

HOSPITAL
ADMINISTRATION
ORAL HISTORY
COLLECTION

Lewis E. Weeks Series

Merwyn R. Greenlick

MERWYN R. GREENLICK

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
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Merwyn R. Greenlick

CHRONOLOGY

- 1935 born in Detroit, Michigan, March 12
- 1957 Wayne State University, B.S. (Pharmacy)
- 1958-1962 Wayne State University, Special Instructor, and
 Instructor in Pharmacy Administration
- 1961 Wayne State University, M.S. (Pharmacy Administration)
- 1962-1964 University of Michigan, U.S. Public Health Service, Trainee
- 1964- Kaiser Permanente Center for Health Research, Director
- 1965- Portland State University, Adjunct Professor of Sociology
- 1967 University of Michigan, Ph.D. (Medical Care Organization)
- 1972-1984 Oregon Health Services University, Associate Clinical
 Professor of Preventive Medicine and Public Health
- 1981- Kaiser Foundation Hospitals, Vice President (Research)
- 1984- Oregon Health Services University, Clinical Professor of
 Preventive Medicine and Public Health

MEMBERSHIPS AND AFFILIATIONS

American Association for the Advancement of Science, Member
American Heart Association, Epidemiological Council, Member
American Public Health Association, Life Fellow; Governing Council,
Member 1970-1974, 1979-1981; Medical Care Section, Secretary
1972-1975; Publication Board, Member 1977-1983, Chairman 1980-1981
American Society on Aging, Member
American Sociological Association, Member
Association for Health Services Research, Board Member, 1983-1985
American Statistical Association, Member
Belgrade, Yugoslavia Faculty of Medicine, Visiting Faculty
Drugs in Health Care, Member Editorial Board, 1974-1977
Governor's Comprehensive Health Planning Council, Study Committee on
Health Delivery Systems, 1970
Governor's Health Manpower Council, Consultant, 1972
Group Health Association of America Journal, Editorial Board Member
Health Services Research, Editorial Board Member
HMO Practice, Editorial Board Member
Inquiry, Editorial Board Member
Inter-Society Commission for Heart Disease Research, Member
Israel Ministry of Health, Jerusalem
Institute of Medicine, National Academy of Sciences, Science Policy
Board, Member
Medical Care, Editorial Board Member
Multnomah County Primary Prevention Advisory Committee, Member 1986-1988
Oregon Graduate School of Professional Psychology, Trustee 1984-1985

MEMBERSHIPS and AFFILIATIONS (Continued)

Portland State University, Human Subjects Review Committee, Member
Social HMO National Consortium, Research Committee Chairman
U.S. DHEW Committee to Evaluate the National Center for Health
Statistics, Member 1972
U.S. DHEW, Priority Setting Committee, Member 1974
U.S. National Heart, Lung, Blood Institute, Beta Blocker Heart Attack Trial,
Member of Publications Review Committee and Assembly of Investigators,
1978-1982
U.S. National Heart, Lung, Blood Institute, Dietary Information Study in
Childhood, Member of Steering Committee; Chairman, Design and
Analysis Committee
U.S. National Heart, Lung, Blood Institute, Multiple Risk Factor Intervention
Trial; Member of the Design and Analysis Committee, Intervention
Committee, Intervention Evaluation Working Group and Steering
Committee, 1973-1982
U.S. National Heart, Lung, and Blood Institute, Systolic Hypertension in
the Elderly Pilot Trial: Chairman, Behavioral Evaluation Committee;
Member, National Steering Committee, 1980-
U.S. National Institutes of Health, Public Health Review Committee,
Member 1971-1973
U.S. Public Health Service, HMO Task Force, Member 1971
Washington County Community Action Organization, Board Member, 1956-1970
WHO consultant, Colombia, S.A. -- to evaluate Colombian Social Security
System, 1976, 1978

AWARDS AND HONORS

Delta Omega

Honorary

Men and Women of Science

National Academy of Sciences, Institutes of Medicine

National Academy of Sciences, Eastern European Scholar, 1987

Omicron Delta Kappa

Honorary

Rho Chi

Honorary (pharmaceutical)

University of Michigan

General University Scholar, 1962

Wayne State University

Mackenzie Honor Society

Who's Who in America

Who's Who in the World

BOOKS

Arnold, C.; Greenlick, M.; Keillor, L. (editors)

Advances in Disease Prevention. New York: Springer, 1981

Greenlick, M. (editor)

Conceptual Issues in the Analysis of Medical Care Utilization Behavior. Washington, DC: Government Printing Office, 1970

Greenlick, M.R.; Freeborn, D.K.; Pope, C.R.

Health Research in an HMO.

Baltimore: The Johns Hopkins University Press, in press.

Hurtado, A.V.; Greenlick, M.R.; Sward, E.W.;

Home Care and Extended Care in a Comprehensive Payment Plan.

Chicago: Hospital Research and Educational Trust, 1972

WEEKS:

I understand you were born in Detroit in 1935.

GREENLICK:

That's correct.

