

A Look at Kaiser CEO's Legacy

Faith in Quality Never Waned

David M. Lawrence, MD, MPH, guided the country's largest not-for-profit health plan through the tumultuous managed care decade.

By Frank Diamond

Senior Editor

When David M. Lawrence, MD, MPH, departing CEO of Kaiser Permanente, says that his immediate plan upon retirement is to write a book, one wonders whether he is following the example of Winston Churchill, who said "History will be kind to me for I intend to write it."

Says Lawrence: "What I'm trying to do is describe why the model of medical care delivery that we've grown up with in the 20th century is obsolete."

Numbers game

It is a subject he has confronted for the last 10 years as head of the largest not-for-profit health plan in the country. Fortunately for Lawrence, history is often a numbers game and any assessment of a CEO's career requires a close reading of the bottom line. By that measure, Lawrence leaves Kaiser Permanente in better shape than when he took over.

"Where did it come out?" asks Glenn Smith, a health care consultant with Watson Wyatt Worldwide. "It came out the strongest health plan in the West, with a strong customer base: Providers, employers, and members who seem to stick with Kaiser through thick and thin. It is making its numbers."

And then some. Net income for 2001 was \$681 million, up 16.6 percent from \$584 million in 2000. The *San Francisco Chronicle* reports that Kaiser earned \$297 million on operating revenue of \$5.5 billion for the first quarter of 2002. "That was 90 percent more than the HMO's \$156 million in net income on operating revenue of \$4.9 billion for the same period of 2001."

During Lawrence's reign, Kaiser has grown from 6.5 million to 8.3 million members, while

"It was terrible,"
says David M. Lawrence of the three years when Kaiser Permanente lost huge sums. Membership grew too fast, forcing enrollees to use non-Kaiser hospitals and providers. Costs exploded.

annual revenues have risen from \$9.83 billion in 1991 to almost \$20 billion today.

That's not to say that Lawrence — who stepped down on May 1 and continues as chairman emeritus though the end of this year — didn't make errors. He's very well respected, very much praised, and could even be called a health care visionary. But he is, after all, human.

"No one would say he didn't make managerial mistakes," says Uwe Reinhardt, PhD, a health care economist at Princeton University, who quickly adds, "If I had been there, I would have too. I would have made different mistakes. And I probably would have hired consultants too, and let them scare the hell out of me."

Oh, yes, the consultants. In the mid-1990s, they told Lawrence — "screamed in his ear," is how Reinhardt puts it — that he needed to abandon the Kaiser model and move the plan into the for-profit HMO world. That advice reportedly cost hundreds of millions of dollars in consultants' fees, and Lawrence, Reinhardt says, had been tempted.

"Well, how do you learn?" Lawrence responds. "We're huge, complex, difficult. We have got to learn from other entities." (For more on Lawrence's thoughts on a wide range of subjects, see our Question and Answer feature at left.)

Stood his ground

Though Lawrence did make Kaiser more bottom-

line oriented, he basically stood his ground for Kaiser's system of delivering care, which some find too rigid. They point to the fact that, in an age where choice is king, Kaiser enrollees must use only Kaiser clinics and hospitals, which exist primarily to serve Kaiser members.

"Everyone was saying, 'Look at this outmoded albatross,'" recalls Reinhardt. "He's keeping hospitals. He can't move, and meanwhile, there are all these smart, nimble HMOs who can do hit-and-run attacks, who can merge and unmerge and dump people. And here he sits there like a big klutz."

Just to illustrate how much of a no-win job being the head of a health plan can be, there are also some who charge that Kaiser has been altered too much in the last decade.

