rest of the “big seven”) seek to work in groups, so there’s a selection process at work. But the bulk of physicians continue to be trained as autonomous professionals, trained to mistrust others and to rely on their own judgment. Most of them know, all through medical school and training, that they’re going to go into independent practice.

Goldsmith: So Kaiser and Mayo and the others still very much represent a counterculture in medicine?

Lawrence: I think they do. You see very little change at the margin in the way in which physicians carry out their medical care work. You’ve seen them organizing into economic groups to try to create some sort of power balance against the insurers, like IPAs (independent practice associations). But they’ve moved with great timidity into the core of what they do: how they actually take care of patients. That has moved at glacial speed, while all around them, consumers are changing, the science and technology are changing, the disease burden is changing. And the gulf between what doctors can deliver and the promise and capabilities of medicine continues to widen.

**Paying By Capitation**

Goldsmith: The real leverage in the Jackson Hole model of managed care–based health reform was to be achieved by abandoning fee-for-service payment in favor of capitation. Kaiser remained with a salaried physician model. Was capitation as an idea doomed from the beginning?

Lawrence: I think so. When you have no medical group organization, no memory, no data, no skills, and you have an inherent distrust in the people who have given you the information that you need to run your business, how in the world are you going to manage risk?

Goldsmith: Good question.

Lawrence: This was especially problematic for independent physician entrepreneurs or even small groups of doctors who came together for economic reasons. It’s a very sophisticated form of payment to manage. Then try to translate that capitation payment on a population basis into an equitable pay system for physicians who have been almost genetically trained to think in terms of “the harder I work and the more patients I see, the more money I get.” No wonder people ran into trouble.

**The Promise Of Technology**

Goldsmith: Is the technological promise of an ubiquitous electronic medical record going to change that equation? Is the ability to identify patterns of care and to feed back to physicians what they’re doing, what works, and what it costs going to be enough to make it possible to move toward paying physicians in some form other than fee-for-service?

Lawrence: Frankly, I don’t see it happening any time soon. It is moving so slowly. The first building block for physicians in solo or small-group practice is practice management. To that you start appending simple clinical tools, such as online disease and pharmacy registries. Then, eventually, you move to ubiquitous electronic medical records. In a closed system like Kaiser Permanente, we’re struggling to roll out a sophisticated clinical infor-
tion system that covers all ten thousand of our physicians and other clinicians. It’s going to take us four years and $1.5 billion. So I just don’t see it happening to the rest of the medical profession very quickly. Our new system forces doctors to change the way they take care of patients—things as fundamental as the choreography in an exam room, where the computer is now a third party.

**Goldsmith:** A lot of health care executives simply assume that the workflow and cultural changes will come when they install a clinical information system.

**Lawrence:** The old saw, that culture eats strategy for lunch every day, certainly applies here.

**Goldsmith:** I thought it was breakfast.

**Lawrence:** Breakfast. Well, we get up late in California. We just have coffee.

**Goldsmith:** It seems to me there is tremendous momentum behind replacing the paper medical record and the paper bill as the core information architecture of medical care delivery, whether it takes four years or ten years. Don’t we have a different health system when we have eliminated those?

**Lawrence:** I think so. Let’s take it way down to the micro level. A physician in private practice or in a small group would no longer have to hire three or four additional people to handle billing and referrals. All of the phone calls, paperwork, and faxes add up to enormous overhead. If you can eliminate that, you start creating opportunities for real-time electronic communication between physicians. Then the fantasy of the virtual group begins to assume some reality. I think it’s a misguided notion that we’re going to create physical, proximate groups of physicians out of all those private practitioners.

The autonomous professional model begin to act differently after a year or two. They’re more comfortable asking for help. As silly as it might sound, in medicine that’s a huge step.

In addition to the cultural changes, the potential for savings—from a quality and a variation management point of view, and from a safety point of view—are enormous. The question is, How do you get in front of that curve so you can start the investment cycle to capture some of those savings? That remains a conundrum for us.

**Consumers And The Internet**

**Goldsmith:** How about the loop to the patient? In addition to the $1.5 billion that Kaiser is spending on electronic medical record conversion, you invested a significant sum of money in building a Web portal for your subscribers.

