The Historical Emergence of Social Mission in Nonprofit Health Care Organizations: the Case of Kaiser Permanente in the Northwest 1945-1959

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Introduction

In an oral history conducted in 1985, Ernest Saward, medical director and founder of Kaiser Permanente in the Northwest, remarked: "....I think there's a great deal to be gained by the early history of the Kaiser Permanente organization, not alone for what the Kaiser Permanente organization has become, but for what the HMO industry has become."[1] More recently Seay and Vladeck, in their work entitled *Mission Matters*, recognized the need for leaders and health care managers to take stock of their institutions' historical mission to understand how voluntary institutions differ from other types of health care institutions: "Voluntary trustees and leaders, as well as the general public, need to know not only what the voluntary institution has been and what it is today, but also what it should be if it is to continue to be distinct and deserving of public support and special treatment."[2]

This thesis takes Saward's, Seay and Vladeck's charge seriously by concentrating on one aspect of Kaiser Permanente Northwest's (KPNW) early history (1945-1959); that is, the emergence and crystallization of this large, well-established organization's social mission. This period of KPNW's earliest operations is followed by two subsequent stages, 1959-1973 and 1974 to the present. Whereas the early period involved resolving the challenges of consolidating the organization's structural base and mission, the second period was marked by the expansion of that mission and greater involvement in policy making on health care issues. This second period ended with the HMO Act of 1973. The most recent stage of Kaiser Permanente is distinguished by a proliferation of for-profit and nonprofit health care organizations and subsequent, increased competition resulting from this Act as well as a consequent re-appraisal of KPNW's direction and unique character.

It is the author's view, in line with Sigmond, Seay and Vladeck, that an organization's "social mission" and its implementation lie at the heart of current and future health care solutions.[3] Although Sigmond, Seay and Vladeck have explored this issue with specific regard to hospitals, the author will extend the discussion to the field of integrated health care systems.[4] Thus, the thesis traces the conceptualization of social mission and its practical application in Kaiser Permanente in the Northwest in its first period in order to add to the current reconsideration of the moral and social bases--the non-

economic motivations-- in the delivery of health care. Consideration of KP's social mission and its historical emergence can inform health care reform and health maintenance organization debates as well as influence how they are constructed. Historical perspectives provide insight into how current social issues can be addressed by presenting how and why various decisions by our predecessors were made and what consequences these decisions bore. Historical analysis can help explain, for example, why balancing market forces and a commitment to social well being are all part of current attempts at re-appraising the health care system. Central to this contemporary debate is the struggle to regain a social imperative traditionally thought to be inherent in a pluralistic health care system in a period when the future of health care delivery seems to be moving in the opposite direction.

Given its long history and position as a model for prepaid group practice, Kaiser Permanente offers one of the richest examples for assessing the development and consequences of a social mission in a nonprofit health organization. By investigating the social and organizational history of KPNW, the author illustrates how an organization's mission and its implementation are dependent upon place, time, as well as internal and external factors. Drawing from the case of KPNW, the author argues that the organization's "social mission" evolved and was consolidated in practice through a dialectical process in which the practicalities of sustaining the operations of a health care organization interacted with efforts to maintain a basic purpose anchored in abstract, social principles. To elucidate this argument, the paper explores the specific, social role of KPNW's prepaid group practice model and discusses what lessons we might learn from examining the development of KPNW's social mission for present day debates about health care and about nonprofit health care organizations.

The paper begins with a conceptual discussion of social mission--what it is, how it gets formulated and how it gets expressed and implemented in a health organization. The author then briefly considers the history of nonprofit health organizations in the United States. This section is intended to give the broader history of nonprofit organizations within which the social mission of Kaiser Permanente Northwest is situated. Finally the author offers a more detailed analysis of how social mission was formulated in the case of Kaiser Permanente Northwest. This thesis focuses on the years 1945-1959 since

they form the crucial, beginning stage of KPNW's prepaid group practice and a critical period in the general expansion and proliferation of nonprofit organizations in America. The concluding section will comment on the value of historical analysis for health care reform and the specific contributions KP's case offers to the policy debate.

What is Social Mission Anyway?

The social character of mission

Social mission is a central component of an organization--its mandate or charter. Social mission deals with issues and interests larger than the individual—it is both inherently engaged in relationships and related to communities.[5] Mission reflects, in its particular content and form, the enterprise's commitment to fulfilling a certain role in a given community. Social mission helps determine the overriding direction of the organization and its philosophical approach to solving problems. It expresses the priorities of an organization-- its philosophical tenets, its economic principles and often determines its organizational behavior. A well articulated social mission positions the organization in relation to its environment, clients and community by addressing or redressing some particular issues or needs of that community in the first place--spiritual, political, health-related, and otherwise--without primary regard for finances. The social role of an organization may differ according to constituency or the institution to which it refers, but its mission generally infers some form of obligation by a business or organization to the needs of a particular community. This commitment, however, does not have to be necessarily charitable or altruistic in nature.

A primary characteristic of social mission, therefore, is that it is extra-economic; it cannot be reduced simply to the pragmatism of an organization to remain economically viable, although this certainly remains a constant consideration. An articulated mission continually helps to answer the questions "why/what's the point?" throughout the life of an organization in order to maintain its long-term success and organizational consistency.

Social mission as dynamic and adaptable

Social mission can be adaptable and dynamic in its content; it can shift in minor ways across different time periods due to changing political, legal and economic circumstances as well as to the needs of the society.[6] An organization's social mission, then, must be seen as sensitive and responsive to the changing needs, problems, desires and capacities of a community.

Since social mission is concerned with a relationship between an organization and a community, it emerges through that relationship. Thus, the relationship between the organization and the community is a central component of social mission and points to its crystallization and implementation as a process, rather than a given from the start. The nature of social mission as responsive to a community's changes and structures raises the issue of the role of non-governmental/nonprofit organizations and of public interest, discussed below.

Formulating and constructing a social mission is not an easy nor straightforward affair. Particularly in an organization's infancy, attempts at negotiating the disparate interests of stakeholders in a struggle over an organization's mandate often take place.[7] Stakeholders of various kinds—funders, volunteers, managers, staff and recipients—all have a certain investment in an organization's mission that gets played out in various ways in both the construction of the mission statement and in its implementation. This negotiation process is associated with the alliance building component of implementing an organization's social mission. Producing social capital, rather than purely financial capital, is a central concern of an organization with a strong social mission. Establishing relationships with diverse social groups as a way to secure social capital is an important factor in determining an organization's long-term effectiveness.[8]

Despite its flexibility, social mission is not characterized by temporary expediency or momentary, radical transformations but is usually rather stable in its embracing of an organization's long term objectives despite the possibility-- indeed inevitability-- of internal and external change.[9] Even though an organization's social mission is sensitive to historical and organizational shifts, once solidified, its basic mission rarely changes in significant ways over time.[10]

Mission tied to organizational identity and growth

Articulation of a social mission should help organizations avoid reactive responses to the pressures of changing environments and should produce "operational decisions" directed at long-term ends.[11] In this way, social mission is intimately tied up with the identity of an organization, as it originally defined itself to be. The concept provides its sustenance and, as a result of its inherent stability, helps to preserve the organization's strength and relative continuity.

As such, an organization's mission influences the capacity of an organization to grow and expand in terms of membership, finances and substantive scope. As an organization grows and becomes more complex, its mission can increasingly become overlooked. Therefore, leaders, trustees and managers must clearly articulate and re-articulate an organization's mission during the development process.

Mission statement

An organization's social mission is generally expressed in the form of a mission statement that presents what the organization is and what it does. Essential components of an organization's mission include "clarity, differentiation, volition, organizational culture, and social compact."[12] An organization's mission statement usually expresses a meaning or set of objectives that provide clarity of thought and action. It is a statement of purpose that ultimately shapes the strategic direction of the organization.[13] In this way, a mission statement is different from an organization's vision statement, which focuses on values in action and attempts to give meaning to an organization's idealized future. In further contrast, a mission statement articulates the present principles of an organization, rather than describes a future world resulting from the organization's successful performance.[14]

A mission statement specifies what an organization contributes to society and the manner in which the organization should carry out its work. The statement frequently promises that the organization will demonstrate a sense of social responsibility to its target community and will engage in activities that reflect that sense of obligation to a broader set of people than the leaders of an organization or its stockholders/investors.[15]

Implementation of mission

Once articulated in a statement, social mission has to be put into practice. Factors both internal and external to the organization significantly contribute to the particular constitution and implementation of a social mission in practice. Prioritizing operations, positing specific outcomes, and strategizing about methods for achieving outcomes are central components of operationalizing an organization's mission. The practical application of social mission interacts with organizational structure, funding sources, governance mechanisms, values-based management and staff development.[16] Even before that point, the social, political, economic, technological and historical contexts out of which organizations emerge significantly influence the orientations, resources, affiliations and values that are then "translated into organizational missions" and the primary set of programs.[17] Examination of these contexts and structures are therefore extremely important for understanding how a social mission emerges and crystallizes.

History of Voluntary, Nonprofit Organizations and Social Mission

Extant historical and organizational analysis has shown that both in the present and past, nonprofit organizations have exhibited greater affinity toward promoting social goals and values than for-profit organizations, despite the fact that they must take financial considerations as serious constraints.[18]

The voluntary organization, in contrast to organizations in the governmental or for-profit sector, is an example of what Dartington has argued is an "organization-as-realization-of-an-idea."[19] The voluntary, nonprofit organization provides a space for employees, funders, managers and members to put their beliefs and values into practice.[20] The defining characteristic of nonprofit health care organizations, for instance, has been their service to patients and doctors. In contrast, for profit organizations, in their attempt to address the financial concerns of their stockholders, tend to focus primarily on the individual stockholder and his interest, rather than the community of members at large. As such, their mandate is not primarily "social" but predominantly economic. In addition to possessing social legitimacy, non-governmental, nonprofit organizations are now seen as important for sustaining a robust global economy by addressing environmental, poverty and health issues.[21]

Given this connection to government revenue, Seay and Vladeck have noted the following five distinguishing characteristics of voluntary, nonprofit health care organizations both historically and presently: serving as a "repository of community values, fiduciary governance and accountability to the community," long term commitment, a physician-hospital (or health plan) relationship and institutional voluntarism. The authors note that such characteristics should not be only descriptive but prescriptive as well; they should provide a blueprint for future decision-making and visionary thinking.[22] As we will see in the case study below, Kaiser Permanente in the Northwest and KP at large have exhibited these five characteristics, even in their earliest stage.

General voluntary associations

American debates about voluntary associations, their role in society, and other private institutions date back to the eighteenth century. Opposition to government interference and a bias for the private sector were solidified in the mid- to late-nineteenth century and were reinforced by the ideologies of social Darwinism, the free market and the threat of socialism. Many business leaders saw private charities at the turn of the century as "contributing to the welfare of the State"; they were necessary to the existence of a "free State" since they served the public good and presumably influenced the public's character.[23] Leaders believed that nonprofit organizations had a clear, social mandate to work towards social justice. They believed that a nonprofit organization's mission should remain within the private sector but assisted by government, rather than led by it.[24]

This view got a boost from Herbert Hoover in the 1920's who saw the government's role as building cooperative relations with the private sector without expanding government bureaucracy. Hoover's ideas, put forth as a private sector alternative to socialism, set the stage for the New Deal programs, especially the National Recovery Administration, during the Roosevelt years. Roosevelt's initiatives ultimately changed government-private sector relations in the long term, favoring government power in the evolving partnership.[25]

Although the interdependence of public and private enterprise in America became firmly established in the twentieth century, that relationship was constantly shifting and continuously contested,

especially after 1942 when the income tax was made universal.[26] This debate was also influenced by the government's production of incentives for private enterprises to provide educational, cultural and welfare services, instead of undertaking the task itself.[27] Increasing government regulation of nonprofit organizations in the 1960s--imposed under the rationalization of making them more democratic--shifted the function of nonprofits as sharing the responsibility with government for advocating social and economic justice to being "instruments of privilege and official policy."[28] Given this historical background, the vast voluntary sector in America, according to Hall, was the creation of a particular *type* of welfare state, where government has encouraged private initiative, rather than a complete alternative to a welfare state.[29]

Health care organizations

The relationship during the Great Depression (1929-1937) between tax-supported hospitals and private nonprofit hospitals sheds light on the roots of the intricate, fluid and longstanding connection between government and non-governmental institutions in the field of American health care. The Depression marked a historical turning point for the articulation and implementation of social mission in health care organizations and shows to what practical use and what organizational consequences such a mission had for the future of American medicine. [30] In particular, the ideals of voluntarism and community in American health care organizations solidified in this period. These ideals helped form the basis for the unique social character of health care organizations as non-profit organizations today.