"Lawrence changed the entire value system of the Kaiser system to undercut the bottom-of-the-barrel practices of its competitors,"

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Q&A with David M. Lawrence

'WE CHANGED THE WAY KAISER MAKES DECISIONS, VIEWS ITSELF'

After 21 years with Kaiser Permanente, first as medical director of its Northwest region in his native Portland, Ore., then as regional health plan manager in Colorado and in Northern California, and culminating as CEO of the entire Kaiser organization for a decade, David M. Lawrence, MD, stepped down May 1. Lawrence, 61, joined Kaiser after serving as director of public health for Multnomah County, which includes Portland, because he believed the HMO offered greater opportunities to work on improving community health than did the cash-strapped county.

As our cover story details, Lawrence's tenure as Kaiser CEO came at a tumultuous time for the country's largest classic HMO, amid new forms of competition, booms and busts in the managed care business, and a mixed record of expansion. Through it all, Lawrence kept his faith in the group practice model of integrated care delivery that has been Kaiser's hallmark for more than half a century.

Lawrence received his medical degree from the University of Kentucky College of Medicine in 1966, completed his residency at Johns Hopkins and the University of Washington, and is board certified in general preventive medicine. He holds a master's degree in public health and served in the Peace Corps. Lawrence spoke recently with Senior Contributing Editor Patrick Mullen.

MANAGED CARE: Why did Kaiser go outside the organization to bring in George C. Halvorson as your successor as CEO?

DAVID LAWRENCE, MD, MPH: I can't answer that, largely because it was a

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Q&A with David Lawrence

board-driven decision. They went through a long process of looking at internal and external candidates to narrow the field, did the interviews, and selected George because he best fit the bill.

MC: What has been the most dramatic change in Kaiser Permanente's corporate culture in the 10 years that you've been CEO?

LAWRENCE: One is that there's a real sense of the importance of the organization as a whole. When I started in 1990, all the action and attention focused on individual regions. It was a real federation kind of organization. We have worked hard over the last decade to balance that important perspective — especially for medical care delivery — with a sense of the organization as a collective. We changed the way the organization makes decisions, how it views itself, how it talks about itself, what it values in people. Collaboration, cooperation, and teamwork across geographic areas are now valued higher than the fierce independent point of view that

I was raised with as a regional manager in Colorado. That has been the most important shift, because it means that we now can start to take advantage of our intellectual scale, this incredible experience that occurs across all the geographic areas with all the clinicians and all the health plan executives.

MC: How has that closer collaboration among the regions benefited the organization?

LAWRENCE: The most notable benefit is the Care Management Institute, which was a top-down decision but done with an enormous amount of collaboration from the regions. We've agreed that we need to review the scientific evidence and medical science in a systematic way and then disseminate it through the entire organization. As a result, a doctor in Atlanta uses the same science and set of evidence and practices with the same understanding of what's best for a patient as a doctor in Hawaii uses. That's been a huge change in the organization. We've systematically reviewed the scientific evidence for the most com-

mon and most devastating illnesses that we see in our membership, such as heart disease, depression, diabetes, and asthma.

MC: How do the standards get into the hands of practicing physicians?

LAWRENCE: The hardest part has always been getting it out into practice. We do it by having doctors talk to doctors through an education network, which we call the CMI distribution network. It involves physician leaders and really talented support people. Over a three-year period, we've seen dramatic shifts in the number and proportion of physicians who practice according to these guidelines as reflected in retro-

Now you see insurers retreating to indemnity and competing over insurance products, and backing away from trying to work with the medical care delivery system in a direct way.

spective medical record reviews and chronic-disease-registry tracking programs. We're getting high levels of compliance with the standards, principles, and the evidence-based practice recommendations that came out of the Care Management Institute. The next step is going to be to build decision-support tools into the clinical information system. Once

that's in place, I think we'll see physicians practicing based on the latest and most effective scientific evidence at levels that haven't been reached in most parts of the country before.

MC: How important to that change is the information technology overhaul that's been under way for several years?

LAWRENCE: It's a reflection of it. I don't think it's driving it. It reflects the fact that we're now able to make decisions as a real integrated national organization. It reflects eight medical directors and eight regional presidents and executives and health plans and hospitals coming together and saying this is what we have to do to be the kind of national organization we need to be.