**Lawrence:** Well, let’s take a step back. I can give you a kind of post-hoc rationale for it. As consumers try to navigate through this maze we call the medical care system, their frustration level is high. So they’re seeking other solutions. One of the fastest-growing niches in medical care is “laboratory” testing done by patients at home or in “point-of-care” ambulatory settings. However, 70 percent of the information that’s generated in this testing never reaches the medical record. And it’s lost to clinicians. Consumers’ attitudes about access, timeliness, and information control have been altered by technological advances and changes in many other sectors, such as interactive finance, banking, and airline reservations. Medicine is way behind. And the bridge between consumers and the medical care system is changing dramatically.

**Goldsmith:** Is it a bridge at all? Isn’t the reason why that information never reaches the medical record that the patient does not want to share the information with the care system?

**Lawrence:** Absolutely.

**Goldsmith:** I recently heard a talk by Alan...
Westin, who studies consumer attitudes toward personal privacy. Westin describes people who are privacy fundamentalists—they don't trust any institution to manage their personal information. About a quarter of Americans, according to his surveys, are privacy fundamentalists, except about medical information, where 45 percent are! Isn't there a barrier of mistrust that prevents the bridge to consumers from being built in the first place? How do we regain their trust?

**Lawrence:** I think this happens in incremental ways. What we're trying to build with KP Online is a kind of bridge. As it happens, most information moves one way: from the plan to the member. We are trying to respond with administrative information, clinical information, lab information, and pharmacy information, including prescription refills, and clinical chatrooms—an opportunity to talk with a doctor, who actually spends time on the Internet now instead of the office. What we don't demand is a lot of consumer information that they may be hoarding on their own. What we're actually doing is increasing consumers' capacity to take care of themselves and answer their own questions. So what we've seen is a decrease in the frequency of medical center visits by those patients who regularly use KP Online.

**Goldsmith:** What percentage of your 8.2 million subscribers have access to KP Online?

**Lawrence:** I think we have in the range of 500,000 to 750,000 members using KP Online right now. We are in the middle of a technology conversion so we can ramp up more rapidly and handle a larger number of people using KP Online.

**Goldsmith:** Where are they located?

**Lawrence:** They're mainly out here in the West. But we have server capacity all over the country. The bigger users are here on the West Coast, particularly in California. Our intent is that as we're rolling out the electronic clinical support capability for our physicians, we're rolling out KP Online in parallel. Our goal in the next three years is to provide all members with access to KP Online.

### Connecting Medical Records

**Goldsmith:** Many people think that the holy grail in all of this connectivity will be seamless integration between the voice contact, the patient visit contact reflected in the medical record, and the electronic contact. What's your sense of how long that's going to take, or if it's even a realistic vision?

**Lawrence:** I think it's the right vision. We're well on the way. All of what we're talking in connectivity connects to the medical record, and we already have a single medical record for each patient. When we have the clinical information system fully up and running, we'll have a unique medical record for each member of Kaiser Permanente. Whether you get your care in the mid-Atlantic or Portland or Honolulu, it will be the same medical record. That information will move seamlessly. Now, in our call centers, using computer-enabled record information, we can plug in the information from the calls and actually have it become part of the medical record.

**Goldsmith:** The toughest area to change in the community hospital is the “blood-brain” barrier between the physician's record and the hospital's record.

**Lawrence:** Even more fundamental than that is the barrier between physician A's medical record and physician B's medical record, when they don't even talk to each other. It's like the situation that existed before Frederick Taylor did the industrial work for Henry Ford in setting up the first production systems. In conventional medical care, the units of production don't relate to each other. People imagine that there's someone managing this whole production enterprise, but is there?

**Goldsmith:** Sure somebody is managing it. It's the patient and his or her family. And a lot of the frustration you talked about earlier comes from the fact that patients and families are doing this without leverage, without decision support, without legitimacy.

**Lawrence:** That's right. And, people wonder why consumers are so damn angry.
Mending The ‘Broken Chassis’

Goldsmith: You spoke eloquently in your Picker Institute “broken chassis” paper about the idea that our medical care system is broken and is failing to leverage the marvelous medical technology we have. How much has Kaiser’s “chassis” changed? It’s a nearly sixty-year-old chassis. Was this just a vision so far ahead of its time that now the rest of the world is catching up? Has Kaiser succeeded in meeting the requirements that you suggested in this paper the broader American health care system has not?