WEEKS:

On the west side?

GREENLICK:

On the west side. Central High School.

WEEKS:

You went to Central High, old Central, which later became part of Wayne?

GREENLICK:

No. I went to "new" Central up on Linwood. I went to Wayne State also.

WEEKS:

I see that you have your degrees in pharmacy and pharmacy administration. Then I have you at the University of Michigan with a Public Health Service traineeship. I am not familiar with that.

GREENLICK:

I got to Michigan by accident. I had been teaching at Wayne State. It was clear to me that in order to be a professor you needed to have a doctoral degree, and there was no equivalent doctoral degree in the state in pharmacy or pharmacy administration. So, I was sort of thrashing about trying to find a doctoral program. I had done my master's thesis on a prepaid drug insurance program in Windsor, Ontario -- one of the first prepaid drug insurance programs in America. Ben Darsky had been a research consultant to that program. He saw a copy of my master's thesis that I had given to the director of the program. He leafed through it and said to Bill Wilkerson, who was the

manager of Prescription Services Theory, that I ought to stop up and see him, that maybe I'd be interested in doing my doctoral work at the University of Michigan. I was pretty naive in those days. I didn't know what public health was. I didn't know what sociology was. I had been trained purely in pharmacy -- physical chemistry, physics, pharmacology stuff. Although I was teaching pharmacy administration and economics, I was teaching a field that I really didn't know much about except in the very narrowest sense.

I came up to talk to Ben and was very intrigued. I thought I'd have a chance to be educated. At twenty-six, it seemed about time for me to do something like that. So you see I got here pretty accidentally.

The traineeship is a funny story. When I came up in 1961, it was March. I had decided to come and I was committed to teaching five classes at Wayne State for the next year. I was sure that I was admitted by mistake, that they were going to find out about me and rescind my acceptance so I really wanted to snap it up as fast as I could. I decided to come in September of 1961. I came up. I had always paid my own tuition, my own way. So I paid my tuition and started school. I was taking five classes in Ann Arbor, and I was teaching five classes in Detroit. I was driving 140 miles a day, working two nights a week and Sunday in a drugstore. I finally got a chance to talk to the people in the School of Public Health. It soon became clear to me that everybody was financed. I mean, not only did they not pay tuition, but they were actually getting support money. For someone to actually get money -- I had never heard of such a thing.

I went into Sy Axelrod who was the chairman of the department and said, "You know, everybody in this school but me is getting money, not only their tuition is paid, but they are actually getting money."

Sy said, "Yeah, that's pretty much the case."

I said, "I got my bill for second semester and I'm supposed to pay the \$97 for tuition here. Everybody else is getting support. I don't want to pay tuition. Can you at least get my tuition waved for me?"

Sy said, "We don't have any way to wave tuition, but we can probably get you a scholarship."

So I said, "Okay. Why don't you get me a scholarship?" I applied for a University scholarship, and I got \$600. Just in trying to save paying \$97. It was very exciting to me. I actually went over to the administration office and got the money in cash. Gee!

The next year I applied for a Public Health Service traineeship and was awarded that for the last two years. I was here three years.

WEEKS:

That's interesting. Sometimes we don't know until we get into a situation what the possibilities are. You didn't have your doctorate at the time Kaiser Permanente approached you, did you?

GREENLICK:

That's right. I was prepared to leave here after three years. I had done all of my class work and I had done the field work on my dissertation, which was also in Windsor. It was on a community study of prescription utilization in populations with and without drug insurance. I was trying to test for the effect of drug insurance on utilization of prescription services. Ben and I had an agreement about the substance of my program when I came up here. He said, "We'll make you a deal. If you don't do anything about pharmacy in all of the time you are here, just learn about medical care organization, then you can write your dissertation on drugs and then you can

go wherever you want in your career." He was sure that after an hour of learning about other things, I wouldn't be interested in pharmacy any more. That was pretty much true.

I had done all of the field work for my dissertation. I had been here for two years. I had three small children. I needed to get to work, so I left -- I intended all the while to leave after three years and finish my dissertaion while I was away. At that time the field of medical care was really burdgeoning. The word got out that I was interested in research. There were job opportunities kind of everywhere.

WEEKS:

Before we leave the Windsor part...is this part of the project that Sinai was interested in?

GREENLICK:

It was Ben Darsky's Ph.D. dissertation which was ultimately published by Harvard University Press that had studied the Windsor Medical Service which was the prepaid physician program that covered essentially everybody in the county, Essex County, Ontario.

About 1952-53, an offshoot of that approach was formed by the Essex County Pharmaceutical Association which was to provide total drug insurance. They provided drug insurance by that time (1964) to probably about a third of the population of Windsor. Ben and Sinai and Axelrod had worked with Windsor Medical, and were still working with them. So it was a natural offshoot for them to be working with the pharmacy insurance program as well. Their access to the program allowed me to get into the Windsor Medical Service physician claims records as well as those of the Greenshield Drug Program. It was a continuation of Ben's original work.