MC: What is the status of the clinical information system? I've seen reports that it's anywhere from one to three years behind schedule.

LAWRENCE: No, I don't think that's fair. Two regions, Northwest and Colorado, are completely on the clinical information system. Five regions were demonstration sites or laboratories for

Q&A with David Lawrence

building the systems. We did that all during the '90s. We chose the IBM-augmented solution that comes out of Colorado, and we've been perfecting the first and second version of that in Hawaii. We're just about completed with Hawaii and the

next step is to roll it through southern California and to upgrade Colorado. It is a slow process, but we now have agreement in the organization that we'll do it one way with one system. When we need to, we'll upgrade the entire system at the same time. We expect to have all parts of the organization on the system by 2004.

MC: How do you train physicians to practice team-based medicine?

LAWRENCE: It really is immersion. The medical groups do a superb job of selecting physicians. They make sure that people come in with their eyes open about what team-based group practice is. Then, of course, they're surrounded by it. They're not going off on their own. We use one medical record across a region so that doctors have a chance to see how others practice. One of the core principles of the old model of profes-

sional autonomy is that you don't believe what anybody else has done. It's a very difficult hurdle to get past because you want that kind of independent view, but you also need a vehicle for building trust within the team. We formally construct a group of clinicians, doctors, nurses, pharmacists, and others to take care of a category of patients — childhood asthmatics, adult diabetes patients, or whomever. The team builds trust so that members know what each other is capable of doing. You have to work at it; it isn't a natural act. Another issue is the difficulty of accessing information in a paper record. That's why we're so committed to creating the clinical information system. When you've got multiple entries and a physician sees as many patients in a day as most physicians do today, the opportunity to go back through the medical record is limited. We've been looking for summary systems and chronic disease registries and other tracking mechanisms that allow a clinician to short-circuit all the data that has to

be in the medical record for legal and record-keeping reasons. You can't practice medicine in the 21st century without information technology. It is too overwhelming.

MC: How surprised were you, if at all, to see Kaiser and other HMOs go from being thought of as a socially progressive force to being the bogeyman that was destroying health care delivery in America?

LAWRENCE: Newer entrants that had transformed from insurance companies into managed care companies took an approach that set them on a collision course with physicians. It was also clear that consumers were going to take their cues about their medical care and the quality of that care from their physicians, not from their employers. We elected not to participate in that collision course. We didn't expand our insurance products very dramatically. We experimented

Q&A with David Lawrence

with contracting with non-Permanente physicians but we still used the Permanente medical groups to do that. Nonetheless, we got swept into the whole upswelling that occurred and then the bashing that went on. And neither surprised me.

MC: What types of health-related initiatives do you see on the political front?

LAWRENCE: We will see window-dressing legislation that doesn't get to the heart of the issues, like the growing ranks of the uninsured and the underinsured, the staggering rise in the cost of medical care insurance, and the problems in quality and safety in the delivery system. Talking about a Patients' Bill of Rights or prescription benefits for the elderly nibbles around the edges. There is absolutely zero will at the federal level and at most state levels to take on anything substantive in medicine. Everybody is still bleeding from 1993. Memories are long. It's a political La Brea Tar Pits for most politicians. The only place that government can be proactive and shape the marketplace is as a purchaser using Medicare, the military purchasing model, and Medicaid. Governments don't have a history of being terribly proactive, visionary purchasers. They're not doing innovative value-purchasing initiatives like the Leapfrog Group, the Washington Business Group on Health, the Pacific Business Group on Health, or other aggressive and advanced private-sector employers. In our political model, politicians don't provide policy leadership except in the case of a major national crisis like depression or war. They wait until political, social, or marketplace trends emerge that become untenable politically. That could happen with the uninsured. The situation has deteriorated markedly since the failure of the Clinton administration bill. Nobody is willing to do very much of anything, and you have a highly regulated incoherent patchwork of a marketplace.