In the 1930s, local voluntarism shifted to community service as an organizing principle for public policy.[31] This shift was spurred by widespread unemployment, a decrease in charitable donations to hospitals and an increase in welfare recipients. Many voluntary hospital administrators sought credit as a way to finance and sustain their hospitals, while others increasingly utilized a prepayment insurance approach to maintain their balance sheets.[32] A drastic increase in government hospital utilization prompted voluntary hospitals to use the banner of voluntarism in order to compete with government hospitals. At the same time, they used this theme to impede government regulation and intervention as inferred in the Committee on the Costs of Medical Care report in 1932. This committee, an independent

body made up of economists, physicians, public health specialists and representatives of interest groups, suggested universal health insurance and hospital based group practice (which challenged the interests of private, fee for service physicians).[33]

Physicians and nonprofit hospitals alike opposed the full-scale adoption of a group practice model. In the heat of the debate about health care financing in the 1930s, hospital-based group practice was deemed "commercialized medicine," a "corporate practice of medicine," and detrimental to the entire enterprise of medicine by physicians and nonprofit hospital administrators.[34] Voluntarism as an ideal became positioned in opposition to "socialist" forms of medicine during this time; it became a counter philosophy to those of the progressive "left."[35]

Given the grave economic circumstances facing voluntary hospitals, hospital administrators blamed government hospitals for their loss in revenue and an encroaching influence on health care developments during the Depression. They fought in court against allowing government hospitals to service paying patients, and won. This ruling produced a distinction between the social missions of tax-supported and nonprofit hospitals that held sway until the late 1960s.[36]

Hospital administrators' challenge to state sponsored medicine, however, did not mean they wanted nothing to do with government. During this time they pressed for government assistance in solving the problem by requesting payment for private, nonprofit, indigent care. As Stevens remarks: "....voluntary hospital administrators throughout the country became aggressive seekers of local government funds for charity patients, proponents of hospital insurance for patients of moderate means, lobbyists for federal funds, and earnest advocates of the value of voluntary institutions as an alternative to government provision."[37] By advocating their commitment to social service—by articulating a particular, social role (mission) of this sector-- voluntary hospitals strengthened their claims to government assistance for new hospital construction and for indigent care, as eventually evidenced in the Hill-Burton Act of 1946.[38]

Promoting the ideal of voluntarism allowed nonprofit hospitals to maintain a public role with a private structure. By asserting a particular form of social commitment, hospital administrators could gain

government subsidies and tax exemption status while avoiding government regulation in relief programs like those of the New Deal. They claimed that their "public" mission made them unlike other businesses and therefore made them subject to exemption from New Deal regulations based on the contention that they, like government institutions, were already acting for the public good.[39] In addition, both private physicians and voluntary hospital administrators, close allies during the Depression due to mutual need, presented themselves as having a "special, private, altruistic mission" in order to distinguish themselves from tax-supported hospitals while still maintaining a community image.[40] Their "public" mission, in addition preventing government regulation, also distinguished nonprofits from for-profit hospitals and from the commercial, industrial sector, a provision required to maintain their tax exemption status; voluntary hospitals increasingly disassociated themselves with the private, proprietary sector and situated themselves as public, charitable institutions.[41] In other words, the mission of voluntarism among nonprofit hospitals, as Rosemary Stevens has argued, crystallized for reasons of political and economic expediency as well as those of organizational unity. In a severe economic crisis, the rhetoric that administrators of nonprofit hospitals used positioned themselves as scientific refuges, promising recovery and healing and presumably upholding the American ideal of community. [42] The consolidation of this special mission of nonprofit hospitals resulted in the distinct formulation of a middle ground or "third way" between governmental institutions and for-profit ones. From this point on, three sectors were designated in discussions about health care.[43]

Cooperative medicine and prepaid group practice in the age of voluntarism

The particular relationship between government and the nonprofit health sector can be extended from hospitals to non-profit health care organizations. Even before private voluntary hospitals solidified their distinct social mission, labor unions and other groups offered alternative ideas to the delivery of health care in America. As a response to a general distrust of corporate management and the lack of government sponsored insurance at the turn of the 20th century, many workers and labor unions formed mutual benefit societies, fraternal lodges or local unionized health plans. These plans dealt with the provision of health care, worker's compensation and retirement pensions.[44] As alternatives to employer-

sponsored programs, these plans tried to alleviate the industrial, urban working class realities and hardships resulting from common occupational injury and disability, disease, and limited financial resources. Their attempt at redressing these needs, however, fell short in several important areas of delivery, mostly due to inadequate financial sources. In particular, these societies failed to provide for workers' dependents, did not provide full medical coverage nor defrayed a substantial portion of expenses resulting from illness, especially illness unrelated to occupational accidents.[45]

During the Great Depression, at the height of working class despair, labor unions and the public again raised the prospect of considering new ways of delivering and financing health care. Given a crisis in organized labor during this time and the influence of New Deal programs, labor leaders called for government sponsored insurance.[46]

Other suggestions for new models of health care delivery centered on nonprofit, third party insurance. New organizations espousing prepaid group practice provided a strong alternative, highlighting their mission as offering innovative approaches to the financing and delivery of health care that would spread the cost of medical care over the insured population. In particular, these pioneer, prepaid group practice plans emerged in the 1930s and 1940s as a response to the Committee on the Cost of Medical Care published in 1932 and as a possible answer to the increasing problem of rising costs of medical care, urbanization and medical specialization. These plans, rather than leaving the medical system to operate under unbridled economic forces, restricted economic forces, consciously directed medical activities, and used long term strategies to reconfigure the delivery of American medical care. Each plan refined their objectives and operations through a process of experimentation in their particular populations.[47]

Despite its various forms, prepaid group practice models—often referred to today as health maintenance organizations-- generally include features of payments made periodically and in advance for a specified time period as a way to budget the costs of illness and provide services, the delivery of accessible services to a defined population of enrollees, voluntary enrollment and emphasis upon preventive services, and comprehensive, integrated care in a multi-specialty setting.[48] The middle ground occupied by these companies-- between government support of high risk populations and commercial

insurers tending to the more healthy-- makes the social role of these health organizations central to the history of health care in America.

Cooperative medicine and the restructuring of health care delivery

There were two types of organizations that particularly advocated the restructuring of health care: consumers' health care cooperatives and producers' health care cooperatives. The idea of cooperative health care developed alongside the rise of the cooperative movement in various other sectors. Modern cooperatism had its roots in mid-nineteenth century England, making its way to the US after the Civil War with its practice by American farmers, especially those in the West.[49]

Rather than focusing on the political and economic expediency of the employers and managers (although not foreclosing on these issues), cooperative medicine focused on extending affordable medical care to the average worker. This structure was meant to avoid workers' financial ruin while still allowing for financial stability amongst doctors. It was an especially suitable model in the years of the Depression when workers of all types found economic relief in sharing resources.[50] Still, in a period of competition, cooperative medicine (and other forms of prepaid group practice) offered a way of providing a stable salary to doctors with the income from prepayment insurance, while also offering collaboration between doctors in a multi-specialty setting. Integrated care also allowed doctors to receive more training without fearing the loss of their practices while away. Collective ownership of medical technologies also facilitated the practice of integrated care.[51]

Organizations like Elk City Cooperative Hospital, Group Health Association of Washington, DC and Group Health Cooperative of Puget Sound were consumer cooperatives, a plan owned and controlled by its members.[52] Consumers' cooperative health care models sought to deliver medical care with prepayment and hospital ownership by the insured. As Dr. Michael Shadid, the founder of the first cooperative hospital in America in 1931, the Elk City Cooperative hospital, stated, "Make medical practice fit them [the people] rather than ask them to accommodate themselves to the doctor's conceptions."[53]

The idea of cooperative medicine posed a serious challenge to the enterprise of private, for profit hospitals. As Shadid stated, "I am convinced that private ownership of hospitals is wrong and detrimental to the best interests of the masses of mankind, physically, morally and financially, in this and every other country of the world."[54] Shadid's innovation was that he took the example of the larger cooperative movement and applied it to medicine. His idea for cooperative medicine in Elk City, Oklahoma, fit nicely with the cooperative farmer's, coal and lumber movements taking hold there during the 1920s.[55] His cooperative health care plan and hospital, like other nonprofit hospitals at the time, affiliated with labor organizations—namely the Farmers' Union—to create the Farmers' Union Cooperative Hospital Association in the mid 1930s.[56] This union sponsored the hospital although Shadid ran it. It provided the solid membership base needed to initiate and run the cooperative idea. The Community Hospital, whose plans were initiated in 1929, was the first of its kind in the nation.

Shadid put forth ways of operationalizing his cooperative, social mission: group medical practice (staff model), periodic payment (dues-paying system), consumer control and preventive services.[57] His ideas about cooperative medicine led others like Addison Shoudy and R.M. Mitchell to consider creating their own application of this model in the form eventually known as Group Health Cooperative of Puget Sound in Washington State.[58] Although local physicians, discouraging Shoudy from pursuing the cooperative model, claimed that full coverage was an impossible goal, Shoudy recognized the successes of the Ross-Loos Clinic and Elk City which both covered workers in their respective locations. Other prepaid programs in Milwaukee, Washington DC, and Little Rock also provided precedents for the viability of the idea. Group Health Cooperative of Puget Sound began its operations in 1945, setting out its principles of full coverage, group practice and co-op membership. Soon thereafter, the Health Insurance Plan of Greater New York was founded in 1947.[59]

Producers' cooperative health care organizations, like Blue Cross and Kaiser Permanente, were also initiated during this period. Producers' cooperatives in the health care setting were formed and governed by providers to restructure the practice of medicine. The Blue Cross surgical plan was founded in Texas in 1929 and in 1938, the California Medical Association established America's first Blue Shield

program of prepaid physician care.[60] In 1945, the establishment of Kaiser Permanente in the Northwest took place, to be discussed in greater detail below. One major difference between the prepayment plans of the Blues and the Kaiser Permanente is that in the latter, prepayment actually applied to the total organization since it both insured and provided the services.[61] Service organizations like Kaiser Permanente faced the particular challenge of maintaining quality of care, affordability and accountability to its members since insurance and health care delivery were intimately linked. KPNW's character as a producers' cooperative was significant in decision-making about the organization's structure. [62]

Whatever their particular form, physicians and leaders of the prepaid group practice movement found power in physician collectivity and patient interests, conceiving this conglomeration as a more "rational" and coordinated basis for health care delivery.[63] Each leader went about organizing the concept of group health and integrated practice differently, with varying measures of ownership, but each sought similar alternatives to the status quo of medical care during and after the years of the Depression.[64] Such alternatives proved especially important during World War II when a shortage a doctors threatened the provision of health care on a fee for service basis.[65] A lack of physicians was coupled with a health care scenario where less than ten percent of the US population had health insurance. In addition, prepaid group practice plans got a huge boost from federal wage and price control policies at the end of the war that restricted wages to industrial employees but exempted health benefits from taxation. This situation enabled labor unions to add health insurance, including prepayment plans, to industrial employee benefits and revealed the intricate relationship between government and the private health care sector.[66]

The Historical Emergence of Social Mission in Kaiser Permanente

Kaiser Permanente (KP), one of the largest and oldest prepaid group practice organizations in the US is unique in the field of health care organizations because of its persistent commitment to its mission and the way that it chose to implement that idea in practice.[67] To examine how KP developed its social mission and whether or not it retained its original mission through time, this section looks at major shifts in growth and government/insurance relations and explores the dynamics of KP's internal politics.

Overview of general history of Kaiser Permanente:

The total Kaiser Permanente program, considered a prototype of the health maintenance organization, comes as a result of an effort to pragmatically and effectively address the health needs of workers of Henry Kaiser's industrial projects. The Program was an indirect result of the New Deal in which Kaiser was a significant participant; it is intimately tied to Henry Kaiser's expansion and contracting of dam building and ship building endeavors. Kaiser's health initiatives for his employees and their families were consistent with efforts by other industrialists beginning after World War I like Gerard Swope of General Electric, who established social welfare programs, including health insurance and benefits for his employees.[68]

Kaiser Permanente developed from a medical care program established in 1933 by Sidney Garfield who sought to deliver care to construction workers of the Metropolitan Water District Aqueduct project in Southern California. The project had already established a contract with physicians in Los Angeles to provide industrial care (care for work-related illness or injury) for the project through a workmen's compensation insurance carrier. Therefore, Garfield was charged with providing non-industrial care on a fee-for-service basis, which proved unprofitable. Garfield subsequently made an arrangement with the Kaiser organization for workers to prepay a percentage of the workers' compensation insurance premium for industrial medical care with an additional deduction for non-industrial care.[69] In 1938, Henry Kaiser undertook the construction of the Grand Coulee Dam in eastern Washington, hiring Dr. Garfield to continue to organize healthcare for his workers. In contrast to the consumers' cooperative or producers' cooperative models, Garfield, in these initial years, owned the practice and hired its doctors. His effort to provide health care to the dam workers and their dependents formed the basis for the California Kaiser Permanente health plans in the future.

During World War II, America's work force shifted towards the war effort. Corporate-sponsored health care both before and during the 1940s sought to win the loyalty of the work force. Companies in industries such as railroad, mining and logging contracted with physicians to provide industrial health services to workers (and sometimes their dependents). This type of care had precedents in nineteenth century America and included the examples of the Southern Pacific Railroad (1868) and the Homestake

Mining Company in South Dakota (1887). These initiatives were part of a larger trend toward welfare capitalism that emphasized the relationship between the corporation and the community. In the early twentieth century, national corporations expanded these practices. [70]

With the outbreak of World War II, Kaiser industry operations shifted to ship-building for the war effort in the San Francisco and Portland areas. A steel plant was also established in Fontana, California. Garfield continued his medical care operation for these workers as well, serving a total of about 200,000 people.

Kaiser Permanente in the Northwest

The establishment of Kaiser Permanente in the Northwest similarly developed as a result of war-time provision of industrial health care. As part of the war effort, Dr. Ernest Saward was asked to join an industrial endeavor of the Dupont Company to provide health care to workers at the plutonium plant in Hanford, Washington. Once he relocated from New England, Saward reorganized the forty solo practice doctors into a group with a set salary, assigning them duties according to their talents. In addition, he built a hospital and ambulatory clinic. The reorganization of medical services at the Dupont plant worked out well for the physicians--they appreciated the ability to call on colleagues for consultations without fear of competition. The doctors didn't have to generate fees and they worked within their own medical capacities.[71]

Saward later commented that it was at the Dupont plant where he learned one central component of what was to become the basis of Kaiser Permanente in the Northwest's solidified "social mission": a commitment to community based medical care through the reorganization of medical care delivery. Saward came to realize that the health of a community--the population (of interest) at risk-- is "really the important thing." If doctors and the delivery of health care could become rationally organized, Saward believed, then community care could be given more effectively. Having a defined, enrolled population, as others have recognized today, facilitates not only accountability on the part of the plan to that enrolled group, but also allows population-based solutions to a variety of questions. As Saward acknowledged,

individual delivery of medical care by physicians causes separate interests to become paramount and impedes the realization of community care.[72]

Indeed Saward recognized in the 1940s what Sigmond, Seay and Vladeck have suggested for the contemporary scene-- that nonprofit health organizations are distinctive because they have missions that focus on community care.[73] As opposed to a broad definition of the term "community " in community care, the notion of community care for Saward at that time was quite circumscribed. Indeed, in contrast to the notion of community benefit today, Saward's concept of community care was restricted to *a fixed population, the membership base of the health care organization*. Still his concept shifted away from the environment of individual patient care dominant during the 1940's to a concern for establishing a population based system that distinguished his organization's mission as "social." Indeed, he thought that this type of health care was simply a better way to practice medicine.

With the lesson about population-based delivery in mind, Saward visited the Kaiser shipyard in 1945 in response to a request made by Dr. Wallace Neighbor, soon to be director of Northern Permanente, in 1944 to initiate a community program in Vancouver, Washington at the Kaiser shipyards like the one in Hanford.[74] Saward spoke with Henry and Edgar Kaiser about his experience at Hanford. Henry Kaiser, being supportive of innovative approaches to health care delivery as seen in his support of Sidney Garfield's work, invited Saward to join the Kaiser ship building industry. Upon accepting the offer, Saward found a lack of medical care supervision and a general lack of acceptable medical care.[75] Just as in Hanford, Saward decided to reorganize medical services and established a teaching hospital, the Vancouver hospital, through Lantham Act funds. This Act took wartime-impacted communities and subsidized their schools, hospitals and other services where local resources were deemed inadequate. In contrast to later years, most of the forty-three doctors at the Kaiser shipyards worked there to avoid the draft and were attracted to the financial stability of the Kaiser medical service.[76] According to Saward, approximately 70% of Kaiser shipyard employees and their dependents (40-45,000 employees and their families) elected to have their non-industrial health care needs taken care of through this arrangement.[77] Industrial medical needs were compulsory under Kaiser employment.