WEEKS:

I regret that I won't have a chance to interview Nathan Sinai. That Windsor project...didn't that cause him trouble with the Michigan medical society and maybe others?

GREENLICK:

Oh, yes. It was viewed as a communist plot for sure. I was talking to Odin Anderson last night at the Association for Health Services Research meeting. Odin, at that time, was head of the Health Information Foundation. He had funded the study that Sinai and Darsky did which ultimately got published as Darsky's book. Odin said he was under tremendous pressure from the pharmaceutical companies that had been stimulated by the Michigan Medical Society and the AMA.

WEEKS:

They were supporting the HIF too.

GREENLICK:

That's right. Odin said that he just had to hang tough and insist that it go forward.

WEEKS:

Odin and Sinai had a nice relationship. It was almost a father and son.

GREENLICK:

That's right. Odin had been his student here.

WEEKS:

Then didn't Sinai go to California?

GREENLICK:

Yes. In my first year here, which was 1961, Nathan was on his pre-retirement year. He was in California studying the state disability program

that had been one of the first statewide disability insurance programs at that time. He was very actively studying that. I remember in my first year, he was back in town at the end of that year and gave one of the evening seminars for the students. That was the only time I met him. Then he was living in California.

WEEKS:

Then he died shortly after that?

GREENLICK:

He died in 1971.

WEEKS:

I have run into several references to his radicalism. He was just ahead of his time.

GREENLICK:

He would be viewed as very mainstream now. He was a veterinarian originally. I don't know how he got into public health. A very dapper, handsome gent.

WEEKS:

He started the research bureau and medical care organization, didn't he?

GREENLICK:

That's right. It was called the Bureau of Public Health Economics when I first came. That's actually what interested me. That sounded like a very logical thing for me to be doing because it was called public health economics. Of course it really wasn't economics. It was really what is now called medical care organization. It had all sorts of disciplines -- sociology, psychology, everything else.

WEEKS:

Would you like to say something about going to Kaiser in 1964?

GREENLICK:

Ernie Saward heard that I was interested in going west, which I definitely was. I had visited there as a high school graduate and fell in love with the west. Ernie called me at home. I was very impressed. I got this call at home and somebody said, "I heard you are interested in coming out west and I am the medical director of the Kaiser program in Portland. I have been looking for three years for somebody to start a reserach program. I would really like to talk to you about it.

I said, "Well, gee, that's fine."

He said, "I'm going to be in Minneapolis on Tuesday. Why don't you fly into Minneapolis, we'll have lunch together."

Well, you know, to a starving graduate student that was very impressive. So I flew into Minneapolis. That was a Group Health Association meeting. It must have been early May of 1964. Ernie met me with Agnes Brewster, who was the head of the Public Health economics program in the Public Health Service. Ernie and Agnes and I had lunch together. Agnes said she had been trying to find a way for a long time to get Kaiser to open up to research and that Ernie was very much intrigued with it. She really wanted to urge me to consider going to work with Ernie to start a research program. That interested me, because Agnes had also offered me a job in Washington. She said this was really an opportunity.

Ernie expressed a view at that time, which he expressed over and over and still does, that group practice prepayment was a social experiment and an important social experiment in the organization of health care. And if it was

going to do its job as a social experiment it had to make itself open to become a research laboratory. It had to be available for health services research if it was to fulfill its social mission. Ernie believed that because he believed in the classical view of the doctor's role, including that it was necessary to create knowledge at the same time that he or she was using the knowledge to treat people. His view was that as medicine became institutionalized, you had to find a new way to express that traditional, classical medical role. He said, "I've got a prepaid medical care program that I essentially run. It's got a population base. I've been convinced from English research that a population base is necessary to proper health care research. It's got centralized medical records, one medical record per person. And essentially, I am in control of the program. I can provide you access. I can provide you a population. I can provide you medical records. And, I can provide you some money. What I would like you to do is come out and start a research laboratory."

It was a very exciting offer. He really impressed me. He also was wise, as he still is. He said, "Why don't you come and bring your wife. I'll pay her way. Come out and see Portland."

I said, "Fine."

He said, "Why don't you come Sunday?" That is the way Ernie does things. It was very, very impressive.

We went out Memorial Day weekend in 1964. We got to Portland. Flew in by Mount Hood. It was my wife's first time to see mountains like that close up. We landed on a beautiful Memorial Day Saturday. A big surprise -- Ernie was at the airport waiting for us. He found out what flight I was on and he and his wife Ginny were there waiting. We went up to their house on a hill.

We were just sold on Portland. It took about ten minutes to fall in love with that city.

WEEKS:

Can you tell me something about Ernie? I have met him, of course, and I have some idea of the person. Can you tell me something about his background, say after he left Hanford? I have pretty good information about his Hanford experience.