This idea of washing your hands as an employer and saying, "Here's a defined contribution, go figure out what you need to do," is one of those wonderful and seductive short-term solutions that comes back to haunt an employer.

There are lots of ways for people to play games in that marketplace, and the consumer is losing.

MC: This, at the very time when everyone says we're moving into a period of consumer-empowered health care.

LAWRENCE: That is so much garbage. Think about it. Here's a consumer making a bet on whether or not he and his family are going to be sick this year. If he bets right, he makes out like a bandit for a year, depending on which kind of benefits he chooses. If he bets wrong, what happens to him that year and the next year as he tries to get insurance for a family in which one of his children or he or a parent is chronically ill with a serious illness? We can't predict who's going to get sick for one person. You can't do it for 10. It's not until you have 50,000 people or 100,000 people, an insurance pool large enough that you can start to apply the principles of statistics and even begin to guess at what your costs and experience will be. This wonderful idea of consumer choice is putting more power in the hands of insurers at the expense of the individual consumer.

MC: You are talking about things like medical savings accounts?

LAWRENCE: Oh criminey, yes. It's just unbelievable. It's a vast seduction that competes over exactly the wrong things: risk, actuarial science, and insurance benefits, instead of competing over which medical care system delivers the best care to you at the most affordable price. Luckily, enlightened employers are saying, "Wait a minute. This doesn't make a whole lot of sense." These plans are horrific to administer. This idea of washing your hands as an employer and saying, "Here's a defined contribution, go figure out what you need to do," is one of those wonderful and seductive short-term solutions that comes back to haunt an employer when an employee suddenly has cancer or diabetes and is saying, "Where do I get my insurance?"

MC: Thank you.

MEET GEORGE C. HALVORSON

When it selected the person who would become only the fourth CEO in Kaiser Permanente's history, it may have seemed that the health plan reached beyond its own culture.

George C. Halvorson, after all, is not a homegrown Kaiser product and, unlike David M. Lawrence, MD, the man he replaces, he is not a physician. Nevertheless, anyone who thinks that this means Kaiser Permanente — with 8.3-million members, \$20 billion in revenue, and 100,000 employees — is moving in a radical new direction should think again.

"He's so much like him," Uwe Reinhardt, PhD, a health care economist at Princeton University, says in comparing Halvorson to Lawrence. Halvorson, who began at Kaiser on May 1, comes from HealthPartners, a not-for-profit, 660,000-member HMO in Minnesota.

"He comes essentially from the not-for-profit Minnesota world," Reinhardt continues, "and every Minnesotan is actually a public citizen. That's their nature. Minnesota people have a much larger view than 'me and my stock options.' I think he is a perfect guy. He's certainly not Kaiser culture — and that could be some problem — but I think he brings this strange mixture of entrepreneurial culture, which certainly Minnesota has, and its not-for-profit [nature]. There was always a public-citizen thing to it."

Lawrence could be described as academic; Halvorson is a bit more informal. He is, in the words of consultant Peter Kongstvedt, MD, "much more of a short-sleeves kind of guy."

As with Lawrence, Halvorson speaks frankly. For instance, in our March cover story on defined contribution, Halvorson discussed why handing over the purse strings to consumers can't motivate all of them to shop for price: "Anyone who has just been diagnosed with cancer is in no position to go out for bids."

Halvorson, chairman of the board of the American Association of Health Plans from June 1994 until June 1996, has been described as a vigorous proponent of managed competition.

As with Lawrence, he is also a big advocate of information technology. In early May, he told the *Minneapolis Star Tribune* that HealthPartners is about five years ahead of Kaiser in implementing information systems, including an electronic medical record.

Considering Lawrence's difficulties on this score, moving every Kaiser physician onto electronic medical records could be quite a chore. The reward, however, seems to be worth it.

The *Star Tribune* also reports that Halvorson made \$814,000 a year at HealthPartners; his Kaiser salary has not been disclosed. Lawrence made \$2.2 million in 2000.