Lawrence: Well, one of the things that continues to startle me is how different the care is that people can get in the Kaiser Permanente system and the care that they get outside. I think we have quite a lead in integration of care over what most Americans get. For a while it seemed that the gap might be closing. National hospital utilization rates, which in the 1990s began to approximate what we and Mayo and other integrated systems achieved, have begun to rise again, as the controls that the insurers have been placing on physician and hospital practices begin to loosen or disappear altogether. So I would dispute the supposition that the gap has closed. I continue to be stunned with how resistant to change the medical care delivery system is.

Now, the other part of your question is, What have we done? In the past decade, enormous changes have taken place inside Kaiser Permanente’s chassis. A friend of mine, Mark Goldberg (the physician who brought me into Kaiser Permanente in Portland in 1981), said that a Permanente Medical Group was the largest collection of solo practices under a single roof in the world. Throughout the 1990s we began to pay much more attention to how one constructs an integrated care delivery capability that is truly team-based. Throughout the Kaiser program, experiments are under way to create the primary care team of the future—physicians, nurse practitioners, nurses, educators—and how that team incorporates specialty care such as asthma care, diabetes care, and renal dialysis.

Evidence Of Improvement

Goldsmith: How much evidence is there that Kaiser makes fewer mistakes than the disorganized delivery system we talked about a moment ago? If there is that much of a difference in “chassis,” there ought to be strong, objective evidence that you’re doing a better job. Is there?

Lawrence: Steve Shortell has a study coming out in which he looked at the performance of medical groups around the country against the standards of evidence-based guidelines for care of six to ten chronic illnesses. As reported to me by Steve, the Permanente Medical Groups tend to perform at the top—at worst, we tie with other medical groups. Typically we were one and a half to two times more likely to be using the standards of evidence in care of diabetes and other chronic diseases.

Goldsmith: What about things like medication errors, postoperative mortality rates, readmission rates, or infection rates?

Lawrence: Our levels tend to be very low compared with the industry standard. But remember, much of those data are of questionable reliability. We don’t have the reporting systems. Nobody really does. We’re in the process of building a reporting system on medical errors very similar to what the VA uses, so we will have some baseline data. We don’t have that now. What we do know is that the work we’ve done to implement best practices in patient safety appears to be among the best in the country. We really want others to look to our system, along with the VA and a couple of others, to see how you do it. We have incentives built in to the managerial groups for safety. We have no broad objective evidence around safety, though, except in regional pockets. For example, with our patients in the Colorado region who are on anticoagulation treatment, an objective study found that compared with other sys-
tems, Kaiser has the largest number of patients who remained within the therapeutic range on heparin treatment and had the fewest complications or sequelae being reported in the U.S. medical literature.

Goldsmith: Is there a system of internal benchmarking within Kaiser, based on best practices, where the Permanente Medical Groups are comparing their performance with each other?

Lawrence: Yes.

Goldsmith: How robust is that?

Lawrence: Well, the best we have right now is the Care Management Institute, which was founded in 1997. Paul Wallace, who’s head of the institute, has actually gone about selecting diseases with high frequency or major morbidity and mortality. This institute has systematically developed the evidence base from what the current science suggests about how we should be taking care of patients with six major chronic diseases: acute myocardial infarction (MI), depression, asthma, diabetes, congestive heart failure, and back pain.

The key to this was not developing the evidence base—which is scientifically difficult. Rather, it was how do you get doctors to comply? We spend about seventy cents of every dollar we invest in the institute on dissemination. We’ve done a lot of work trying to figure out what dissemination models make the most sense with physicians. Our physicians want to be shown why following the guidelines results in improved outcomes. Most of us want doctors like that—we don’t want a doctor who is a sheep.

What we’ve seen each year, which is really quite exciting for us, is a growing proportion of physicians, not just in a single locale but across all medical groups, moving toward compliance with evidence-based standards. We’re getting levels of compliance that no one else is reporting. And we’re also showing that we can move in that direction in a systematic way, in a way that has befuddled most medical care organizations. Along with this, we’re building decision support tools into the clinical information system so that it becomes easiest to practice medicine the way the science supports.

Physician Groups And The Culture Of Medicine

Goldsmith: Certainly one major challenge that your successor will face is the relationship to the Permanente Medical Groups. When I first encountered Kaiser, someone explained to me that the Medical Groups were more like labor unions than like businesses, in that they functioned more like interest groups in battling for resources and for control over work rules. Is that a fair characterization? Have they moved more in the direction of being businesses during your tenure at Kaiser?