GREENLICK:

He is, first of all, the smartest person I have ever met in terms of knowledge of the way the medical care system works and where the levers are. He understands how the medical care system works at a cognitive level and at an intuitive level. I'm not quite sure where that knowledge came from. I suspect he always had it. He is absolutely the best medical care administrator that I have ever known. He is a classically trained physician, an internist of the old school. He trained at the Brigham, and at Washington University in St. Louis. He absolutely believed in medicine, but believed in it in a very classical sense -- the old internist approach of parsimonious thinking, understanding what is going on, understanding the patient as a person. He never believed very much in technology. I think Ernie was always disappointed that you had to use laboratories for a urine analysis. I always accused him of wanting to taste the urine to see if it was sweet, because he distrusted laboratories. He is a classic physician.

He also is a classic organizer. He understands the power of organization. He understands the way to move and to manipulate the environment to achieve objectives. It is that combination, I think, of the classical, parsimonious internist on the one hand and the brilliant manager on

the other hand that brings these things together. He has a social view that is extraordinary for somebody so classically trained in medicine. He is absolutely not, in any way, some wild radical as you would expect a pioneer in his field to be. My impression is that the pioneers in the group practice movement mostly aren't. They are mostly relatively conservative people who believe in pluralism, but who believe in the power to better the human condition by bringing together the organization of medical care services.

I think he inherently distrusted the fee-for-service system. I think he felt from a physician's perspective that fee-for-service was very demeaning. I believe Ernie's medical role models were all the professors of medicine. I think he felt that being out in the market-place and grubbing for money on an individual basis as a part of medical practice, simply demeaned the profession. His notion was to move the physicians away from that, particularly away from the perverse incentives that are caused by the fee-for-service system. He saw a much better way to organize things, to let the business people -- he also was very much a business person -- organize medical practice and let the physicians deal with the professional aspect of it.

I think he was also influenced by what he saw in the practice of medicine during the war. I think other physicians came to it and said, "Well, this is just temporary. This is wartime and I must practice this way until I can go back to fee-for-service private practice. Ernie looked around and saw the miracles that were being done. He was the chief of medicine in what was a 550 bed hospital, a place that was treating thousands of people day and night, and organized in a way that the physicians had different incentives, different practice patterns. He was smart enough to look around and say this is really a better way to do things.

Ernie is never locked in a box. He never is constrained by his prior experiences. He can learn from them, and he is always seeking solutions.

WEEKS:

He was a very young man when the war ended and the question about setting up a new practice in Portland came up. Something I haven't been able to understand. I had a feeling in talking with him that there is a little rivalry between him and Garfield.

GREENLICK:

Oh, no. There was a big rivalry between them. They both have very strong egos. Ernie had been working with the medical group at the shipyards. Sid was sort of involved in the Northern California shipyards and in Portland. I think he wasn't very actively dominant in the Portland. I think some of the other people, Cec Cutting and some of the other folks that ultimately went to Northern California, were more involved in Portland. So when a very small group of physicians in Oregon decided to hang on and to start the Northern Permanente Foundation, it really didn't have anything to do with Garfield. Garfield was busy setting up shop in Northern California. It didn't have much to do with Kaiser either. Essentially the main contribution that the Kaiser enterprise made was to give Ernie an interest-free loan on the building. The Northern Permanente Foundation was able to use the hospital on a loan that he ultimately paid back. It was really an independent activity in the Oregon area -- in fact it was in Vancouver, Washington. It really was not a Garfield enterprise in any way.

Later, Ernie decided in order to make a go of the practice in Oregon and they needed to have a hospital to do it. He became convinced that he needed to have a Portland base and that the hospital needed to be a modern hospital.

He really brought the Foundation into the Kaiser Permanente system. It was at the same time that the Kaiser Permanente system was being institutionalized in northern California as a result of pressure by the lender, the Bank of America, to regularize the Kaiser system. I am sure you have heard from Sid about the Lake Tahoe events. But it was Ernie's decision at that time, an independent decision really, to bring the Northern Permanente Foundation into Kaiser Permanente. Consequently, he really felt that the Oregon operation was his operation. And I suspect it smarted when he saw Garfield getting the credit for being the founder of Kaiser Permanente.

WEEKS:

I don't know the exact dates, but my impression is that in the beginning, after the desert experience, then came Grand Coulee. I am under the impression that Garfield had a proprietorship.

GREENLICK:

He did. He had a proprietorship at Grand Coulee, and he had a proprietorship at the Bonneville, which came after Grand Coulee. I think he probably had a proprietorship at the shipyards as well, although it is possible that the medical care program in the shipyards was an industrial medical care program that was tied to industries. His original arrangement with Henry Kaiser was that he would provide the medical care as a proprietorship -- I suppose a partnership, maybe, at that time -- and that Mr. Kaiser would pay him on a capitation basis and that the employees would pay him on a capitation basis for their family care when it got to Grand Coulee and Bonneville. Garfield had moved that enterprise from Grand Coulee to Bonneville so that when the war broke out they were based in the Portland area.

But after the war ended, in 1945 Ernie incorporated the Northern Permanente Foundation, I think as a partnership. I am not sure when the health plan became incorporated, but it would have been slightly after that time. The medical group at that time was a partnership with an executive committee. It was a permanent executive committee. When I came in 1964 it was still the Northern Permanente Medical Group, and it still at that time was a partnership and it had a three person executive board, each member of which was a permanent member. There was no election for anybody else on the executive board.

