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Commentary

Dennis Kodner: reply to editorial Guus Schrijvers December 2007

As the editorial points out, Kaiser—which began as a prepaid medical group practise in 1946—is a regionalized, integrated healthcare system in which members are 'locked-in'; that is, they must use Kaiser clinics, Kaiser physicians and other providers, and Kaiser hospitals for their care. A little history may be useful in understanding Kaiser's unique position in the American healthcare marketplace. At first, Kaiser had little competition—except from then-prevalent fee-for-service (FFS), pay-as-you-go system and the small number of closed panel Health Maintenance Organizations (HMOs) that began to sprout in the mid-1970s. However, with the shift away from traditional FFS service medicine in the U.S. and the rapid proliferation of new open-ended, point-of-service health plans, Kaiser has had to figure out how to survive enormous competitive pressures, including a deeply-held consumer preference for free choice, and a stubborn physician predilection for private solo practice. This market reality has had a major impact on Kaiser. Over the years, it has been forced to pull out of markets in the North East, North Carolina and Texas. Today, Kaiser remains concentrated in the West (California, Colorado, Washington, Oregon, and Hawaii) and to a lesser extent in the Mid-Atlantic region (Washington, DC and Virginia), Ohio and Georgia. To stay competitive, albeit in these core markets, Kaiser has had to redesign its care processes—without sacrificing the overall model. This has meant placing an emphasis on integrated services, chronic care, patient self-management, and the widespread use of health information technology.

Despite these pace-setting, quality-enhancing changes, Kaiser still looks 'foreign' to most Americans. It may be that Kaiser's time-tested model is a better 'fit' with the way care is to some extent already organized and delivered in parts of Europe. This probably explains the interest of the National Health Service (NHS) in England. However, if the past is really a prologue to the future, I predict that it will be just as difficult to 'sell' Kaiser or similar models in other parts of Europe as it has been in most of the U.S. But, why must Europeans 'buy' the Kaiser model whole hog? I would argue that Europeans can find a way to benefit from Kaiser's many innovations in disease management and other fields without institutionalizing the model itself. As for the role of competition, I'm not sure we can find very much evidence—at least in the U.S.—that it produces the kind of positive results cited in the editorial. Kaiser is the rare example. Indeed, earlier efforts to develop integrated delivery systems (IDSs) in the U.S. created a merger mania. However, they failed disappointingly in terms of yielding improved efficiency or health outcomes. Perhaps a better place to look is Canada, where some regional health agencies—like Capital Health in Edmonton, Alberta—have successfully taken on responsibilities for the provision of integrated, outcomes-oriented health services—preventive, acute, long-term and mental health care—in addition to the public health function and the funding and regulation of the regional health system itself.

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