Lawrence: That’s a very good question. I think they have moved to a better balance than what I observed in the late 1980s. Having come up through the Permanente Medical Groups, I saw a tremendous amount of protection built into the Medical Group—“this is my territory, don’t mess with it!”—which, by the way, happened to include the way I took care of patients. I think we’ve broken down many of those barriers. So yes, the Medical Groups still are protecting the interests of the physicians, and yes, they negotiate with management over how much money they’re going to get and the conditions of employment, and in this way they act like a union.

But they also are professional organizations. They have explicitly set standards of performance. They have explicitly adopted standards of evidence-based care. They have not been willing to be economically more at risk. So in that sense, they’re not full business partners. They would argue, though, that their risk is the ultimate risk: If they don’t perform well as a group, there is no place for them to go organizationally.

Goldsmith: They clearly made contributions to controlling expenses during your recent financial crisis.

Lawrence: Well, they did, through managing quality and practice variations.

Goldsmith: And by increasing their work week, if I remember correctly.

Lawrence: Productivity improved in several places, quite markedly. So, it’s not a fair characterization to say they are a union per se. It is
fair to say that some elements of what they do are unionlike, but other elements are more like professional services. So it’s a hybrid. I see that balance being more productive today than it was ten years ago.

**Goldsmith:** How many of your 10,000 physicians view Kaiser as an enterprise in which they are participants as opposed to a support structure for their practices?

**Lawrence:** I would say that the vast majority of physicians in our program view Kaiser Permanente as a region that is the center of their world, which happens to be attached, unwillingly or uncomfortably, to a bunch of other regions and, oh, by the way, to a corporate structure. Generally, physicians’ awareness of the enterprise called Kaiser Permanente is somewhat vague. The big change that we’ve tried to make at Kaiser is to create that sense of an enterprise. Over the past decade we have put in place a whole list of things—like the Care Management Institute and our IT strategy—that were intended to redraw the balance, not to take over local initiative and local control. Some things, medical care delivery being one of them, have to be organized locally. Every professional services organization has learned that painful lesson. On the other hand, the financing and insurance function has become a national business. It was a mom-and-pop business until the late 1980s and early 1990s, when the insurance business became highly concentrated.

**Goldsmith:** You have said how hard it is to change an atomized medical community. Is it all that much easier to change physicians that are part of a collective enterprise like Kaiser?

**Lawrence:** One challenge is like climbing K2, the other, climbing Mt. Everest. They are both tough, cold, hard, uphill climbs. And a lot of people die along the way.

**Goldsmith:** K2 is a lot harder.

**Lawrence:** That’s right. That’s exactly the way they were organized. Now, what’s happened is that the medical groups have ceded authority to the Permanente Federation for a defined set of decisions. Where I told the medical directors that I would no longer deal with them as a collective, because they had no way to implement a collective decision. I was certainly not going to waste my time in conversations where they would agree at one level and then go back into their fiefdoms and do whatever they wanted.

**Goldsmith:** They changed their charter?

**Lawrence:** Yes. They actually got the approval of physicians to do this. Part of the reason was that they realized that some set of decisions needed to be debated and resolved at the national level. That’s a huge change that emerged in 1997 or 1998, out of the financial and relationship crisis that was occurring. Now every other week, a dialogue goes on about the strategy that we need to pursue, about the places we’re going to put our capital, how we’re going to move this forward as an enterprise. It’s a very different conversation of changing physician behavior in any system as easy. The old joke still stands. You know, “What do you get when you put a physician in a closet by himself?” The answer is, “An argument.” And it is true. We’re trained that way. But those who hire us want that kind of attitude. I don’t want to go to a surgeon who’s a Milquetoast intellectually. So no, it’s not easy.

But I think that our physician organization today is a much stronger organization. We have different conversations about what needs to happen for the good of the patient and for the good of medical care than we did ten years ago. Ten years ago we had one conversation in Southern California, another in Northern California, and yet another in the Northwest. It finally reached the point in the mid-1990s where I told the medical directors that I would no longer deal with them as a collective, because they had no way to implement a collective decision. I was certainly not going to waste my time in conversations where they would agree at one level and then go back into their fiefdoms and do whatever they wanted.

**Goldsmith:** But they were elected representatives of their physician constituents. How else were they supposed to behave?

**Lawrence:** That’s right. That’s exactly the way they were organized. Now, what’s happened is that the medical groups have ceded authority to the Permanente Federation for a defined set of decisions.