WEEKS:

It's still a partnership, isn't it?

GREENLICK:

No. It's a professional corporation now. After Ernie left it became a professional corporation, probably about 1977-78 I would say.

WEEKS:

Can we go back a bit? The Kaiser Foundation Health Plan is one corporation, isn't it?

GREENLICK:

That's right.

WEEKS:

That takes care of enrollment and payment -- general supervision so that there is agreement between... What I am trying to express is that although the Permanentes are separate corporations they still have to work with the health plan and the hospitals as far as monies and how the capitation rate is set and how the gross amount collected is divided. Then the Permanente itself has to have some way of paying the physicians either through partnership or

through some professional corporation. Then there has to be some arrangement for new staff members coming on, sort of a probationary period?

GREENLICK:

That's right. Kaiser Foundation Health Plan, Kaiser Foundation Hospitals, and the Permanente Medical Groups make up the Kaiser Permanente program. Kaiser Foundation Health Plan sells the insurance and deals at an arms-length relationship with the Permanente medical groups to establish the capitation rates. The Permanente medical groups, full-time medical groups in each case, provide all the medical care for the members of the Kaiser Foundation Health Plan.

In the hospital-based regions, Kaiser Foundation Hospitals provide the facility services and the ancillary services. The basic principle of the management of the program, which actually works, is that at every key level there is a manager from the medical group and a manager from health plan hospitals that work together as a partnership at that level. They are independent organizations, so they need to reach consensus on important decisions. So in the Northwest region -- it is now called the Northwest region rather than the Oregon region -- there is a senior vice president regional manager who is in charge of both health plan and hospitals and a medical director of, what is now, the Northwest Permanente PC. They are co-equal in the region and they manage by concensus. Then each of the two hospital areas in Oregon has an administrator who is a hospital administrator and a manager who is a physician manager. They are in charge of their hospital and their group of five or six clinics. At every clinic there is a medical manager and a non-medical manager. They make joint decisions.

Medical groups are paid on a capitation basis and they distribute their

income, mostly on salary. There is an incentive compensation program as well, based on how well both the medical group and the health plan hospitals do against their budget, and they provide all of the medical resources -- or they arrange for them in the community. They do hire new physicians who are to be full-time employed physicians, employed in the Northwest Permanente PC. They are on a probationary period for two years. Most stay, although some go.

WEEKS:

You were saying about the early days...

GREENLICK:

About the early days before I got to the Northwest region -- Ernie managed that medical enterprise. It was small. In fact, it had perhaps ten thousand members, about 1947 or '48, at the most. It ultimately got to about 25,000 members in the early fifties. There were really two kinds of physicians who joined in that original enterprise. It was a very small group. One was a group of people who were politically very progressive. They were interested in the practice as a kind of utopian medical care system. There was then another group that was led by Ernie that were essentially pragmatists who were in it because they thought that was an interesting way to practice medicine. There was a big fight in that group, probably about 1948, with this sort of Utopian left-wing group on the one side and Ernie's pragmatism on the other side. Ernie believed, and told everybody of the group practice movement over and over that in order to be a social experiment you had to be self-sufficient because the person who puts in the last dollar is the person who controls the program.

So Ernie was determined to operate the medical care program in a business like way in order to be a successful social experiment. There was this very

big battle which, Ernie reports, turned on a parliamentary maneuver. It was about the use of a motion to adjourn which wasn't debatable, at a point where a real debate could have been very disturbing. This ended up in the acrimonious resignation of a group of at least three or four physicians, some of whom I still see in Oregon and are still fairly bitter about Kaiser Permanente. It was an interesting split, an interesting dichotomy. There were bitter feelings by some of those physicians in the community, that persist to this day. So, not only was the program hated and feared from the right of the medical community, it was also resented from the political left at the same time.

WEEKS:

How about the quality of the people who might apply for staff membership?

GREENLICK:

Well, the physicians that started the group were really extraordinary physicians. They were folks that had been involved.

WEEKS:

It was almost a crusade?

GREENLICK:

Some of them really didn't even notice what they were doing. They had been in this business, they liked practice, they were very fine internists, very fine surgeons, very fine people. It was a very small group.

The people who were recruited in the late fifties and in the early sixties -- the people who were there before I got there in 1964 -- were definitely crusaders. They were the people who had come to that program because there was a social reason to come to the program. Fellows like Arnie Hurtado and Pete Hurst. I would say about half of the physicians who had been

recruited about that time were very much interested in the notion of prepaid group practice. They were the leaders in a lot of ways when I came to the program. They are at the age where they are just getting ready to retire now.

They are also a group that Ernie just charmed. He can be as charming and as persuasive as possible. He got some people to join who honest to gosh didn't know they were doing anything different. They were just practicing medicine. Ernie always provided very good incomes for them. He also used a lot of that physician income to help support the health plan in the days before it became solvent. They were in many ways just practicing medicine.