Jamie Court, who heads the Foundation for Taxpayer and Consumer Rights, tells the *San Francisco Chronicle*.

And a recent article in the *Sacramento Bee* begins, "Kaiser Permanente may well be the HMO that people love to complain about." Perhaps. Still, the system is attractive enough to corner more than a third of the state's HMO market. And employers, generally, seem happy.

"Our customer-satisfaction surveys have given Kaiser high marks on behalf of almost 400,000 CalPERS enrollees," says Clark McKinley, a spokesman for the California Public Employees' Retirement System. "On a scale of 1 to 10, 66 percent of CalPERS members who rated our present seven HMO partners gave Kaiser 8, 9, or 10, compared with 58 percent for the next highest-rated plan."

As far as quality is concerned, Kaiser also garners good reviews — even from overseas. (See "Benefits of Competitive Edge" on page 24.)

Downside

Of course, as Reinhardt indicates, Lawrence's tenure was not without bumps.

There were the expansion attempts that didn't fly. (Or, as Lawrence explains, attempts to stabilize expansions that occurred in the 1980s that didn't pan out: "The 1990s were devoted to trying to fix programs that were badly broken.")

There were also three consecutive years of financial losses in 1997, 1998, and 1999 (the first losses the company suffered in its 57-year existence). Kaiser bled \$288 million in 1998, its worst year.

Kaiser attracted more members than it could accommodate. Costs rose when the plan had to refer overflow patients to non-Kaiser physicians and specialists.

"Once you get outside our providers into the community, your costs go bad," says Lawrence. "We got into that cycle, and it took us 18 months to get out."

There were other problems as well, such

How Kaiser matches up against Britain's National Health Service

The *British Medical Journal* this year published a comparison of Kaiser Permanente and the National Health Service, concluding that health care "costs per capita in Kaiser and the NHS are similar to within 10 percent and that Kaiser's performance is considerably better in certain respects, particularly access to specialist diagnosis and treatment, and hospital waiting times."

Primary care

Measure	NHS	Kaiser (California)
Time to see a primary care physician	2001: average 3 days; <48 hours by 2004	Urgent: <24 hours; routine: 80% <7 days
Telephone help line and associated services	NHS direct help line available. By 2004, NHS Direct will provide gateway to advice, appointments, and out of hours care.	24-hour hot line available for advice and appointments. Appointments can also be made online.
Repeat prescription available without calling or visiting a doctor	Available nationwide by 2004	Available now
Time spent with primary care physician	8.8 minutes	Medical: 20 minutes; Ob/Gyn: 15 minutes; pediatrics: 10 minutes

Specialist referral

Waiting time to see a specialist	2001: 36% <4 weeks, 20% >13 weeks, 4% >6 months; by 2005, average 5 weeks and maximum 3 months	2001: 80% <2 weeks
Waiting time for inpatient treatment or surgery	2001: 41% <13 weeks, 33% >5 months, 7% >12 months; by 2005: average 7 weeks and maximum 6 months	2001: 90% <13 weeks

Vaccination

Children who received various immunizations by 2 years old	DTP=95%, MMR=88%, Hib=94%	DTP=91%*, Polio=93%*, MMR=94%*, Hib=91%*, Hepatitis B=86%*, Chicken pox=83%*
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Specialists per 100,000 people

Pediatricians	4.9	12.3
Ob/Gyn	4.1	8.3
Oncologists	0.9	1.7
Radiologists	4.3	6.0
Cardiologists	0.8	2.4

Cancer screening

Breast	69% of women age 50-64 had mammogram in past 3 years†	78% of women age 52-69 had ≥1 mammogram in the past 2 years*
Cervical	84% of women age 25-64 screened at least once in past 5 years‡	80% of women age 21-64 screened at least once in past 3 years*

Diabetic care

People with diabetes who received annual retinal examination	60%	70% for <65 years; 80% for = 65 years
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Coronary revascularization procedures per 100,000

Angioplasty	38 §	116
Bypass graft	47 §	127

Transplantation per 100,000

Heart	0.5	0.5
Kidney	2.7	4.8

* Data from Kaiser US (not California). †2000, England. ‡1997, England. §1998, England.