After World War II: KP takes shape as community program.

Although it is during World War II that Saward began to implement his idea for the "rational" delivery of health care to Kaiser employees, it is after the war, starting in 1945 with the extension of the provision of medical services to the public, that prepaid group practice started to take shape in the Northwest. Prepaid group practice, to Saward, seemed to be the best, most rational way to deliver care. He therefore used this model as his starting point for his plan to reorganize health care delivery. Besides this basic component, however, subsequent strategies used by Saward and his colleagues to operationalize the reorganization of health care, were conceived of in a piecemeal fashion, tested and tried in a community before becoming institutionalized. Indeed Scott Fleming, long term lawyer and leader of Kaiser Permanente medical care program, recognized that the Kaiser Permanente program "does not represent a preconceived systematic design;" rather its extension to the general community was a "response of practical people to practical problems"—to the exigencies of historical shifts and the practical consequences of those changes.[78] Dr. Clifford Keene, president of Kaiser Foundation Health Plan and hospitals in the 1950's, agreed when he said, "We [do] see it (KP) as one valid solution to some long standing problems. We do see it as an *evolving* [italics mine] method of organizing and delivering medical care which is intended to be responsive to the changing needs of the people it serves."[79] This mixture of responding to practical issues while strongly considering certain social principles is recapitulated in (and constitutive of) the emergent process of building and implementing KP's social mission.

After World War II, many of the workers (about 40,000 total in California and Oregon) joined Kaiser Permanente to continue their medical coverage. Most of the doctors and shipyard workers headed home at the end of war. Only a core, dedicated group of five physicians stayed on to expand the delivery of medical services beyond the Kaiser business to become a community health plan in the Portland, Oregon and Vancouver, Washington areas. In so doing, these doctors responded to a local, public need and desire for the continuation of services while they also showed their own preference for offering this type of care.[80] In September 1945, five physicians met with Edgar Kaiser, Henry Kaiser's son who was in

the Kaiser business, to discuss the prospect of continuing the group practice plan. They received his moral but not financial support.

Structuring the organization: implementing social mission

Despite a mission of reorganizing the delivery of medical services, the creation and growth of the structural arrangement between the medical group and the health plan--as part of operationalizing that mission-- had its share of internal conflicts. In its original form, the medical group in the Portland area was called the Northern Permanente Foundation. This foundation was set up in 1942 for wartime purposes but was considered a charitable (IRS 501 c3) corporation.[81] It was controlled by Sidney Garfield and managed by Wally Neighbor. Once Edgar Kaiser gave his support, the foundation put up a sign on the highway by the entrance of the Vancouver, Washington, hospital advertising their initiation: "A community health plan, Northern Permanente Foundation." Although a community health plan was considered an "inflammatory" concept by organized medicine at the time because it was associated with liberalism and socialism, Northern Permanente Foundation did receive visits from such noted figures as Eleanor Roosevelt and Henry Wallace.[82]

After Dr. Neighbor returned to Oakland in 1947, Saward became the medical director of the organization. Then the partnership between the medical group and the plan solidly took the form of a prepaid group practice model. In subsequent years, the partnership took on many different, short-lived forms, primarily due to disagreements between partners. Despite these configurations, the prepaid group practice arrangement remained integral to the character of KPNW as a health care organization.

At first, the medical group portion of the partnership with the health plan was known as the Permanente Medical Group and was operated by three partners—Dr. Norman Frink (surgeon), Roger George (obstetrician/gynecologist) and Dr. Saward-- who employed the rest of the physicians. Although a partnership, the physicians were still salaried at this point.[83] Saward was the director of the medical group and the de facto director of the health plan and the hospital.[84] This organizational formulation lasted from 1947-1949. Although the executive boards of the Permanente Foundation in the Bay Area and the Northern Permanente Foundation had duplicate membership during this time, they never met. The

salaried, partnership arrangement of the Northern Permanente Foundation not only reflected the principles of the group's innovative alternative for the delivery of services, but was a response to broader opposition of the medical establishment: "Due to the difficulty with the American Medical Association, it was felt best to organize the physicians separately from the [Northern Permanente] Foundation so that they wouldn't be employees [of Henry Kaiser], and a partnership was formed."[85]

Although no records have been located, oral histories of and lectures by Saward and Oswald, reveal that it was during the initial years of existence that the core group—chaired by Dr. Saward--engaged in heated "Monday night" debates that discussed philosophical, semantic and detailed organizational issues. According to Saward, discussions at these weekly meetings in KPNW's first three years (1945-1948) encompassed issues of organizational identity, mission and principles.

One of the debates that the organization faced in those meetings was a clash of ideas about how to implement KPNW's mission. Some of the physicians who made up the initial partnership after World War II were quite ideological, while others were more pragmatic. This led to heated debates about such issues as the role of the new organization in extending health care to the needy.

Saward saw his creation as a "social experiment" in a sea of fee-for-service medical practice, but he felt that in the initial phase of the organization it was vital to build the organization first on sound, business principles. Implementing the social mission of KPNW, in other words, did not mean engaging in what he perceived as irresponsible financial operations that would threaten the long-term objectives and survival of the organization.[86] A commitment to not only social principles but also to "market led performance" enabled the founders to strongly compete in the medical care environment in which they were a part. But, in so doing, they also provided an alternative to health care delivery, medical practice and financing that exhibited a social ideal without attempting to overthrow the American allegiance to a free market economy. Saward's plan worked within a wider system while trying to revolutionize it from within.

A conflict between Saward and other, more ideological partners eventually led to changes in the partnership. As Saward relates:

> It was an ongoing, constant struggle, in which we lived with people who had very strong left leaning ideology and nevertheless, in a way, they helped shape the program. Eventually amongst these people, strong disagreement occurred about how far to the left this organization was really going to go and the two people....were forced out of it. But that took three or four years.[87]

Ultimately this liberal thinking, considered "of an unpopular kind," was felt by Saward to be casting a shadow on the organization which was already in a marginalized position with regard to organized medicine.[88] Such philosophical differences between initial stakeholders points to the process of "working out" the ideological principles (and its nuances) underlying KPNW's social mission. Saward recognized the contribution of these physicians to the initial effort of starting KPNW, "because of their commitment to what to them seemed like an ideological cause." But these providers, in the eyes of Saward, ultimately became a liability for the organization.[89] As new doctors entered the Kaiser system and the plan itself began to grow, the social idealism of the early days shifted to a sense of having greater autonomy over decision making traditionally undertaken by the partnership's executive committee.[90]

For its part, the Permanente health plan and Permanente hospitals were renamed in the 1950s as the Kaiser Foundation Health Plan and the Kaiser Foundation Hospitals. The medical group did not take on the name of Kaiser. Adding the Kaiser name was part of an effort by Henry Kaiser and associates to consolidate Kaiser companies under one name.[91] In the 1960s, the health plan separated in Oregon because of pressure from the I.R.S. to separate these entities for tax reasons. Whereas the medical group was a professional organization, the hospital was considered a nonprofit philanthropic entity. The health plan, on the other hand, was considered a nonprofit but not a tax-exempt entity.

The conflict between the original physicians eventually caused the Permanente Group to be dissolved and reorganized in 1949/1950 as Roger H. George, M.D. and Associates, minus those original, more idealistic doctors. From that point on, a particular, less radical framing of the mission was agreed upon. From 1951-1952, the partnership was then renamed the Doctors Clinic consisting of ten partners. Finally, in 1952 the partnership was dissolved again, only to be renamed the Permanente Clinic. The Permanente Clinic contracted with the Kaiser Permanente Foundation to provide medical services.[92] This

medical group became a professional corporation of its own in the 1970s and named itself again as Northwest Permanente, PC.

The internal struggles in the organization illustrate the negotiation of the discursive and practical boundaries of a mission that ultimately get resolved and defined in light of pressures internal and external to the organization. A commitment to KP's social mission, including that of KPNW, did not necessarily mean possessing a revolutionary, political viewpoint or an opportunity for a complete transformation in the social relations of health care, as the more ideological physicians saw it. Avram Yedidia, medical economist and pioneer of the Kaiser Permanente medical care program, has explained this point in reference to developments in the Bay Area and the integration of African-American members:

> It is not my contention that the health plan was blazing a new trail in civil rights, in human relations and so on. We were doing what we had to do in order to survive, in order to have patients, and in order to live within our work circumstances in as reasonable and humane a fashion as possible.[93]

Consolidating the organization's configuration is an important structural component in the implementation of a social mission. Today, Kaiser Permanente is a tripartite organization with the Permanente medical groups, Kaiser Foundation Health Plan and Kaiser Foundation Hospitals as separate three arms.

Thus, both external and internal politics influenced the group practice structure of the Permanente Group as a crucial component of KPNW's organizational identity. This identity proved to be an essential element in reflecting its mission of modeling a new, rational basis in the delivery of medical services. To be sure, changes in the organization's configuration reflected the "working out" of the operationalization of KPNW mission. Acknowledging the emergent process in implementing the organization's social mission, Saward observed: "We didn't get there all in one day."[94]

Community of providers: the changing relationship between doctors/patients and the health plan

Dr. Sandy MacColl, a strong proponent of group practice and leader of Group Health Cooperative of Puget Sound, once stated: "...the most satisfying aspect of these programs is that the physician is a member of the family of doctors for the family of patients."[95] Indeed a social mission is concerned with a

duty towards society not only because it seeks to benefit all (or a certain community) but also because, as part of that society, it seeks to benefit the organization and its providers, the doctors. In this sense, the reorganization of health care delivery from fee-for-service to group practice with capitation payments (payment per patient per year as seen in the KP case), must been seen as something that not only benefited patients-- especially for those with little to no access to care in the post World War II, solo practice environment-- but also (and perhaps first and foremost) cultivated professional autonomy and reward for physicians.[96] The traditional system of fee-for-service (FFS) benefited (and continues to benefit) the doctors and those patients who could afford care; it certainly did not attempt to rectify access issues related to financial resources on the side of patients. Capitation payment, although seemingly counter to the capitalist logic of maximizing profits for physicians through an unrestricted market, in fact offered physicians financial and professional stability in a period when the American economy in the field of health was extremely unpredictable and competition was rife. Although a capitation system still depended upon the ability of patients to pay a set, usually more affordable fee, the core group of doctors of KPNW understood that offering a capitated reimbursement scheme would, according to Greenlick, produce a distinct organizational culture different from the fee-for-service sector.[97]

That culture, based in the producers' cooperative model, reflected how the economic and group structure was linked to physician practice. It included physician practices that encouraged periodic, patient examinations, early detection of diseases and preventive services to benefit not only the patient but also to secure cost containment in the interest of maximizing physicians' salaries.[98]

Kaiser Permanente Northwest's organizational culture also promoted consultations with other physicians without additional charge to the patient or loss of future income to the physician. In addition, doctors understood that substandard care or withholding of services could potentially result in higher costs of care in the future. As Saward and Fleming have argued about this Kaiser Permanente model: "Self interest and peer pressure combine to establish an environment in which efficiency in professional practice and the appropriate use of hospital facilities and other health-care resources become the goal of both professionals and administrators."[99]

Ultimately, prepaid group practice in this case facilitated and encouraged the sharing of resources, responsibility and knowledge for the goal of achieving quality care. Especially during a period of physician behavior that generally included uncoordinated care, unnecessary surgery and treatments, and long hospital stays coupled by a strong, general emphasis upon curative medicine, the Kaiser Permanente approach offered a fresh and more economically conservative and integrated model.

Financial solvency and social mission in KPNW

Saward's proposal for the management of health care merged global budgeting with the delivery of services as a central, innovative yet resourceful strategy; he believed that the two could not be separated and their integration would work in the best interests of both the members and the providers. By attaching the financial health of the organization to the work of the providers, Saward's group practice model produced a system of mutual interest. Such a commitment reflects what Seay and Vladeck note as the dual, and sometimes conflicting, obligation of nonprofit organizations--to serve a community but to also maintain financial solvency to assure the organization's survival in order to fulfill the first community obligation.[100] Working to deliver medical care within a fixed budget locates cost containment strategies within the delivery system (instead of upon the enrollee through increased deductibles or co-payments), links inpatient with outpatient care, and also attaches benefit coverage with quality of care. As Luft and Greenlick have explained for the contemporary scene, whereas a conventional insurer may be held accountable for failing to reimburse a service, they are usually not held responsible for having high quality physicians and hospitals. In a staff and group practice model, responsibility for delivering services includes issues of quality of care. [101]

Within the financial arrangement of global budgeting, Saward recognized that he would have to provide certain incentives in order to keep providers productive while the Permanente Group was still salaried. Working within the fixed budget structure, then, Saward developed the idea in the initial years of the organization that the Permanente Group would get a percentage of the health plan dues. The Group would receive 43% of the dues to operate all outpatient facilities and to provide inpatient medical services. The balance of funds would go to the hospital and to the health plan (which were not separate at

this point). This kind of inextricable relationship between the income, job security and identity of the individual doctors and the performance of the health plan meant that utilization and hiring practices would adjust to maximize doctor's salaries.[102] Hiring an additional staff member, for instance, meant getting less of the financial pie for oneself, thus resulting in greater productivity of providers.