The time that recruitment was the biggest problem was about the time I got to the program in 1964. There were 75,000 members. It had gone from 25,000 members in about 1955 to about 50,000 members after the hospital opened in Portland in 1956-57, and then about 75,000 members in 1964 when I got there. It had really begun to grow very rapidly. It was at a time when physicians were very hard to recruit because the opportunity in medical practice was enormous. We soon went from 75,000 to 150,000 in a period of eight or nine years. So it was an extraordinary growth. The major problem at that time was to recruit physicians and build facilities -- and recruiting was very tough. Recruiting was really based on the charisma of the chairs of the departments. I don't think they ever took bad physicians, but they were willing to take people who were somewhat marginal. They got some really wonderful ones and they got some ones who I would say were just average.

It seemed to me, as somebody observing the system, that the real problem was that they would keep physicians who were good technically but who tended to be somewhat snarly and probably would have had trouble making it in private practice. And it was difficult to keep the snarly people under control.

There were a few whom I would have gotten rid of but about whom the chiefs of the departments said, "Oh, my God, the person practices very fine quality medical care and we are just going to have to recruit somebody to replace him." And it was very hard to recruit.

I would say by 1980, that log-jam had cleared and from then on recruitment was very easy. I would say the period from about 1965 to 1979 recruitment was very tough and was maybe the major limiting factor to growth.

WEEKS:

I remember Ernie saying that when he was at Hanford during the war he had to put up with not only regular employees but with physicians who might have been so-called 4F for one reason or another and it made it very difficult to get by sometimes. I suppose the same is true in a lesser sense here. There might be people who want security rather than being out battling on the fee-for-service line.

GREENLICK:

They all worked pretty hard. My guess is that they worked harder than their fee-for-service contemporaries most of the time.

WEEKS:

But they did operate within a structure where somebody was worrying about their insurance, somebody was worrying about all these other details.

GREENLICK:

Right. And they could take the time off and go away.

WEEKS:

I wanted to ask you about the Oregon Health Sciences University. This is the first I have heard of this. What is this?

GREENLICK:

That's the medical school of the University of Oregon system. The way the higher education system in Oregon is organized is the four major universities are each independent, but each reports to the State Board of Higher Education. Then the next tier of universities, which used to be colleges but are now universities also report to the State Board. So there are now thirteen, I think, schools in Oregon, colleges and universities, reporting to the State Board of Higher Education. There is the University of Oregon down in Eugene, Oregon State in Corvallis, Portland State in Portland, and the Oregon Health Sciences University, which has the state system's medical school, dental school, nursing school, and state hospital as a separate unit.

WEEKS:

No pharmacy?

GREENLICK:

The pharmacy school is at Oregon State.

WEEKS:

So many of the big universities are trying to organize on a health sciences section under a special vice president or something.

GREENLICK:

That's right. There is a vice chancellor for health affairs or something like that. No, this is a separate university with its own president. Len Laster is the president and is equivalent to the president of the University of Oregon, although he makes more money. He makes more money than the governor, in fact.

WEEKS:

I was at a meeting of deans of medical schools founded since 1960. This was five years ago. There was a three-day meeting on the problems of the new medical schools. The question came up at one of the dinners as we sat around and somebody asked, "Why is it that the dean of the medical school makes more money than the governor of the state?" They said, "Well, you can't get a physician to take the job at any less. The governor is expendable. You can elect another one."

GREENLICK:

Everybody likes to be governor anyway, no one likes to be dean. Also you have to pay the chiefs of surgery and of other major departments a lot of money.

WEEKS:

So the dean has to make a little more, even if it is only \$100 more.

GREENLICK:

Exactly. Even if he doesn't get any money from the practice association.

WEEKS:

You are teaching there as a clinical professor?

GREENLICK:

That's right. In the public health department.

WEEKS:

We talked a bit about the topic of conversation being a drug study. What was that again?

GREENLICK:

In my dissertation?

WEEKS:

Yes.

GREENLICK:

Well, it was a study of the prescribing patterns in a whole community. It was a probability sample of all the prescriptions in the community, sampled in a two-stage probability sample out of the pharmacies. Since we had all of the doctors identified through Windsor Medical, we could study the physician prescribing as well as the utilization of the population. The main hypothesis tested was that the drug insurance would affect the way physicians prescribed medication. It really required total community prescribing patterns in order to have a population base. There weren't many communities that were so nicely self-contained as Windsor is. It really was an intriguing study for a doctoral dissertation. And it had some very interesting findings about what differentiated the prescription patterns of the population -- in fact, they kind of surprised me.

WEEKS:

How did the Windsor Medical Plan come about?

GREENLICK:

I think it came about in the same way that most of the organizations of medical care came about at that time. There was a physician or two in Windsor who got the idea and who had the charisma to put it together. They also had, then, the access of the school. I don't know how Sinai actually got to them at that time, but by the time he did I think the program was well organized. It had to have been organized in the late 1930s, at the same time the foundation plans were starting in the United States. I think it came out of the medical community and came out of a couple of pioneers. Before they

finished out of the depression, they had all of the physicians in the whole county organized.