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“*We believe that through retraining and redeployment, we can capture the savings that occur as we improve quality and safety.*"
now than it was even five years ago.

**Goldsmith:** But weren't there different people involved then?

**Lawrence:** Yes, but I don't think you can attribute it only to that. I really think that there has been an institutional change. An articulate, capable person—Jay Crosson—is now in charge of the Permanente Federation. He works at the pleasure of the medical directors in the federation. He has done a marvelous job at striking a balance that works for the medical groups. But is this where I'd like to see it? No. Because I still think we take too long to make our decisions about how we act as an enterprise. I still think we argue over many of the wrong things. But when I compare it to where we were ten years ago, it's remarkable.

Ten years ago, when we were making national decisions, it was thirty-eight people sitting around the table three times a year—the Kaiser Permanente Committee. It was a great debating society.

### Weathering Financial Crises

**Goldsmith:** You've alluded to the 1997–98 financial crisis. Aren't we going to experience a renewal of that crisis here in about eighteen months, when employers start saying "no" to double-digit premium increases?

**Lawrence:** Yes.

**Goldsmith:** Well, what are you going to do then?

**Lawrence:** We're trying to establish a cost structure that is sustainable across a much more modest set of rate increases. We know what we need to go forward in terms of margins. We know what we need to do in terms of capital expense for information technology. We know what we have to do to rebuild the hospital stock for earthquake compliance, about adding new outpatient facilities, and so forth. It's a large number.

**Goldsmith:** More than $10 billion?

**Lawrence:** Probably, and to generate the margin required to finance those expenses takes extraordinary effort. The other thing is that in a time of substantial uncertainty, we also need more cash reserves to be able to balance our way through these things.

**Goldsmith:** Have you ever generated a billion dollars in operating margin in a single year?

**Lawrence:** No. I think the closest we've been is somewhere around $750 million.

**Goldsmith:** So, the capital requirements are more than ten times the maximum annual operating earnings by the organization.

**Lawrence:** I think that's about right. First of all, you don't do it all at once. You obviously spread the costs over a period of time. And you borrow for it.

**Goldsmith:** You've been extremely conservative on debt. You have, what, a billion dollars in debt on $18 billion in revenues?

**Lawrence:** Yes. It's very low. Since the 1997–98 financial crisis, we've rebuilt cash, we've rebuilt margins, and so enhanced our borrowing capability.

**Goldsmith:** But that is clearly going to come to an end. We've talked about how very difficult it is to achieve change on the clinical practice side. What we haven't talked about is that you've also committed to a partnership at the national level with the labor unions that goes all the way down to the level of local units. It seems as if you have limited flexibility on the cost side.

**Lawrence:** We were making some substantial headway in the 1994–96 period on the cost structure. We were taking costs out of the system. We actually had a real decrease, about a half-percent, in our underlying cost structure in 1996 over 1995. That came from a systematic look at ways to reduce variation. We're making a conscious effort to move to a different level of performance for this chassis: team-based, integrated, much more consistent ways of doing things based on the evidence. We believe that there is a significant amount of room in our cost structure to improve based on these further reductions in variation and improvements in quality and safety.

**Goldsmith:** But, of course, you don't get to capture those reductions unless you reduce staff.

**Lawrence:** Well, unless we don't add staff as we grow our membership.

**Goldsmith:** So growth is really important!

**Lawrence:** It's quite important to us. Not
only for that reason, but also because if you're not growing, you're basically getting an aging member pool while you're trying to get the costs down. So it's quite important to us that we continue to grow, but not at too rapid of a rate, which is what happened in the 1997–98 period. We believe—and this is what we've worked through with the unions—that through retraining and redeployment and continuing to be careful about how we add staff as we grow, we can actually capture the savings that occur as we work to improve quality and safety. That's our basic core approach. If we can't do that, we're in serious trouble. We are just like everybody else concerning cost pressures, except that we offer a more comprehensive schedule of benefits. That's on the good side. The down side is we probably are less productive in some ways than what goes on elsewhere. But we are trying to do something else: to establish with the employers, once and for all, whether employer-related health care costs, broadly defined (lost productivity, absenteeism, disability), go up or down if benefits are comprehensive and if one uses an integrated care model. We hope, but we also think, based on what happens to patients and their ability to go back to work, that our approach will look good compared with the way most people get their care. And when you start thinking in terms of total employer-related health care costs as opposed to insurance premium costs, you'll have a different conversation with the employer. We have several employers that are interested in pursuing that. If we head just straight down the insurance premium side, there's not a lot of wiggle room for anybody, not just us.