Physician autonomy and the Tahoe Agreement

Saward's belief in the relative autonomy of physicians from the health plan led him, in the 1950's, to support the adoption of the same model by KP in the Bay Area. The push for greater physician autonomy by California physicians corresponded with an organizational period when the respective expectations in the relationship between Henry Kaiser and the contracted physicians had reached a serious impasse. Mr. Kaiser wanted the doctors to behave like the other employees of his industries, allowing the businessmen to manage the medical care operation. The doctors, on the other hand, believed that Kaiser and his associates were, especially since 1952, becoming too involved in the daily management and policies of the organization.[103] They wanted the trustees and board of directors to act more like philanthropists and to allow the "basic concept of an integrated operation of clinics, hospitals and health plan under physician management" to proceed unfettered.[104] In a memo written in May 1955 to leaders of the organization calling for the renewal of full physician representation in decision-making, management and operations, physician representatives acknowledged the importance of understanding the history of the Kaiser Permanente program--its basic principles, character as a physicians' cooperative, and its impact upon the health care industry-- for the resolution of this crisis:

> Together we have created a great medical care organization without an equal in the entire world. Together we can make it even greater. We have a sincere desire to join with the Kaiser organization in furthering our objective--better medical care for the people at the most reasonable cost. In order to better understand our views it is important to approach the problem of representation in policy making with knowledge of the history of our development. Physician representation is not a new concept but was fundamental to our origins and our evolution....This organization was founded on the basic principles of integrated operation under physician management...It developed and prospered because of the soundness of these principles and we and all the physicians to whom we are responsible believed in these concepts and had faith they would be maintained...We urge a return to these fundamental principles, not only for our own benefit, but for that of *our successors and our imitators* [italics mine] and for what all of us believe to be an ideal of medical practice worth maintaining.[105]

In another working document written by physician representatives (but never submitted to the Kaiser Foundation trustees), the importance of a physician managed system was re-emphasized; this time noting, in particular, the emergent nature of the organization's structure and mission. In order to further their case, the physician representatives explicitly acknowledged their desired solution as a paragon for the future of health care delivery:

> We do not believe that this concept [of an integrated medical organization with responsibility of operational functions upon the producing group-- the doctors] is revolutionary, but that it is evolutionary and a natural result of a progressive trend through one-man ownership [Garfield in California], trustee direction with one-man management, split management by partnership and trusteeships, to partnership direction of the entire operational organization with a central management responsible to the physicians who have the ultimate responsibility of providing service to subscribers....Kaiser health plan has a worldwide audience. It serves as an advance experiment in medical care, which should therefore approach an ideal as nearly as possible. It will be copied and followed very extensively in time to come. As such an example, it is almost axiomatic to what we are trying to preserve in American medicine that all of its functions should be controlled by the working doctors.[106]

In order to resolve the stalemate, Kaiser executives and physicians decided to establish a working council at a joint meeting at Henry Kaiser's home at Lake Tahoe. On July 14, 1955, the working council decided to then establish an Advisory Council to negotiate a new relationship between the respective parties. The Advisory Council's health plan trustee membership consisted of Henry J. and Edgar Kaiser, E.E. Trefethen, Jr.(top advisor to Henry Kaiser), George Link (attorney for KP trustees), Sidney Garfield (medical director of Northern region), Clifford Keene (president of Kaiser Permanente), and Ernest Saward (medical director of KPNW). The medical group representatives included Frederick Scharles, Herman Weiner, A. Lamont Baritell, Morris Collen, Cecil Cutting, J. Wallace Neighbor and Raymond M. Kay.[107]

As a way to establish full professional autonomy, the medical groups initially proposed buying out the Kaiser Foundation hospitals and taking over control of the health plan. This plan would have, in effect, marked the end of the Kaiser Permanente medical program in its existing form (i.e. linked to Kaiser industries) and would have altered the Kaiser Foundation's relationship with the Bank of America, its long-time loaning institution. According to George Link, the attorney for Kaiser Foundation trustees,

the proposal went against the basic purpose of the organization; it would have created a situation in which the doctors would have a personal financial interest in the health plan, thereby potentially upsetting the "objective of the program which is better medical care of the people at a price that they can afford to pay."[108] Harry Fledderman, an attorney for the medical groups, surmised that the proposal was partly motivated by the desire of the doctors to improve their professional standing due to pressure felt from organized medicine with regard to their association with a lay-managed medical care program. Indeed, professional acceptance was a constant, usually unspoken consideration in organizational decision-making regarding the implementation of social mission.[109] Ultimately, the alternative proved impractical because it could have potentially threatened the non-profit, tax-exempt status of the hospitals and would have certainly substantially increased income taxes of all parties. It was therefore abandoned-- but not without a response from the physician representatives that focused on the principle of integration:

> We appreciate the desire to protect the non-profit status of the hospitals and will go along with it as far as possible but that protection must not be an excuse for exercising unilateral control over any part of the care of our patients. There must be an acceptance of the fact that we are dedicated to the idea of physician management of hospitals, in the health plan and in the clinics because all of these are indivisible parts of the medical care of our patients. Historically, this is why we joined the plan, how we built the plan, and the only method by which we are willing to continue to dedicate our lives to it.[110]

A new tactic for resolving the crisis that addressed these demands had to be found. As the "top level management team" of the overall medical program and liaison between the regional management teams, the trustees, directors and executive committee of the medical group, the Advisory Council established a structural arrangement whereby the medical group would be contracted on a per capita basis with incentives that would tie the doctors' group and personal financial interests with the performance of the Program.[111] In addition to resolving the contractual issues between the health plan and the medical groups, founding the Advisory Council was seen as a way to "strengthen and coordinate the health program, represent an internal knitting together of responsibilities of a growing organization" which would, it was thought, again provide health plan members with the "best possible health services at reasonable costs."[112] The Council did indeed deal with other operational issues in their meetings.

The entire process of resolving the organizational crisis is now referred to as the Tahoe negotiations even though the Tahoe agreement itself only marked the establishment of a working council and a commitment to resolve the organizational crisis. Most of the work occurred after the actual Tahoe meeting, during the years 1955-1956, when the Advisory Council met and, with the significant participation of Scott Fleming, Arthur Weissman and Karl Palmaer, devised the formal partnership between the medical group and the medical plan of all of Kaiser Permanente's regions.[113]

The Tahoe Accords, as they came to be known, founded a detailed structure and management system whereby the medical staff and the health plan would work together to forward the mission of KP while leaving a space for professional autonomy by the medical group. The concept of equal partnership, from that point on, became a central, organizational component of the implementation of Kaiser Permanente's mission. It resulted in the regional, medical group structure of the organization, in operation today, where physician responsibility for not only the care of the patients but also for the successful performance of the Program is expected and delivered in each region. Physicians of each respective medical group would have equal voice on decisions made by board of directors of the health plan and trustees of the hospitals.[114] In addition to giving the right to the medical groups to approve key personnel, the agreement also limited professional competition by forbidding the health plan from establishing new medical groups within an area so long as the current physician group was "providing quality care."[115] The concept of pooling revenue, like in Saward's model, was also adopted and, as in the Northwest, a per capita payment basis inextricably linked the financial interests of the medical group with the growth of the health plan.[116] The medical group and health plan would annually negotiate the capitation payment. Documents about the details of determining this payment explicitly state that a sufficient amount of money should be allocated to the medical group by health plan revenue in order to assure the "best possible service to the people" through high quality of care, top recruitment and selection of doctors, maximum availability of services, and greatest benefits. As Saward had done from the start of his operations in the Northwest (thus explicitly recognizing the connection between the abstract principles and applied structure of an organization's mission), this official contractual arrangement for the entirety of

KP assured financial incentives and job security for the physicians through participation and partnership earnings as well as attractive pension plans without abandoning "maximum economy," and, as repeatedly stated in the Council minutes, "high quality medicine at a reasonable cost."[117] Structure, budgeting and mission in the entire Kaiser Permanente system, therefore, became intimately connected.

The structural readjustments enacted in the Tahoe Accord reflect the wider issue of governance, which, as Seay and Vladeck have argued, serves as a distinctive component in the implementation of a nonprofit organization's social mission. Saward related the issue of governance to provider productivity and long term survival of the organization even before the Tahoe crisis:

> By becoming both responsible and having the authority as well, the medical group then began to structure itself, I think in a quite healthy manner in which productivity was sort of the all encompassing goal. If we're going to have a growing program [and] we're going to sustain anything that satisfies us, we'd better be very productive.... Under those circumstances productivity is different than if that same group is saying to the Northern Permanente Foundation of which they're employees-'We need another pediatrician.' In the staff model, the foundation would just say no. In the group model, decisions were made amongst themselves....So if you combine authority and responsibility together by making a payment for the whole function, then having it fought about internally as to who gets what....That's how you control productivity."[118]

The Southern Permanente partners were the first to sign a contract with the Kaiser trustees in June 1956. For his part, Saward was the next to accept the conditions of the Tahoe Agreement with the Northern California group following in 1958.[119]

In addition to a belief in the final partnership arrangement, Saward's motivations were primarily built on his need for financial backing from the Kaisers to establish a Portland-based hospital in order to keep his operation alive.[120] Still, Saward realized early on that organizational issues were "very determinative of the way we function," and thus influential in the way a social mission would or should be implemented. The way organizational issues were resolved was not deterministic but rather involved a gradual process of convincing and receiving acceptance by others as well as practical and legal measures to secure this particular organizational structure. In this particular case, the organizational arrangement tied the interests of the health plan and the medical group together while also allowing for professional authority and relative autonomy.[121] A mutuality of interests utilized both principles of the free market

economy, of productivity and of organizational behavior, while also worked to forward KP's (and KPNW) mission as a service health plan, of providing quality health care to a community and of improving the working atmosphere for providers.

Systematizing the management structure of the organization in the entire Program's initial years allowed it to focus later on other directions related to its mission, like the extension of services and membership growth. Once the issue of governance was resolved in the Tahoe Accords, the Kaiser Permanente Program entered a period of growth with extension into the Hawaii, Cleveland and Colorado regions in the late 1950's and 1960's.[122] As other nonprofit health care organizations confronted issues of productivity and physician ownership, such as Group Health Cooperative of Puget Sound, Ernest Saward served as a consultant to the group and used the lessons of the KPNW case to help them resolve similar issues.

Membership and recruitment --social mission and finding long term strategies

In its initial years, the Permanente Group and the health plan faced extreme difficulties with both membership/recruitment and financial solvency. In fact, Avram Yedidia writes that perhaps instead of calling the plan the Permanente Health Plan, during those days it should have been called the "Uncertain Health plan" reflecting its quality as a community experiment and occasional ill-defined measures.[123] Yet strategies to sustain a solid membership base reflected both the social goal of providing care to the population at risk coupled with the practical objective of delivering services within a fixed budget. These strategies took advantage of both broad historical developments of the time and created innovative alternatives that did not compromise KPNW's mission. Once some of these strategies solidified and were shown to be effective, they were then integrated conceptually and explicitly into the KPNW social mission and became foundations for subsequent operations.

As stated earlier, for example, during the 1930s and 1940s labor unions began to bargain with third party insurers to arrange the provision of medical care for workers. Whereas prior to this period, health plans had to convince an individual that the plan was beneficial for him or her, in the late 1940s

and early 1950s, employers, through collective bargaining under the National Labor Relations Act (Wagner Act of 1935), increasingly began to pay a portion or the total of their employee's health benefits.[124] Labor unions and employers-- what Yedidia calls the fourth party-- negotiated with health insurance organizations to decide who the third party would be. The patient, considered the second party (the provider is considered by Yedidia to be the first party), began to have less and less of an impact upon the decision-making process.[125] These broader, external developments changed the role of the health insurance industry and influenced a decision by KPNW to insist upon the practice of dual choice, a point to be taken up later in this thesis.

In 1950, Harry Bridges' Longshoremen and the Pacific Maritime Association in Portland (approximately 3000 families) joined the health plan as did civil service employees.[126] Although crucial for the survival of the organization, having to deal with large and well-established labor unions meant having to also deal with their national headquarters. Building up the health plan meant acknowledging the importance of establishing strong interrelationships with the community. Operationalizing KPNW's social mission meant not only addressing local needs but also involved negotiating policies with high level labor union figures outside of the immediate community.[127] Thus ties to both the local, geographical community and to the extended organizational community were vital for sustaining the membership of the health plan. Labor union/health plan negotiations in many ways helped to maintain the survival of KPNW.[128]

For its part, the Veteran's Administration contracted with the Permanente Group in March 1946 for care of their tuberculosis patients because the VA didn't have enough room in its hospital.[129] This arrangement lasted from 1946-1950 and proved vital for the survival of KPNW in its early operational phase. According to the organization's controller, Berniece Oswald, the VA contract offered a volume of income and services that offset the organization's expenses. This contract enabled the medical group to continue its work while membership enrollment gradually reached a self-sustaining number of 14,000 from the original 3000.[130]

A second strategy to maintain organizational survival involved the use of revenue from non-member, fee-for- service patients. Unlike traditional fee-for-service arrangements, in this case, the income from private patients was pooled and used to underwrite general expenses.

To achieve further financial solvency and a self-sustaining number of enrollees, representatives of the health plan went door- to- door trying to sign up people in the Vancouver, Washington area.[131] Many potential members became interested in the health plan because of its conceptual underpinnings. Faculty of Reed College in Portland, for example were some of KPNW's first members, joining in 1945, "because they saw the ideology that lay behind the plan."[132] Although a "really rough" time for the fledging organization, this deliberate, albeit necessary, extension into the community helped embed the plan within its geographical and social environment which had significant and positive consequences for membership in the years to come.[133]

One of the most important developments in the early stage of KPNW that resolved the early issue of recruitment and crystallized its mission was the opening of a hospital in Portland, Oregon in 1959. In fact, the author believes that the establishment of this hospital marked the beginning of the end of the earliest period of KPNW because it effectively rid the organization of a membership and financial crisis by providing a substantial membership base that brought in adequate and stable revenue.

Saward's description of putting up a public sign in front of the building's planned location resembles the process of "going public" with an organization's mission.[134] Putting up a sign announcing the construction of Bess Kaiser Hospital not only served to attract much-needed members to the organization but also had the effect of making KPNW accountable to itself and to its community. Before the construction of Bess Kaiser, the Vancouver hospital served as the main facility for patient care. Its location, across the Columbia River from the population center in Portland, was inconvenient for many potential members and thus inhibited membership growth. Construction of the Bess Kaiser Hospital responded to this community need.

Such action was central to the operationalization of KPNW's social mission and, in this case, was met with great rewards. As Berniece Oswald relates: "We even signed them up with the idea that while

the hospital was under construction, they could see our intent."[135] By the time the hospital opened, another 15,000 members had joined KPNW due in part to the announcement. From that point on, the health plan membership expanded dramatically, averaging 30-40% per year growth to reach a total of 130,000 members by the end of the 1960s. [136] The organization was, in turn, on solid financial ground.