WEEKS:

I wondered about the point of Sinai's entering into this.

GREENLICK:

I think it was after it was formed. It was as a study laboratory for him. Ben's book, a Harvard University Press book, that is still available in the library, traces the history of the Windsor Medical Plan.

WEEKS:

I'll have to get that and read it. Do you want to say anything about the other faculty members at Michigan when you were there?

GREENLICK:

Oh, I would be very happy to. It was an extraordinarily exciting time for me. I had come out of pharmacy. I had never had a sociology class. I had had about one semester of economics. I didn't know anything about the dynamics of medical care organization. I also came from the political environment of the pharmacy school. In terms of my general orientation I think it was somewhat liberal. As I said before, my father had interested me in labor movement kinds of activities, and I was a bit liberal. But, being raised in a pharmacy school you have some very specific ideas. I remember lecturing in one of my pharmacy economics classes about the dangers of socialized medicine. Well, what I was talking about was something like the Forand bill or Kerr-Mills or King-Anderson or something like that. It was really strange.

I remember thinking as I was lecturing at that time that there was something about what I was saying that didn't make sense. But I wasn't sure

what it was. It wasn't until I came up here and ran across some of the people who really became my intellectual fathers that I got some political insights. Sy Axelrod, Ben, Chuck Metzner, and Avedis Donabedian are the four that had the most impact on me. I was a child in a candy shop -- having the academic classes, being able to meet people like Les Kish in the Institute for Social Research, and the giants of the field in economics and social sciences and methodology. There was wonderful faculty in what became the Department of Medical Care Organization. It just blew me away.

At the time the department was very small. In my first year we had three doctoral students who came that year. There were two other doctoral students here at the time. Roger Battistella was still here. He graduated shortly after that and went to Cornell. And Tom Weil was here. I think there were one or two who had gotten doctorates sometime before that. It was really the very early stage. We had six masters students in that first class, including Bev Myers, who recently passed away. It was Avedis' first year here. He was sort of buried in the library behind this mountain of books. I remember seeing him. I had been wondering who that man was behind this huge pile of books in the library getting ready for his classes. They were just extraordinary. The relationship between the faculty and the students was so intense and so close. They actually spoiled me for academia. I went out assuming that's the way that graduate programs were, that you expected your advisor to spend 500 hours with you.

I remember sitting in a lawn chair at Ben's with him in his old Marine fatigues, mowing the lawn, marching back and forth with the lawnmower criticizing the thirtieth draft of my research proposal. It was that kind of intense, personal relationship. One of the things that was very common then

was that we would have evening seminars with visitors who were in town. Students would come to one of the faculty homes and sit around and drink beer and eat pretzels and hear George Baehr, for example, and Nate talking about his work in California. Sort of all the heroes of the medical care field passing through. I remember Franz Goldmann, very late in his life passing through, Dick Weinerman, and Baehr. And Jim Dixon who was president of Antioch at the time, had been the health commissioner in Philadelphia. One after the other passing through. Just sort of sitting at the feet of these masters.

WEEKS:

All of these people with ideas just bursting out of them.

GREENLICK:

It was extraordinary. Of course I had three young children. My youngest daughter had been born October of the year I started, and we moved to Ann Arbor the next year. My kids were one, three and five. My wife was home struggling with these three young kids, the first time we had ever left home, even though we just moved from Detroit. Here I was just learning and excited -- all of those new ideas, and Harriet was at home struggling. I don't know how she survived that. We still talk about it. She said at that time, "I don't ever want to hear about the good old days in Ann Arbor. They are not good old days." She still, twenty-three years later, sticks to that story. But it was wonderful.

Donabedian was fresh and exciting, just starting to formulate some of the things he was working on. Axelrod had fascinating, exciting social ideas. Ideas that I had never heard. I remember sitting in Max Shain's house at a party one time and singing "Joe Hill," learning about the Wobblies and the

Socialist Labor Movement. Things I had never been in contact with.

WEEKS:

I think Medical Care Organization had quite a different set of circumstances from what Hospital Administration did.

GREENLICK:

Hospital Administration was in the business school and had a very different view.

WEEKS:

Yes, when I came there they were in the business school and finally didn't get to the new public health building until the 1970s.

GREENLICK:

Long after I was here. McNerney was here in those days.

WEEKS:

I came right after McNerney left, within the year.

GREENLICK:

Was that 1963?

WEEKS:

I came in 1962.

GREENLICK:

He was here in 1961. Don Riedel was here.

WEEKS:

Don Riedel, Barney Tresnowski and John Griffith, Larry Hill.

GREENLICK:

That was a good faculty. We had a lot of contact with that group as well because we shared the medical care organization classes. Duncan Neuhauser was in that class the year before he went off. There was a lot of contact there.

But they were very conservative, very business school oriented. The public health people were certainly left of center.

WEEKS:

They were still living the Michigan study. I discovered there had been some jealousy between the two.