The Relative Benefit Of Not-For-Profit Status

**Goldsmith:** But you aren't just like everybody else. You are a not-for-profit in an increasingly investor-owned business. You are more thinly capitalized than those against whom you are competing. So the margin for error in dealing with these cyclical changes and actually being able to take the long view is much thinner for you than it is for most of your competitors.

**Lawrence:** On the insurance side, but not on the delivery side.

**Goldsmith:** But you own all of these assets that they do not.

**Lawrence:** On the delivery system side, other insurers lease or buy or rent from the hospitals and the physicians the clinical capacity they need. It's not easy to move patients from one hospital to another. It's not easy for a medical group to move from one health system to another. So our insurance competitors are as locked in, in many ways, with their rents and their leases, as we are with our own facilities.

*The public still operates with a set of myths that are rooted in the delivery system of the kindley Dr. Welby.*

The big issue is on the insurance side. There, unless we can develop the capability to compete head to head with the insurance giants that are beginning to emerge, the notion of integrating the financing and delivery of health care may be unsustainable. The Blues are also really struggling—the not-for-profit Blues—with their capitalization.

**Goldsmith:** They're converting.

**Lawrence:** Yes, they are.

**Goldsmith:** In time, it's going to be an almost completely for-profit business.

**Lawrence:** Well, on the insurance side. For-profit insurers do have access to capital that we don't have. We have to generate it out of how we manage the medical care delivery system. On the premium side, if the top line is going to be constrained, except through enrollment growth, we've got to generate it out of our management of the delivery system. And that's extremely difficult.

**Goldsmith:** But they also don't have the $10 billion in capital demands necessary for you to do that.

**Lawrence:** Who's going to pay for the nonprofit hospitals to replace their capital if our insurance competitors don't? The nonprofit hospitals have been living off of the capital...
investments of the 1970s and 1980s. At some point, someone’s going to have to pay the piper.

**Goldsmith:** So it’s essentially the same problem. It’s just a question of where the capital liability is. Is there going to be a sufficient willingness on the part of the people who pay the bills to renew this infrastructure and to pay for the conversion to a modern information-based architecture?

**Lawrence:** Who knows? At the present time, I’d guess no. I think that the public still operates with a set of stories and myths that are rooted in the delivery system of the kindly Dr. Welby of the twentieth century. We have not replaced these myths with the realities of what it’s like to get care in a more integrated setting. Those stories aren’t yet emerging. If you believe that political will comes from people’s emotional attachments to a particular set of views of how things work, you’d have to argue that the will to change is not there.

Right out there, right out that window (in Oakland), is Summit Health, a part of Sutter. Two short blocks away is a Kaiser Hospital that needed to be closed. That was the distance that patients would have had to navigate. Every bit of objective evidence argued in favor of putting ourselves together with Summit to create a major medical center in Oakland. Did we get it done? Not on your life. Summit’s a quasi-public utility. And the people who use one quasi-public utility didn’t want to go over there to another quasi-public utility.

**Goldsmith:** You’re talking about the physicians here too, aren’t you?

**Lawrence:** Physicians, staff, unions.

**Goldsmith:** Were your physicians any more interested in working with the community physicians than they were with you?

**Lawrence:** It was a doc issue, but it was also a union issue, and it became a very hot political issue as the community activists got involved. Basically, it brought what was potentially a highly rational, capital-conserving, quality-improving process to ground.

**Goldsmith:** But isn’t it appropriate for the consumer to have a fairly high hurdle of benefit realized from all of this system consolidation? Are consumers being unreasonable to expect that they will notice a difference in the quality of their experience or their health?

**Lawrence:** Not unreasonable.

**Goldsmith:** Have we met that hurdle?

**Lawrence:** Well, objectively, when you consolidate services, you get the benefit of repetition and of volume, and we link volume to quality, I think you can say yes.

**Goldsmith:** But, that’s an industrial model. That’s not a consumer model.

**Lawrence:** It is if you’re talking about dying or not. But we’ve also seen, and the Philadelphia experience is a good example, information on the performance of hospitals around things that affect consumers—how likely are you to die from your heart surgery—doesn’t change demand that much. That’s what I meant by changing the myths and stories. We’re still struggling to find the language that enables consumers to understand what they will get if they go into a system with more integrated delivery capability.