Dual choice and voluntary enrollment

Another strategy used by Kaiser Permanente to penetrate the health care market to recruit new members was an emphasis upon dual choice and voluntary enrollment. Dual choice means that beneficiaries of employer health funds can choose between a prepaid group practice plan like KP, and at least one other plan such as BC/BS, or an indemnity insurance plan. With a dual choice arrangement, the beneficiary is able to choose the kinds of prepaid medical care arrangements he or she wants in order to maintain voluntary enrollment in fourth party negotiations.[137]

A focus on voluntary enrollment became a basic principle of the community-based development of the Kaiser Foundation Health Plan and of other group and staff model health care organizations in the middle of the century.[138] It was originally used to prove to the community the value and competitive edge of the prepaid group practice approach in an era where the idea was unfamiliar.[139]

Although initially offered as a pragmatic solution to a seemingly closed market and after that, prices competitive with other commercial insurance plans and the "organized medical profession," these strategies became fully integrated into the blueprint for operationalizing KPNW's social mission.[140] Since KPNW was generally a second or supplementary option for employees of large corporations in the 1940's and 1950s, KPNW felt it necessary to emphasize this provision not only to gain access to markets and be designated as a health plan option but, later, to structurally establish a doctor/patient/insurer relationship that was not based on coercion but voluntarism.[141] Even in cases where KP originally had an exclusive contract with a union, KP eventually appealed to have dual choice as an option. When their contract with the Longshoremen (ILWU-PMA) expired in 1953, for instance, KP convinced the union trustees that they should adopt dual choice so that workers could choose either to continue with KP or to switch to another plan. As Yedidia explains:

> By that time, we already were committed to a dual choice policy in all instances. We thought that because dual choice was a good thing in places where we were the outsiders trying to get in, it should also be good in those places where we were the insiders. If the principle was right, it should be applied evenly across the board.[142]

Stressing dual choice also served as a tool to counter the medical society's resistance to KPNW and to KP--a topic to be taken up below-- its claims that Kaiser Permanente was socialized medicine and that group practice models restricted the freedom to choose the provider.[143] Practical strategies of survival, responses to counter claims by the medical establishment, and concerns for the doctor/patient relationship came together in the insistence upon dual choice, a concept that, as stated above, would become concretized as central to the implementation of KPNW's mission.

Moreover, an emphasis upon dual choice was consistent with the historic emphasis upon autonomy and voluntarism within the American medical system. According to Scott Fleming, the concept of dual choice, or as he puts it, consumer choice, would prove to be one of the most significant developments in the history of health care in the twentieth century because it provides the essential foundation for a system of competing alternative health care delivery arrangements.[144] Conceptually then, dual choice also wedded market competition, choice and pluralism in American medicine. Again, leaders of KP drew upon (and worked with) important principles in the American tradition in order to work within the system while at the same time, change it.

Indeed the concept of dual choice was tacitly acknowledged in the Federal Employees Health Benefits Act of 1959 (FEHB). This was, according to Yedidia, the first time that Congress recognized the need to encourage different types of health care delivery and financing organization, thus legitimizing such prepaid group practice programs as KPNW. Auspiciously that same year, a Commission on Medical Care Plans, appointed by the Trustees of the American Medical Association in 1954, reported that prepaid group practice plans provided quality medical care, and recognized the importance of choice of system. Once the FEHB Act was put into effect, federal employees became an extremely large constituency of the Kaiser Permanente plans, making up the largest single group. Later, in 1973, the Health Maintenance Organization Act officially recognized dual choice, mandating that employers with more than twenty-five

workers offer their employees a choice between conventional health coverage and an health maintenance organization if available.[145]

Experience rating

Discussions in the mid 1950's concerning a shift to an experience rating system from a community rating one involved discussions of competitive advantage as well. The community rating method establishes the same premium rates for a given set of benefits for all members; risk is shared across the enrolled population. In contrast, the experience rating method sets premiums at different rates for the same benefits according to a group's actual health care expenses in a prior period. Experience rating therefore allows healthier groups to pay less while often drives premium rates up for the elderly and disabled populations.

The debate about experience rating among Kaiser Permanente leaders sheds light upon the interplay between social purpose and financial concerns in the emergence, consolidation and operationalization of social mission. So, for example, in the sixth Advisory Council meeting on January 12-13, 1956, Herman Weiner suggested that, like other insurance companies, Kaiser Permanente should adopt experience rating in order to make a "reasonable excess of revenue over expenses on all users of its services." Arthur Weissman dissented, remarking that experience rating "would be a major departure from the fundamental principles on which the health plan had been organized-- a prepayment program predicated on the idea that the entire membership taken as a whole would pay its own way on a pay as you go basis, thereby providing a relatively stable income to finance costs of facilities and services."[146] Dr. Morris Collen responded with a request to study the rating question in depth, analyzing in particular how experience rating interacts with the "principles underlying the health plan concept."[147]

Ultimately, KP leaders dealt with the growing shift from community rating to experience rating in the health insurance industry during the 1970s and early 1980s by merging the two concepts to produce a "socialization of the experience rating system."[148] While other organizations during this time, like Blue Shield and Blue Cross, were progressively shifting to experience rating systems in order to remain competitive with other insurance companies, Kaiser Permanente's rate setting system adhered to a

community rated method.[149] In its adaptation to this new health care financing environment, KP created a community rating system where members were grouped by utilization patterns into classes and then a community rating system was applied to those differential sections of the plan's population, rather than adopting the more common method of adjusting premiums according to recent group experience.[150] This type of "social decision-making" reflected an ability of the organization to adjust its policies according to the external, economic developments in its field without abandoning its purpose of providing a new, affordable way of delivering health care to its members. At the same time, it was able to facilitate what was considered a more attractive way of practicing medicine for doctors through the prepaid group practice model.[151]

Membership, recruitment, financial and growth issues of the organization--and the ways they were tackled-- reveals that the process of implementing the social mission of KP in general and KPNW in particular was fraught with problems in need of long term, innovative solutions. As Kaiser Permanente in California and in the Northwest consolidated its membership base and place in the health care market, new challenges for implementing its social mission emerged that marked a new, distinct period in the history of the Program. A discussion of this phase is outside the scope of this thesis.[152]

Opposition as consolidation: crystallizing social mission

Part of the problem of initial growth in membership and staff was the strong opposition that KPNW faced from organized medicine. Opposition by medical societies to Saward and to KP in general actually helped consolidate KPNW's social mission in its response to external threat.[153] It seems from other historical examples in the field of medical service that external threats act to solidify the implementation of social mission.[154] For example, in arguing his case in a letter to the County Medical Society in Oklahoma in 1938, Shadid explicitly set out his vision and mission:

> I will tell you how to compete with the Community Hospital. Do it on economic and legitimate grounds, not by playing politics and calling me names, but by serving your fellowmen better and cheaper, and more honestly and more faithfully....The Community hospital has succeeded because it has met a long-felt need. It is in tune with the times. The individualism in medicine, as in many other fields, is past. We are living in a period of transition from a system of 'laissez faire' to a system of order in human relations.[155]

Such opposition and conflict occurs when the values presented in a social mission do not fit within the larger business values of the period or of the industry. This was certainly the case with KPNW and also with other types of cooperative (producer or consumer) medical organizations.

From its inception in the mid 1940s, the medical establishment regarded the Permanente Group's scheme as unethical; this despite the fact that Saward was the only Permanente doctor with membership in the Clark County Medical Society.[156] According to Yedidia, the "[medical] profession denounced it [Kaiser Permanente] as an un-American idea that must be eradicated before it polluted the pure American scene."[157] In the 1950's, for instance, organized medicine posed severe obstacles to pursuing new forms of delivering health services as seen in prepaid group practice by excluding doctors involved in these endeavors from membership in medical societies. The American Medical Association also challenged the disbursal of Hill-Burton grants to organizations considered "closed panels."[158]

Even before the 1950's, resistance by organized medicine proved politically formidable. Opposition by the American Medical Association to the US Committee on Economic Security's recommendation for mandatory health insurance caused President Roosevelt to drop this provision from the Social Security Act of 1935.[159] In the 1940's, the American Medical Association resisted prepaid practice models in general although in 1942 it endorsed prepaid physician managed plans along the Blue Shield model. However, it tried to impede-- but failed due to a Supreme Court ruling in 1943-- the operation of Group Health Association of Washington DC. After World War II, organized medicine launched a campaign against "socialized medicine," succeeding in obstructing the passage of a national health insurance bill, the Wagner-Murray-Dingle bill, in 1946, despite President Truman's commitment to healthcare reform.[160]

Despite such rulings in favor of prepaid group practice plans, continued opposition to this type of health care delivery continued to be formidable. Indeed in the late 1940s, Shadid warned Shoudy in the initial years of Group Health Cooperative of Puget Sound that blacklisting by medical societies would make it extremely difficult to recruit the needed amount of doctors for operation.[161]

Similarly, resistance by organized medicine affected the Permanente Group, making recruitment of qualified doctors difficult in its early years. The Washington State Medical Society charged Saward and his group as being unethical because, they claimed, KPNW solicited patients, emphasized community rather than individual practice, arranged salary based work, and offered contracts with groups of people to use their services exclusively, thus hampering free market competition and blocking choice.[162] In December 1945, after several attempts to resolve the problems with state society representatives, Ernest Saward appealed the ethics allegation made against the Permanente Group by the Washington State Medical Society to the AMA Judicial Council.[163] By 1946, the council had withdrawn its charge against KPNW, but stresses between the two parties still remained. Such luck did not apply to Sidney Garfield, however, who was charged with violation of the state Medical Practice Act in 1946 by the Alameda County Medical Association and the California State Board of Medical Examiners and given five years' probation and a suspension of his license for a year. The case dragged on until 1951 and, according to Hendricks, caused Garfield to withdraw as partner of the Northern California Permanente Medical Group in 1949 to defuse opposition by AMA societies.[164]

In 1948, the federal government charged the Oregon Medical Association with excluding physicians of cooperative plans that worked in Oregon and across state lines (i.e. Vancouver, Washington).[165] A memo to Gene Trefethen, advisor to Henry Kaiser and overseer of the Tahoe meetings, dated October 28, 1948, noted the details of the legal complaint filed by the Government against the Oregon State Medical Society, Oregon Physicians' Service and other county medical societies. The Government's case stated that the "conspiracies" were violative of the Sherman Act, an act which concerned interstate commerce, and resulted in a situation whereby:

> a) prepaid medical care organizations other than those sponsored by defendants have been hindered in entering into or expanding their business in Oregon; b) the public has been deprived of a fair opportunity to acquire prepaid medical care insurance from organizations competing with one another in a free market; c) members of the public have been deprived of medical care which, save for the restraints here in above described, would have been afforded to them; d) doctors have been deprived of an opportunity to practice medicine in Oregon on terms of their own choosing; e) doctors in Oregon have been denied the right to use the hospital facilities in Oregon and ; f) the market for sale and distribution of medicines, drugs, medical supplies, and medical equipment have been unduly restricted, etc.[166]

The federal government called for the defendants to be

> ....perpetually enjoined from further engaging in any of the restraints described, from refusing to admit to membership or expelling or threatening to expel from membership any doctor because of cooperation in medical care plans other than those sponsored by defendants, from persuading hospitals, doctors or the public from having normal relationships with medical care plans and that defendant medical societies upon application by any doctor shall reinstate as a member in good standing any doctor expelled....and that defendant medical societies be required to advise in writing all of the component county medical societies and to publish a statement in *Northwest Medicine* that it no longer is a policy of said societies to do those things which are alleged to have been the subject matter of the conspiracies...[167]

Additional claims that KPNW and KP at large had communist tendencies by the medical society were part of larger anti-Communist rhetoric in America with the start of the Cold War. Charges by organized medicine were situated within a general attack against policy elites, philanthropic organizations, and other tax-exempt organizations by the anti-subversive movement.[168] Resistance to nationalized health care continued in 1959 when the American Medical Association denounced the Forand Bill, which sought to add healthcare to Social Security benefits, as a step again toward socialized medicine by the government.[169]

Saward fought these changes in court and in the community in order to push forward with his organization's social mission. Like the Government's complaint in 1948, he presented a counter claim that the medical society, by excluding Permanente doctors from membership, was itself restraining trade. Opposition by the medical establishment, however, continued such that in the 1960s, amidst debates about federally funded welfare programs, the Multomah County Medical Society (Portland) rejected all twenty-two of KPNW's applicants to the society en masse. In order to avoid a lawsuit by KPNW, the medical society negotiated with Saward, suggesting that applicants apply in groups of two, rather than the full lot all at once. The society explained that that method would allow them "not to lose face" while also securing the acceptance of all the KPNW applicants. Such a settlement showed that organized medicine's supposed solidified professional authority was actually breakable. Once that proposal was accepted, the society ended its opposition. The end of organized AMA opposition to the Kaiser Permanente medical program, --as manifested in a reluctant public acceptance of prepaid group practice in the Larson Report

(1959)-- roughly corresponded with, and indeed was part of, the shift in KP's development to its second phase of operations.[170]

Formidable resistance by organized medicine to prepaid group practice reflected the fact that both the professional and wider culture were not yet ready for such a shift in delivery of services. The norms of society at this historical juncture posed an obstacle to establishing a broad base of support for these new ways of delivering services.[171] Yet the contrast of missions between organized medicine, based in the fee-for-service, individual arrangement, and the prepaid forms of delivery based on extended, integrated health services to a wide community-- as well as the struggles between these groups that ensued -- only helped to further crystallize the social missions of the marginal groups and forced the formation of new alliances in order to achieve their mission.

Conclusion

As shown in the previous pages, leaders of Kaiser Permanente considered both principles and practicalities when determining its immediate and long term future. In many instances during the early stage of the organization's operation, just ensuring its survival was a huge challenge. The social mission of Kaiser Permanente in the Northwest developed out of a particular historical context in which access to medical care was limited to most Americans while physicians' income and job security were unstable. The implementation of KPNW's social mission developed from the interplay between these practical exigencies and a sense of purpose that essentially involved delivering health care by (and for) physicians in a new and affordable way to the community.

The method chosen from the beginning, and sustained throughout the organization's life, was prepaid group practice with a producers' cooperative model. Many of the other pieces of the applied structure of the mission--what Ernest Saward eventually called the "genetic code"--were institutionalized as a product of working out particular recruitment, management, and financial problems.[172] Concepts such as dual choice, an emphasis upon preventive services and pooled revenue were integrated piecemeal into the mission of Kaiser Permanente as a by-product of tactical decision-making, but then became central to the way KP operates and expresses its mission.

After the structure was consolidated at the end of the first phase of its organizational life, Kaiser Permanente not only expanded the implementation of its mission by extending its services but also became increasingly involved in public policy.[173] Participation in legal and public policy affairs, according to Vladeck and Seay, is a vital characteristic of leaders of nonprofit health care organizations.[174] Involvement in public policy allowed Saward and other leaders in the organization to expand KP's core principles, as solidified in the first period of its development, to the broader health care system.