SOURCE: "GETTING MORE FOR THEIR DOLLAR: A COMPARISON OF THE NHS WITH CALIFORNIA'S KAISER," *BRITISH MEDICAL JOURNAL*, JAN. 19, 2002

as strained labor relations, a focus on improving information technology that alienated some in the staid Kaiser culture, and a \$1.1-million fine levied against the plan by California's Department of Managed Health Care. There were also attempts to expand — with mixed results.

Lawrence says that many of the problems Kaiser encountered in the Northeast stemmed from running IPAs.

"Nearly 60 percent of our system in the Northeast was a network-based, IPA-like delivery system," he says. "What we found was that we were as bad at running it as everybody else was."

Now, he also blames what he calls Kaiser's missionary approach to expansion.

"We, unlike other organizations that have expanded in a systematic way, used what I describe as the missionary model," says Lawrence. "We chose somebody from a medical group and somebody from the health plan and we sent them off into the hinterlands to try to convert the locals. So instead of coming in with detailed plans and systems and support services like IT and all of the administrative services, instead of understanding that we needed to keep the costs way down by having all sorts of back office activities and administrative activities done at centers where there was scale, we made each of these an independent entity that replicated what we were in Colorado or California or the Northwest."

While revenue and membership grew during Lawrence's reign, the number of states in which the health plan has a presence decreased. In 1991, Kaiser was in 16 states and Washington, D.C. Today, it's in eight states and D.C.

Remember Westchester

Two years ago, when Kaiser's turnaround had just gotten under way, MANAGED CARE interviewed Lawrence about his plans for the company's future. "We're a national health care organization," he insisted. His opinion hasn't changed, though some experts wonder if maybe it should.

On Westchester Avenue in White Plains, N.Y., sits the Westchester Medical Group, which is doing just fine, says Stuart Hayman, executive director of the Westchester County Medical Society. Its success stands in contrast to the last occupant of the building, Kaiser Permanente. Why?

"Because these are all physicians who join together to form a group, and they all have their own fees — and they're not limited to Kaiser only," says Hayman. "They take multiple insurances. With Kaiser, you had to elect Kaiser, therefore basically Kaiser was your gatekeeper for any health care. That type of strict managed care model just did not go over here."

Problems with information technology

There's also some doubt about how Lawrence's focus on information technology will pan out. He's invested \$2 billion in the effort, but there have been problems.

As the publication *CIO Insight* points out, the Kaiser experience shows the difficulty of IT reform.

"Since embarking on its 'Net effort in 1997, the HMO has fallen nearly two years behind schedule," *CIO Insight* notes. "It now expects to have back-office, insurance, and patient records fully digitized by 2005 or 2006, rather than by the end of this year." (In our Q&A, beginning on page 17, Lawrence disputes that the plan is that much behind schedule.)

Still, what has been accomplished, especially in terms of creating electronic medical records, has received some plaudits.

A study in the *British Medical Journal* that compares Kaiser with Britain's National Health Service cited Kaiser's IT push as something to be emulated. (For more on the study, see tables on page 24.)

Kaiser's difficulties with expansion and IT, while painful, help to underscore one of the health plan's best attributes: size.

"You can absorb shocks," says Peter Kongstvedt, MD, a partner with Cap Gemini Ernst and Young. "You can disseminate best practices. You can try some experimental things in one location without betting the farm."

Reinhardt believes that as the horrific years — '97, '98, and '99 — recede, the focus will be not so much on what Kaiser did wrong, but rather on just why Kaiser succeeded in the end.

He recalls going out to California during the red-ink days and addressing a meeting of physicians of the Permanente Medical Groups. "I told them if you have faith and hold off, you will be the only model of managed care that will survive. You're the only model that actually manages care." **MC**