Understanding the power and the ability of government and legislation to implement its social mission, Kaiser Permanente leaders took an active role in promoting certain health care policies. Figures like Robert Erickson (KP director of legal services and government relations), James Vohs (regional manager in Southern California and later KP CEO and board chair), and Gibson Kingren (Kaiser Permanente representative in Washington) were actively involved in lobbying for and implementing the Federal Employees Health Benefits Act.[175] This Act recognized the importance of private sector reform health care as a "substitute for the centralized public welfare state."[176] KP leaders recognized that this legislation would clearly be advantageous for improving the membership numbers of the organization but would also be beneficial for prepaid group practice programs throughout the United States. Again, the interplay of practical concerns and social purpose played a part in the logic and nature of their involvement. As Erickson stated in August 18, 1959 in a Special Report on Federal Legislation:

> It should be recognized that the influence of Kaiser Health Plan with regard to the Federal Employees Health Benefits bill thus far has been immeasurably greater than our importance in the over all federal employee picture would merit. Our success can be attributed to the effective development and presentation of our ideas; to our generally good reputation as an organization interested in improving health care; and to our policy of presenting reasonable, defensible approaches to problems which emphasize, in fact and in theory, valid public interest and are not limited to our own self interest.[177]

Indeed, passage of the Act resulted in the entry of half a million federal and state employees to Kaiser Permanente.[178]

As a participant in public policy debates, Saward and other Kaiser Permanente leaders, like Yedidia, Weissman, Fleming and Erickson, took an active role in providing advice and assistance to the

US Government on the principles of Medicare and Medicaid reimbursement in 1965.[179] Part of their effort was dedicated to integrating language into the legislation that would permit forms of payment other than fee-for-service. Despite the fact that at that time, only about 4% of the Kaiser enrollees were over the age of 65, these leaders realized that the proportionate health care costs of the elderly population would be very high so that if services were delivered on a FFS basis, it would be almost

> impossible to retain this revenue as program income rather than the exclusive income of the physicians. Such a development would alter the nature of the health plan's relationship with the medical group, and would create a serious flaw in the structure of the organization.[180]

These leaders, accompanied by other people in Health Insurance Plan of Greater New York and Group Health Association of America, therefore found it essential to work for the inclusion of alternative approaches for the delivery and financing of Medicare in order to achieve the long term survival of the program. Wilbur Cohen, then Secretary of the Department of Health, Education and Welfare, amended Part B of Medicare to facilitate capitation payment to plans like KP.[181]

Wholesale acknowledgement of the innovation and principles of the prepaid group practice model was eventually made by John Cashman, Assistant Surgeon General of the US Public Health Service in 1969. In a foreword attached to Ernest Saward's paper entitled, "The Relevance of Prepaid Group Practice to the Effective Delivery of Health Services," Cashman recognized the need for innovation in providing health care access and the various alternative to providing the delivery and financing of health care. He then commented on the particular value of the group practice model:

> We plan in the future to issue other examples of the ways in which group practice, through its potential for efficient organization and continual peer review of quality, can offer acceptable health care to the people who need it.[182]

Social mission, History and the future of health care organizations

Seay and Vladeck have noted that "The clear articulation of a series of rationales and an appropriate sense of mission for voluntary health care institutions will have immediate and significant public policy implications."[183] A reflective assessment that includes in-depth historical analysis of the distinguishing characteristics of nonprofit health organizations, including social mission, by both its leaders and the health policy scholarly community will help drive new discussions about the particular

contributions nonprofit organizations can make in current circumstances as well as help challenge the seeming convergence of for profit and nonprofit organizations.

Editors of the *Journal of Health Policy, Politics and Law* attempted to examine the rationales of non-profit health care organizations by dedicating a full volume to the history of Blue Cross/Blue Shield and its impact upon the provision of health care in New York State.[184] Like this author, Robert Padgug looked specifically at the history of Blue Cross/Blue Shield's social mission-- that of "making health insurance available to as large a part of the self-sustaining population as possible"--in order to assess the company's future direction.[185]

As opposed to a for-profit American corporation whose history has been viewed as a "mere curiosity," Padgug noted that for a nonprofit organization, a sense of history and an understanding of its position in the past and present are vital for a nonprofit health organization to succeed:

> For the key to the nature of its purpose and the manner in which it can successfully carry out that purpose lies as much in the past, when its 'mission' was established and implemented, as in its present circumstances.[186]

Although Padgug does not theorize the concept of social mission nor describe the process of its constitution, he does point out the uniqueness of a nonprofit health organization in that it commonly struggles with its mission's meaning, examines whether or not that mission is still relevant and assesses what its present role is in light of its past.[187]

Peter Dobkin Hall agrees that solid historical inquiries of the nonprofit sector, rather than "self-serving folklore and wishful thinking" could aid nonprofits in dealing with their greatest problems and challenges. Historical perspectives can inspire and inform stakeholders' options during the period in which they frame their missions and objectives.[188] In addition, historical exploration is useful in organizational development by providing a point of continuity and a guide to future direction.[189] These uses of historical analysis can be extended to health care reformers, policymakers, and health services researchers and managers.

Expanding this call for historical perspective, the late public health scholar, Avedis Donabedian, recognized the indebtedness the field of health services research has towards its past.[190] Exploring the emergence of social mission(s) in nonprofit health care organizations as part of the story of the delivery of US health care is a central task of that field.

Like Blue Cross/Blue Shield, an understanding of Kaiser Permanente's social role in society in historical perspective is vital not only as an inquiry in its own right but especially in light of the current crisis of financing health care in America.[191] The historical example of Kaiser Permanente--which as of 1985 made up about 40% of the HMO membership in the US--and its decisions about form and function, provide estimates to what can be expected from other large, long term, nonprofit health maintenance organizations.[192] By studying the history of Kaiser Permanente, for example, we understand that it was not the only organization that tried to restructure the delivery of services and restructure the financing mechanism to reform medical practice in America. Yet unlike other pioneer health programs of its time, Kaiser Permanente has explicitly chosen to retain its nonprofit status.[193] A commitment to retain its original charter and identity makes Kaiser Permanente unique in the contemporary world of health maintenance organizations. Further exploration as why and how it maintained its nonprofit status, and the debates behind this issue, can help further elucidate strategies to do the same to other nonprofit organizations.

Understanding the historical emergence of social mission can help Kaiser Permanente and others reassess their direction and values and use the knowledge of the past to carve out a solid future role in health care. So, as this paper has shown, the innovative financing system of prepaid group practice in the early part of the 20th century served as a way to resolve the crisis of the Great Depression. Fully understanding this alternative and the particular ways it addressed societal problems can help shed light on ways to construct creative options for solving the current crisis in health care.

Persistent reflection about the past and future of Kaiser Permanente and America's health care system was made by Ernest Saward in the 1970's and 1980's. After leaving Kaiser Permanente in 1971 and moving on to Rochester, NY to become associate dean of the medical school of University of

Rochester, Saward returned to Portland to comment on the future of health care and the role of social mission in it. Saward argued that prepaid group practices that adhere to their solidified "social mission" naturally provide high quality, effective and efficient health services to their members. A commitment to social principles, in Saward's view, necessarily produces as its by-product the capitalist benefits of productivity and efficiency--not the other way around.

In his lecture, " A Tale of Two Cities," Saward merged the lessons he learned from the industrial medical experience, the KPNW experience and the Rochester work. In addition to noting the importance of excellence, efficiency and equity in a rational, managed care system, two additional factors include financing and community responsibility.[194] Community organization, according to Saward, can result in a more efficient and "equitable health system with better outcomes."[195] A focus on the market and revenue by medical providers poses an obstacle to achieving community organization since it shifts that element of human agency, societal improvement, and community empowerment based on ideological or philosophical substance to a focus on profit. This strong ethos of individualism influenced the American failure to create a national health plan. As Saward concludes: "America has, in addition to the highest per capita health costs, the highest mental and emotional barriers to a sense of a shared, mutual responsibility. This inevitably conditions the range of possible choices of how to manage the allocation of resources in the zero-sum game."[196] It was these barriers that Saward addressed in his work with KPNW.[197]

Utilizing prepaid group practice from the start, the first clinics set up by Kaiser were able to coordinate and address the unmet medical needs of its workers and later, its members. Such coordination of patient care is what Sigmond and Seay believe to be the key to better health outcomes, access and cost reduction in the contemporary health market.[198] A concern for the kind of populations served and the coordination of services was a strategy used by KP since its inception.[199]

Examination of KPNW's history and mission, as Saward, other KP leaders, and this author have done, provides substance to the claim by Vladeck and Seay that "mission matters."[200] Mission matters in influencing the relationship between an organization and its community. Mission matters in terms of organizational performance and long term success. A clear articulation of their social purpose--here of

delivering health care in an integrated prepaid fashion --allowed the pioneers of KPNW and KP at large to avoid short term actions that would have threatened the very survival of their organization. A strong belief in this basic mission also allowed for continued resistance to the medical establishment in the beginning years of its work.

Yet, as this paper has shown, the implementation of a social mission is not a preordained given; the practical application of social mission emerges as a result of a dialectical process between practical concerns to maintain the organization and essential social principles upon which the organization is based. A health care organization's mission, during and after the gradual process of its consolidation and solidification, helps determine the organization's culture. Having a sense of an organization's historical mission can boost employee morale and cohesiveness and shapes effective decision-making, management and strategic planning by the organization's leadership. As such, the continual process of assessing an organization's mission should include an historical perspective in order to help orient the organization, produce humility amongst its trustees and members as well as understand how the external environment both changes and impacts the future direction of an organization.

Endnotes

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[1] Kaiser Permanente. "An Oral History of the Kaiser Permanente Medical Care Program." As told by Ernest W. Saward, MD. Volume XV. Interview conducted by Sally Smith Hughest, 1985. Regional Oral History Office, Bancroft Library, University of California, Berkeley. P.50.

[2] J. David Seay and Bruce C. Vladeck. *Mission Matters: a Report on the Future of Voluntary Health Care Institutions*. (United Hospital Fund of New York: New York, 1987) 12, 38.

[3] In particular, examining issues of "ownership and profit status" or centering health policy debates solely around "competitive" or market theories is simply not enough to explain the differences between nonprofit and for-profit health care organizations. Sigmond and Seay point out that a focus on mission, in the contemporary debate, would encourage the Internal Revenue Service and the field of health care to more explicitly articulate the process of achieving a charitable/social mission. Robert Sigmond and J. David Seay. "In Health Care Reform, Who Cares for the Community?" *Journal of Health Administration Education* 12(3): Summer 1994, 260-1.

[4] See J. David Seay and Bruce C. Vladeck. *Mission Matters: a Report on the Future of Voluntary Health Care Institutions*. (United Hospital Fund of New York: New York, 1987) 6.

[5] Community can be defined by common geographic area, common interest or background, common approach to solving problems, membership in a particular organization and other forms of connection that bring people together in groups. Community is a dynamic concept whose boundaries and nature of ascription changes according to an individual's needs and living situation at a particular time. Communities do not exist alone; decisions by one community may influence or be affected by decisions of other communities. At the same time, the scope of

community may be broadened or contracted according to the type of problem needing to be solved; in some instances, linkages between smaller communities can serve to solve larger, regional or national problems. Marion Folsom. "Health is a Community Affair" Report of the National Commission on Community Health Services. May 9-11, 1966, 36, 40-41.; Similarly, the term "health" is not self-contained but rather involves the interdependency of environmental, economic and social factors for its organization and outcomes.

[6] Dartington describes primary task as a term used to differentiate between the main operating activities of the organization as opposed to activities involving regulation or maintenance. Primary task is strongly linked to mission in non-profit organizations. Tim Dartington, "From altruism to action: primary task and not-for-profit organization. Human Relations. 51(12): December 1998, 1477-1478.

[7] Dartington, 1488; For discussion of the common good in business, see Antonio Argandona. "The stakeholder theory and the common good." *Journal of Business Ethics*. 17 (9/10): 1093-1102.

[8] Darcy Ashman, L.D. Brown and Elizabeth Zwick. "The strength of strong and weak ties: building social capital for the formation of governance of civil society resource organizations." *Nonprofit Management and Leadership*. 9(2): Winter 1998, 154.

[9] Dartington, 1478-1479.

[10] Ira Levin. "Vision Revisited: Telling the Story of the Future." Journal of Applied Behavioral Science 36(1): March 2000, 93-95.

[11] Seay and Vladeck, *Mission Matters*, 28.

[12] Seay and Vladeck, *Mission Matters* 28.

[13] Levin, 93.

[14] Levin, 94.

[15] For historical origins of this tendency in American nonprofit organizations at the turn of the twentieth century, which tried to promote Christian and democratic values by industrialists, see Hall, 4-5, 41.

[16] Ashman, Brown and Zwick, 158-159; Carl Anderson. "Values-based management." *The Academy of Management Executive*. 11(4): November 1997, 25. Anderson argues that values based management lays the foundation for the development of mission and corporate plans and goals as well as the ability to address and resolve conflicts.

[17] Ashman, Brown, and Zwick, 156.

[18] Merwyn Greenlick. "Profit and Non-Profit Organizations in Health Care: a Sociological Perspective." *In Sickness and in Health: The Mission of Voluntary Health Care Institutions*. Eds. J. David Seay and Bruce C. Vladeck. (New York: McGraw-Hill, 1988) 155-176; Seay and Vladeck, *Mission Matters*, 13, 29.

[19] Voluntary, Dartington explains, means that the organizations ahs a non-paid board or management committee and is subject to charitable laws. Dartington, 1480.

[20] Many grass roots, non-governmental organizations, especially abroad, for example, seek to empower communities as part of their "social mission." Other NGO's today provide emergency relief as their "social mission."

[21] Ashman, Brown and Zwick, 153.

[22] Seay and Vladeck, *Mission Matters*, 16, 27.

[23] See Eliot's words in Hall, 43.

[24] According to Hall, the distinctive organizational sector of nonprofit organizations with a clear, collective consciousness in the United States has only come about in the past forty years. Before then, charitable, tax-exempt organizations existed but their presence was uncoordinated until significant growth after 1960. According to Hall, in 1940 there were only 12,500 secular charitable tax exempt organizations as compared to contemporary figures of 700,000. The treatment of the nonprofit sector as a separate, institutional sector by the National Income Accounts, only dates from 1980. During that time, their distinctiveness was measured in their tax code status, their method of governance and the sources of their revenue. Peter Dobkin Hall. *Inventing the nonprofit Sector and other essays on philanthropy, voluntarism and nonprofit organizations.* (Baltimore: Johns Hopkins University Press, 1992) 2, 13, 44.

[25] Hall, 53. For influence of Hoover on Roosevelt's National Recovery Administration (NRA) see pages 57-58, 60.

[26] Hall marks 1942 as a turning point, when income tax became universal through withholding, because it is then that the status of voluntary organizations (especially those owned by the wealthy) was questioned in terms of their relative privilege of being tax exempt in relation to taxpayers. Still Hall argues that the uniqueness of American nonprofit organizations lies not in their tax-exempt status, the services they deliver, nor in their voluntarism or charitable works but in "their concrete historical association with a particular institutional culture, a configuration of values, resources, organizational technologies, legal infrastructure and styles of leadership." Hall, 2, 13, 15.

[27] Hall notes that because these incentives grew slowly, it took a long time before tax exempt organizations realized their common interests with regard to government regulation and taxation. Consciousness as a distinct sector by these organizations only came in the 1960's and especially the 1970's when the issues of tax and regulatory policies and the role of private enterprise in public life were raised. Hall, 15.
[28] Hall, 8.
[29] Hall, 7.
[30] The story of the emergence of voluntarism complicates the idea of fixed boundaries between government and civil society.
[31] Rosemary Stevens. *In Sickness and in Wealth: American Hospitals in the Twentieth Century.* (Basic Books: New York, 1989) 140.
[32] Prepaid insurance was used among nonprofit hospitals during the Depression as a way to bring paying patients that had been using government hospitals back into the voluntary hospital fold. One difference between for-profit and non-profit hospitals during this time was that for-profit hospitals entered the Depression with more outstanding debts. Many of them had to declare bankruptcy with the Depression. Non-profit hospitals on the other hand, usually raised funds in advance for such things as building costs so had less debt. In any event, many hospitals of all types had to close during the Depression due to decreases in revenue. Stevens, 146-147, 158; See also Shadid, 212.
[33] Stevens notes, however, that utilization of government hospitals was largely due to increased patient numbers in chronic disease and psychiatric hospitals, two types of hospitals that nonprofits did not undertake. She remarks that the alleged shift to government hospitals during this time was a statistical artifact. Even still, the abstract threat of government hospitals mobilized voluntary hospital administrators to use competition as a way to organize and promote their agenda. The Committee on the Costs of Medical Care was established in 1926 by fifteen men at a conference in Washington D.C. They assigned a smaller committee (with included Michael Davis, Walton Hamilton and C.E.A. Winslow) to formulate a plan. In 1927, the group of almost fifty people made up of representatives of interest groups and health care professionals and decided to seek foundation support to study the organization of American medical care. The committee was chaired by Dr. Ray Lyman Wilbur, president of Stanford University, past president of the American Medical Association, and Hoover's secretary of the interior. The final report of the Committee, endorsed by 35 of its members, concluded that every person in the population should have access to medical care but that the costs of services were "inequitably distributed" and terribly unorganized. Paul Starr. *The Social Transformation of American Medicine.* (New York: Basic Books, 1982) 261-266; Stevens, 123,135, 149-151, 154-1956; Merwyn Greenlick, Donald Freeborn and Cyde Pope. *Health Care Research in an HMO: Two Decades of Discovery.* (Baltimore: Johns Hopkins University Press, 1988) 4.
[34] As such, the AMA resolved in 1934 to accredit only those internships that were members of the local medical society (which excluded group practice physicians). Stevens, 155. See also Michael Shadid. *A Doctor for the People: An Autobiography of the Founder of America's First cooperative hospital.* (Vanguard Press: New York, 1939). Shadid notes that the report noted that half of illness in America occurred among people earning $1200 or less. Shadid asked how these people could afford medical care when they couldn't even afford adequate food. 111.
[35] Stevens, 156; Shadid describes the various back-handed strategies the medical societies took to thwart his efforts to establish a cooperative hospital in Elk City, Oklahoma. Shadid, 120, 133, 210-211. Finally in 1938, the US Department of Justice ruled that the AMA could not prevent or thwart the functioning of Group Health Association of Washington. This ruling set the precedent for inquiries into other injustices done by the AMA and local medical societies towards group practice and cooperative hospitals. In its struggle with government intervention in medicine, the AMA refused to support a government proposal to spend millions of dollars on public health facilities and preventive medical care. Shadid, 236-242.
[36] Voluntary hospital administrators fought against California local government hospitals from accepting paying patients since it posed outright competition to nonprofit private hospitals. The court's ruling that government hospitals could only care for indigent patients, except in extreme circumstances, was held until the late 1960s. This ruling also provided a clear preference of voluntary hospitals over government hospitals and that tax-supported hospitals had a different mission from voluntary ones. Stevens, 154.
[37] Stevens, 149-150.
[38] Hendricks, 95.
[39] Stevens, 141, 150. This type of argument has been reiterated in contemporary debates with regard to removing the health care field from the classification of "charitable" in the IRS code and providing a new category for "health services" that would sustain tax exempt status without having to provide charitable services in a strict sense. See Sigmond and Seay's discussion of Gray. Sigmond and Seay, 260.
[40] Stevens, 150, 159.

[41] This claim was substantiated by statistics that presented by the AMA Council on Medical Education and Hospitals in 1934, that distinguished between nonprofit and for-profit hospitals for the first time. The hospital lobby also successfully negotiated exclusion from the Social Security program in 1935 on the same basis. Stevens, 159, 164-166. Ironically, an argument is being made today in order to distinguish health services organizations from charitable ones. This contemporary argument centers on removing the health care field from the classification of "charitable" in the IRS code and providing a new category for "health services" that would sustain tax exempt status without having to provide charitable services in a strict sense. See Sigmond and Seay's discussion of Gray. Sigmond and Seay, 260.

[42] Stevens, 152, 161, 162, 170.

[43] According to Padgug, it is that space where the third way provided what has now disintegrated and has caused the exacerbation of today's health crisis. Robert Padgug. "Looking Backward: Empire Blue Cross and Blue Shield as an Object of Historical Analysis." *Journal of Health Politics, Policy and Law*. 16(4): Winter 1991, 797.

[44] Gerald Markowitz and David Rosner. "Seeking Common Ground: A History of Labor and Blue Cross." *Journal of Health Politics, Policy and Law*. 16(4): Winter 1991, 699; Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States*. (Cambridge: Harvard University Press, 1992) 46-47,155, 157, 189, 193-204, .

[45] Markowitz and Rosner, 698.

[46] Markowitz and Rosner. 696, 700.

[47]These plans included Group Health Cooperative of Puget Sound in Seattle, Group Health Association of Washington D.C., Health Insurance Plan of Greater New York and Kaiser Permanente in California, Oregon and Washington. M. Greenlick, D. Freeborn and C. Pope. *Health Care Research in an HMO: Two decades of discovery*. (Johns Hopkins University: Baltimore, 1988) 4.

[48] Saward and Fleming. 47-48; Crowley, 31, 33, 96-97.

[49] For discussion on cooperatism, see Walt Crowley. *To Serve the Greatest Number: A History of Group Health Cooperative of Puget Sound*. (University of Washington Press: Seattle, 1996) 6-7.

[50] Crowley, 9.

[51] Shadid, 109, 150.

[52] See also examples of Group Health Cooperative of Puget Sound, Group Health of Washington DC, Wage Earners Health Association of St. Louis, San Diego Beneficial Society, the Ross-Loos Medical Group, Milwaukee Medical Center and Trinity Hospital. Shadid preferred the cooperative hospital over and above the prepaid group practice model. During this time as well, other methods of health care delivery were emerging that continue to have a significant effect upon health care today. Shadid, 226-227.

[53] Shadid, 112, 249.

[54] Shadid, 123; Crowley, 5.

[55] Shadid, 113.

[56] Shadid, 152; Crowley, 5.

[57] Shadid, 254.

[58] Group Health Cooperative's mission was "to serve the greatest number of people in the Puget Sound Area upon the consumer's cooperative plan." Crowley, 113.

[59] Ironically the Group Health Cooperative of Puget Sound established itself as a not-for-profit association (rather than a legal cooperative) in order to take advantage of new federal law for nonprofit organizations. Group Health also decided to vest management authority in a Board of Trustees. Shoudy insisted on full coverage, including prescription coverage, despite Shadid's hesistancy concerning impeding profit making for the drug store. Crowley, 13, 17, 19; Saward and Fleming. "Health Maintenance Organizations." 48.

[60] Crowley, 24.

[61] I treat the organization as a unit here despite the fact that the health plan and hospital are separate entities from the medical group. Still, Kaiser Permanente as a whole both enrolls members and delivers services. In addition, although separate corporations, these entities are managed as a unit with a shared board of directors and officers. Fleming, "Prepaid group practice in a multi-state setting." 33; Scott Fleming. "Health Maintenance Organizations: a prototype-California. Kaiser Foundation-Permanente Program." *Hospitals*. 45(6): March 16, 1971: 57.

[62] See discussion on Tahoe Accords.

[63] Saward town hall meeting 3/89.

[64] Saward's model was a producer-owned cooperative, rather than a consumer-owned one.

[65] Greenlick, Freeborn and Pope. 5.

[66] Greenlick, Freeborn and Pope, 5; Ernest Saward and Scott Fleming, "Health Maintenance Organizations." *Scientific American*. 243(4): October 1980. 48.
[67] Padgug claims this for Blue Cross, p. 797.
[68] Hall, 55.
[69] Scott Fleming. "Prepaid Group Medical Practice in a Multi-State Organization: The Kaiser Permanente Program." *Health Matrix*. 2(1). Spring 1984. 31.
[70] Hall, 50; Markowitz and Rosner, 699-700.
[71] Town Hall Meeting. Saward lecture. Center for Health Research. Portland, OR. 3/3/89.
[72] H.S. Luft and M. R. Greenlick. "The Contribution of Group and Staff model HMOs to American Medicine." *Milbank Quarterly*. 74(4):1996. 448; Town Hall Meeting. Saward lecture. Center for Health Research. Portland, OR. 3/3/89.
[73] Sigmond and Seay, 259.
[74] Saward oral history, 21; Hendricks, 101.
[75] Kaiser medical employees, all 750 of them, took care of 2/3 of the 37,000 employees at the Kaiser shipyard in Washington. Town Hall meeting. Saward lecture. Center for Health Research. Portland, OR. 3/3/89.
[76] Saward oral history 24.
[77] Saward oral history, 23.
[78] Fleming, "Prepaid Group Medical Practice in a Multi-State organization," 31.
[79] Clifford Keene. "The Growing Demand for Information on Prepaid Group Practice." In Anne R. Somers, ed. *The Kaiser-Permanente Medical Care Program* (Commonwealth Fund: New York, 1971) 4.
[80] Fleming, "Prepaid Group Medical Practice in a Multi-State Organization," 31.
[81] Saward oral history 25. Yedidia relates that the plan between a trust in 1946 and the physicians and other managers became employees of the trust. Yedidia oral history, 27.
[82] Saward oral history 26-27.
[83] Saward oral history 39-40.
[84] Hendricks, 101.
[85] Saward oral history 38; Hendricks, 101.
[86] We should recall that Seay and Vladeck noted long term commitment and governance as central concepts of voluntary organizations. Group Health Cooperative utilized a similar strategy to that of KP in their early years in order to remain financially solvent and stable. See Crowley, 49. Given this experience, Saward later became a leader in the development of prepaid Medicaid and Medicare. See Ernest Saward. "Medicare, medical practice and the medical profession." *Public Health Rep*. 91(4). Jul-Aug 1976: 317-21.
[87] Saward oral history, 37; See also Rickey Hendricks. *A Model for National Health Care: The History of Kaiser Permanente* (New Brunswick: Rutgers University Press, 1993) 90.
[88] Saward Oral History, 38.
[89] Saward Oral history, 38.
[90] Oswald oral history, 26.
[91] Oswald oral history, 3, 4, 28; Steve Gilford. "How KP Got its Name." *KaPeRs Newsletter*, April 2001. 3-4.
[92] Hendricks 101.
[93] Yedidia oral history, 35.
[94] Saward oral history 50.
[95] MacColl as quoted in Crowley, 28.
[96] Antonio Argandona. "The stakeholder theory and the common good." *Journal of Business Ethics*. 17 (9/10): 1093-1102.
[97] Merwyn Greenlick. "The Development of the Social Mission of Kaiser Permanente." *The Permanente Journal*. 1(1): 1997, 64; Bob Mitchell, when speaking of Group Health Cooperative, noted the virtues of group practice in its ability to avoid exploitation and sickness and to banish "the element of greed and profit" from medicine. Crowley, 48.
[98] Saward explained later that many elements like cost containment were, in fact, by-products of the Permanente program-- "not its goal as a societally desirable alternative to the prevailing fee-for service solo practice." Saward, "Lessons," 8; Greenlick, "Diverse Cultures," 18.
[99] Saward and Fleming. "Health Maintenance Organizations." 47, 51; See also Group Health innovative preventive services. Crowley, 97-99.
[100] No such dual obligation exists amongst for-profits where financial solvency is primary and service is only intended to produce greater profit. Seay and Vladeck, 21.

[101] Luft and Greenlick, 449, 454.
[102] See Luft and Greenlick, 452; Fleming, "Health Maintenance Organizations: a prototype." 57; For handling of this issue by Group Health Cooperative, see Crowley, 118. Crowley notes that capitation was used by Group Health as a way to keep Kaiser Permanente and other competitors from penetrating the Washington market.
[103] In response to strong anti-communist sentiment during this time (the McCarthy era) and claims by organized medicine that the Kaiser Permanente program was socialized medicine, Henry Kaiser instituted a corporate loyalty oath similar to the one used by the FBI. This move caused great dissatisfaction by some of the physicians, especially in the Northern Permanente region, because it threatened professional security. See Hendricks, 129-131. See E. Richard Weinerman's assessment of the situation. Hendricks, 134-137 and 140-141, 169-172.
[104] Memo to E. Kaiser, Trefethen, Link, Garfield, Keene, Baritell, Collen, Cutting, Kay, Neighbor, Saward and Weiner. May 12, 1955. 1-2. MSS 91/12c/1. Bancroft Library. Berkeley, CA; Fleming. "Prepaid Group Medical Practice in a multi-state organization." 31; For another example of crisis between the Board and the medical staff, see Group Health Cooperative. Crowley, 79-84.
[105] Memo to E. Kaiser, Trefethen, Link, Garfield, Keene, Baritell, Collen, Cutting, Kay, Neighbor, Saward and Weiner. May 12, 1955. 1-3. MSS 91/12c/1. Bancroft Library. Berkeley, CA; Working principles drafted by Baritell, Cutting and Collen. Never presented to Trustees. March 1955. 1-2. MSS91/12c/1. Bancroft Library. Berkeley, CA.
[106] Working principles drafted by Baritell, Cutting and Collen. Never presented to Trustees. March 1955. MSS 91/12c/1. Bancroft Library. Berkeley, CA.
[107] Decisions of the Working Council (Tahoe Agreement). July 14, 1955. Fleming Oral History. 202; Hendricks 175, 182.
[108] Attachment to Minutes of Working Council Meeting of June 7, 1955 dated May 13, 1955. 4. MSS 91/12c/1. Bancroft Library. Berkeley, CA; Hendricks 186-187.
[109] Confidential memo: Meeting with Health plan and Hospital attorneys regarding legality of proposed integration. April 19, 1955. 3. MSS 91/12c/1. Bancroft Library. Berkeley, CA; Hendricks, 124.
[110] Additional version of Memo to E. Kaiser, Trefethen, Link, Garfield, Keene, Baritell, Collen, Cutting, Kay, Neighbor, Saward and Weiner. May 12, 1955. 2. MSS 91/12c/1. Bancroft Library. Berkeley, CA; Attachment to Minutes of Working Council Meeting of June 7, 1955 dated May 13, 1955. 1-5, 8-9. MSS 91/12c/1; Confidential Memo: Meeting with Health Plan and Hospital attorneys regarding legality of proposed integration. April 19, 1955. 1-4. MSS 91/12c/1. Bancroft Library. Berkeley, CA; Meeting of Special Subcommittee. Suggestion of George Link. June 20, 1955. MSS 91/12c/1. Bancroft Library. Berkeley, CA; Letter from Trefethen to Baritell, Collen, Steil, Reis and Link. June 16, 1955. MSS 91/12c/1. Bancroft; Letter from George Link of Thelen, Marrin, Johnson and Bridges to Board of Directors of Kaiser Foundation hospitals. June 3, 1955. MSS91/12c/1; Letter from Link to H. Kaiser, E. Kaiser, Trefethen, Garfield, Baritell, Cutting, Collen, Kay, Neighbor, Saward, Weiner, Keene, Reis, Steil, Inch. June 24, 1955. This letter included the minutes of the June 22nd working council meeting in which purchase of the Foundation hospitals by the doctors was discussed. 4; Letters between Harry Fledderman to Morris Collen. June 9, 1955 and June 14, 1955; Minutes of Working Council meeting. June 7, 1955. 2. MSS 91/12c/1. Bancroft Library. Berkeley, CA; See also Kaiser's response, Hendricks 188-189.
[111] The regional management teams were to "maintain a medical care program in the region of high quality at a reasonable cost," to review matters in the region that would go before the Advisory Council and serve as the liaison between the personnel in the region and the Advisory Council, and to be the coordinating body for the regional activities. See Fleming Oral History, p. 203; At the beginning of the process there was some confusion among the working council about the extent of direct communication between the board of trustees, the executive vice president and operating level personnel. See Memo to Trefethen from George Link and Scott Fleming. October 6, 1955. Trefethen Papers, 15/1. Bancroft Library. Berkeley.
[112] Memorandum from Henry Kaiser Jr. July 20, 1955. MSS 91/12c/1. 1-2; Advisory Council Submitted to Working Council. July 12, 1955. MSS 91/12c/1. Bancroft Library. Berkeley, CA.
[113] Interview of Scott Fleming done by author. June, 2001. Berkeley, CA.
[114] Attachment to Minutes of Working Council Meeting of June 7, 1955 dated May 13, 1955. 8. MSS 91/12c/1.
[115] Decisions of the Working Council. July 14, 1955. 3-4. MSS 91/12c/1; Letter from Link to Kaisers, Trefethen, Garfield, Baritell, Cutting, Collen, Kay, Neighbor, Saward, Weiner, Keene, Reis, Steil, Inch. June 24, 1955. 6. Of June 22nd minutes included in this document. MSS 91/12c/1. Bancroft Library. Berkeley, CA.
[116] Fleming, "Prepaid group medical practice." 33-34; See also Group Health Cooperative case, Crowley, 102.
[117] There were interim financial arrangements between the health plan and the medical group between the period July 1, 1955 to June 30, 1956 until final determination of contract price was determined. See Exhibit 2-4. Advisory Council Meeting December 8-9, 1955. P. 1. MSS 91/12c/1. Bancroft Library; Basis for division of health plan funds

in each area. July 12, 1955. MSS91/12c/1. Bancroft Library. Berkeley, CA; Letter from Trefethen to Baritell, Collen, Steil, Reis, Link, H. Kaiser, E. Kaiser, Garfield, Frink, Kay, Neighbor, Saward and Weiner. June 30, 1955. MSS 91/12c/1. Bancroft Library. Berkeley, CA; For additional details on how contract price was determined, see Decisions of Working Council, July 14, 1955 and subsequent, similar drafts. 4-5. MSS 91/12c/1. Bancroft Library. Berkeley, CA.

[118] Saward oral history 42, 43.

[119] Hendricks 193.

[120] Saward never did receive the money promised to him for the Portland hospital. See discussions in minutes of Advisory Council meetings, December 8-9, 1955. 32 . MSS 91/12c/1. Bancroft Library. Berkeley, CA.

[121] Saward oral history 44.

[122] Fleming, "Prepaid group medical practice." 32.

[123] A. Yedidia. "Remembering Frank Jones April 30, 1987." Presented at the Frank Jones Memorial Service. In Yedidia oral history, 86.

[124] Saward and Fleming, 48.

[125] Yedidia oral history, 37.

[126] KP also helped ILWU-PMA arrange similar health care coverage with longshoremen in Seattle with the Group Health Cooperative of Puget Sound. Yedidia oral history, 58.

[127] See Yedidia oral history, 55 where he discusses the case of the steelworkers union in northern California.

[128] These contracts were also important for Group Health Cooperative of Puget Sound's survival. See Crowley, 45.

[129] Saward oral history 32; Saward, town hall meeting March 3, 1989. Center for Health Research. Portland, Oregon

[130] Saward oral history 32.

[131] Oswald oral history, 7.

[132] Saward Oral history, 35.

[133] Saward oral history, 35.

[134] Seay and Vladeck, 30.

[135] Oswald oral history, 11.

[136] Saward Town Hall Meeting March 3, 1989 Center for Health Research, Portland, OR.

[137] Yedidia. "Dual Choice Programs." 1476.

[138] Luft and Greenlick, 450.

[139] A. Yedidia. "Dual Choice Programs." *American Journal of Public Health*. Vol 49, No. 11 November 1959. 1475. In 1942, when the health plan at the Kaiser shipyards was established and recruitment began, Avram Yedidia relates a story about the importance of the concept of voluntary choice in the Kaiser tradition. Agreeing to undertake the enrollment of Kaiser workers, Yedidia, in charge at the time of taking inventory and storing steel for the Permanente Metals Corporation Shipbuilding Division in Richmond, sent out his supervisors to recruit members from his payroll. All of the workers signed up except for one woman. Yedidia first asked the supervisor why the woman didn't sign up and was told that her English was faulty. Yedidia thereafter went to the woman and asked her why she didn't sign up for the health plan. She explained that she was told that she had to sign up, rather than it being solely her choice, and so she refused. Yedidia explained that enrollment in the health plan was purely voluntary and continued to stress this point as he became more involved in the extension of the health plan to the community after the war. Yedidia oral history, 22-23.

[140] Report to Advisory council by Northern California Dues Increase Committee. November 25, 1955. Exhibit 2-2- of Advisory Council Meeting in December. 2, 6. MSS 91/12c/1. Bancroft Library. Berkeley, CA.

[141] See Yedidia oral history, 54-55 on steel workers union for example in Bay Area.

[142] After having an argument with Harry Bridges of the International Longshoremen and Warehousemen's Union, Yedidia remembers Bridges providing another perspective—since the union was the largest subscriber to the plan, they possessed a great deal of negotiating power. Having dual choice reduced the chance of having the union withdraw the whole group because those members who did not like the plan could withdraw at any time and shift to another plan. Yedidia acknowledged that although he hadn't thought of it, that explanation was also extremely valid. Yedidia oral history, 59; Yedidia found in a study of health plan hospital utilization in 1957, that the dual choice option does not result in favorable risks selecting one plan and unfavorable risks selecting another. See Yedidia. "Dual Choice Programs." 1477.

[143] Hendricks 196.

[144] Fleming oral history 108.

[145]Yedidia oral history, 46. See also "Report of the Commission on Medical Care Plans, Findings, Conclusions and Recommendations." *The Journal of the American Medical Association*. Special Edition 17, January 17, 1959; Saward and Fleming. 50.

[146] Weissman added the particular problems a service health care organization has as compared to indemnity plans. These included the particular issues a service organization has with respect to quality of care, the problem of discouraging utilization in a program that focuses on preventive services, the high proportion of cost that would remain constant, despite a decrease in membership by those would couldn't meet the premiums, the issues of rebates and reserves as a result of experience rating, and the administrative issue of measuring utilization of services in comparison to the determination of rates according to payments in insurance companies. See Minutes of meeting of Advisory Council. January 12-13, 1956. 8-9. MSS 91/21c/1. Bancroft Library. Berkeley.

[147] Minutes of meeting of Advisory Council. January 12-13, 1956. 9. MSS 91/21c/1. Bancroft Library. Berkeley.

[148] Discussion with Dr. Merwyn Greenlick. Portland, Oregon. March 22, 1001.

[149] Avram Yedidia oral history, vii, 72.

[150] Interview with Scott Fleming. June 2001. Berkeley, CA.

[151] Seay and Vladeck. *Mission Matters*, 20; According to Avram Yedidia, the overall shift to experience rating in the industry led to the need for Medicare and Medicaid in 1965 because it priced retirees out of the market and produced an unbridgeable gap between the poor and the wealthy. As a response, the HMO Act in 1973 required that all federally qualified HMOs work with community rating systems. Since then, amendments have allowed modifications to the strict community rating system. Yedidia oral history, 73.

[152] Some of these challenges have included maintaining personal service, access to all members, cost effectiveness as well as new competition and market challenges. See Fleming, "Prepaid group medical practice." 34.

[153] This hypothesis was confirmed by Scott Fleming in my interview with him. June 2001. Berkeley.

[154] For another example of this formidable opposition, see physician-led Public Health League's opposition to New Deal healthcare reform, deeming it "Red Medicine." Crowley, 12.

[155] Shadid, 175-177.

[156] Hendricks, 96.

[157] Yedidia. "Remembering Frank Jones." Yedidia oral history, 86.

[158] See case of Group Health Cooperative of Puget Sound. Crowley, 116.

[159] Crowley, 24.

[160] Crowley, 59.

[161] Crowley, 19, 25.

[162] Saward oral history, 27-28.

[163] Hendricks 96.

[164] Hendricks 97-100.

[165] Crowley, 63; Hendricks 161.

[166] Memo to Trefethen from Tod Inch. October 28, 1948. cc'd to Ordway, Garfield and T.K. McCarthy. Trefethen Papers. 51/7. Bancroft Library. Berkeley.

[167] Memo to Trefethen from Tod Inch. October 28, 1948. cc'd to Ordway, Garfield and T.K. McCarthy. Trefethen Papers. 51/7. Bancroft Library. Berkeley, CA.

[168] See discussion of the Select Committee (1952) and Reece Committee (1954), Hall 67-69.

[169] The bill for federally funded healthcare in welfare programs was introduced by Wilbur Mills and then proposed in more modest form by Richard Nixon and Arthur Fleming. See Crowley, 105.

[170] The Larson Report is named after Dr. Leonard W. Larson who chaired an AMA sponsored commission on medical care plans in 1954. In 1950, Larson had chaired the AMA Medical Service Council's Correlating Committee on Relations with Lay-sponsored Voluntary Health Plans. According to Hendricks, by the end of the 1950's the AMA warned against denial of membership by a local society to a qualified doctor. Hendricks 161-62, 197-199, 208.

[171] On norms and cultures of professional and business organizations, see Greenlick. "The Diverse cultures of Physicians and Managers--a Perspective on Professional and Business Organizations." Kaiser Permanente Executive Program. July 1983. 7; For more detailed discussion of organized resistance to Kaiser Permanente medical plan, see Hendricks 142-172.

[172] Center for Health Research Town Hall meeting 1989 cassette tape. Lecture by Ernest Saward; "Tale of Two Cities."

[173] Henry Kaiser became quite involved in public policy and lobbying in his promotion of the Wolverton Bill already in the 1950's. His involvement, with the help of Kaiser lobbyist in Washington Craig Calhoun, this did not,

to the article's author, mark a distinctive period shift as seen in the 1960's and 1970's. Similarly, expansion of the program to several areas before the 1960's occurred but structural issues and survival of the program were primary during the earliest period of development. See Hendricks 106-110, 116.

[174] Seay and Vladeck, *Mission Matters*, 36.

[175] Yedidia oral history, 47.

[176] Hendricks 207.

[177] Letter from Robert Erickson to Mr. Fred W. Tennant. August 18, 1959. "Summary of Special Report on Federal Legislation made by Avram Yedidia and Bob Erickson at the Staff Meeting Held on August 10, 1959. in Yedidia oral history, 98.

[178] Hendricks 208.

[179] Legislation prior to the Medicare and Medicaid programs included a bill introduced by Aime Forand in 1957 to include hospital and nursing home expenses for the elderly as part of social security benefits, the Kerr Mills Act of 1960 which extended federal grants to states to provide health services to low income elderly who did not qualify for state welfare programs. These efforts provided precedents to Presidents Johnson's Great Society programs. Leiyu Shi and Douglas Singh. *Delivering Health Care in America: a systems approach*. Second Edition. (Aspen Publishing: Gaithersburg, Maryland, 2001) 99-100.

[180] Yedidia oral history, 62.

[181] Yedidia oral history, 61-63.

[182] As quoted in Luft and Greenlick, 453.

[183] Seay and Vladeck. *Mission Matters*, 9.

[184] See the *Journal of Health Politics, Policy and Law* special volume on Blue Cross/Blue Shield. 16(4): Winter 1991.

[185] Robert Padgug. "Looking Backward: Empire Blue Cross and Blue Shield as an Object of Historical Analysis." *Journal of Health Politics, Policy and Law*. 16(4): Winter 1991, 793-806.

[186] Padgug, 794.

[187] Padgug, 794.

[188] Hall, 10.

[189] Ira M. Levin. "Vision revisited." *Journal of Applied Behavioral Science*. 36(1): March 2000, 101.

[190] A. Donabedian quoted in M. Greenlick, D. Freeborn and C. Pope, eds. in *Health care Research in an HMO: Two decades of discovery*. (John Hopkins University Press: Baltimore, 1988) 3.

[191] Padgug, 795.

[192] Saward oral history 50.

[193] M. Greenlick. "The Development of the Social mission of Kaiser Permanente." 1.

[194] Ernest Saward. "Lessons and Parables in Health Care: A Tale of Two Cities." 1989 Ernest Saward Lecture. March 2, 1989. Center for Health Research. Portland, OR.

[195] Saward, "Lessons," 17.

[196] Saward "Lessons" 8.

[197] In addition, the "capitalist paradox of medicine" involves the conflicting interest of being "efficient" while also being caring. Implicit in the mission of prepaid group practice, undertaken by Kaiser Permanente and other groups in the 30's and 40's, was the attempt to eliminate this conflict of interests and to facilitate affordable and quality health care to a circumscribed community of members.

[198] Sigmond and Seay, 267.

[199] Greenlick. "The Development of Social Mission of Kaiser Permanente." 63-64.

[200] Seay and Vladeck, 38-39.