GREENLICK:

There still is.

WEEKS:

I don't know how the joint program is going to do.

GREENLICK:

It will be interesting to see.

WEEKS:

And it is going to be interesting to see who is picked to chair it too because it's going to be very difficult. They have had a search committee for a year, but I don't think they have made a decision yet.

GREENLICK:

No, they have not. They asked me to apply very early on. We had a lot of communications, but I love what I do. No way would I get back into the academic madhouse.

WEEKS:

If you can lecture once in a while somewhere else.

GREENLICK:

I love teaching and I love the academic lifestyle that we have developed at the research center. We have a very strong academic program, but you certainly can't have an academic lifestyle in the university any more. Life is too confusing.

WEEKS:

It's promotion and publication. Of course, you have done a lot of publishing.

GREENLICK:

Oh, yes. The faculty really has changed a lot, though. It's very much more a hotbed of pragmatism. It is much more mainstream and it seems to me not as dedicated to understanding the underlying phenomenon in the field as it once was. It seems much more policy oriented, much more programmatic oriented. We had both things happening. We had Axelrod and Shain and people who could talk about the mechanics of the field. But then you learned from Darsky and from Metzner and Paul Feldstein about the underlying phenomenon. It seems to me that exciting dual tension that is available isn't quite as much in the field any more as it once was.

WEEKS:

I think you are right. It's going to be a very difficult thing to come up with a combined program which does it as well as the old program did.

GREENLICK:

I think it's going to be difficult. If there is some tolerance of diversity it would help. If there is some way to build some strong academic pockets inside the policy, administrative effort. I think it's possible. There hasn't been a lot of tolerance in the last few years. The conflict has been policy.

WEEKS:

Let's hope for the best.

GREENLICK:

I do, indeed. It's still the best around.

WEEKS:

Yes. The program received the best recognition of any program in health administration last year.

GREENLICK:

I'm pleased to hear that, but I am not surprised. It is definitely the best around.

WEEKS:

Your appointment at Northwest Permanente was as Director for the Center for Research.

GREENLICK:

That's what it is now. It's the same position. I was originally named director of research for the Oregon region. There was no research when I came. Ernie and I essentially started the program.

WEEKS:

In talking to Sid Garfield he spoke of research that he was familiar with. I don't know if he was directing it or not. I thought I would mention these two before we begin talking about the specifics on your job. Garfield talked about medical methods and he talked about total health care. I think he was working on that at the time of his death.

GREENLICK:

Yes, he was.

WEEKS:

He also talked about health hazard reviews...

GREENLICK:

Health risk appraisals?

WEEKS:

Possibly so.

GREENLICK:

The multiphasic screening program.

WEEKS:

He talked about hazards too.

GREENLICK:

I am not familiar with that.

WEEKS:

Would you like to talk about what Garfield was doing or begin with your own?

GREENLICK:

Let's get Northern California out of the way briefly. I would rather talk about my own program. They started in Northern California with a research program slightly before we did. The basis of this research activity comes out of something called the community services program. When Kaiser Foundation Hospitals became tax-exempt institutions, 501-C3 institutions, people on the board were informed that in order to stay tax exempt they needed to spend about five percent of the hospital income on education, research, and charitable care. They developed something called the community services program which was the vehicle for spending those funds. Because Kaiser Permanente is essentially a regional institution, has great regional autonomy, the decisions on how to spend that money were vested in each of the regions. The funding and the stimulation for the research activity had a sort of different philosophy in each of the regions.

In Northern California the research enterprise originally started as

something called the Kaiser Foundation Research Institute which Garfield started very, very early. It was viewed as a scientific research enterprise, doing biomedical research originally. They actually had this research institute where they hired scientists and studied things like the regeneration of limbs on nematodes and a variety of other things that Sid thought was interesting to do, in the way of biomedical research. But the Northern California region, even in those days, was run by a triumvirate of physicians that included Sidney but also included Morrie Cullen, who is a very bright physician and engineer in Northern California. Because he was a part of the power structure, he got the region to start something called the Medical Methods Research Unit. It is now called the Division of Research of the Northern California region. It started in 1961. Morrie was an engineer. He was also the chairman of the executive committee of Northern California Permanente at the time I first knew him. In 1961 he started this thing called Medical Methods Research Unit. It was intended to develop medical technology kinds of activities, things to be applied in clinical practice. Morrie is, in fact, the inventor of the automated multiphasic screening program. It was started in the Medical Methods Research Unit. By the time I got to the program in 1964, it was under way. They were already doing thousands of examinations in this automated multiphasic screening. They were studying a matched population of people who were invited to get multiphasic screening with a group of people who were not invited to get it. Morrie has only recently finished the ten year and fifteen year follow-ups that indicate improvements in disability in the serviced population. Cullen is another one of these brilliant, charismatic individuals like Seward who starts something, finds out how to do it and then just carries through.

About the mid-seventies, Garfield came up with the notion that the worried-well were clogging up the medical system. He believed that one of the disfunctional elements of the comprehensive prepaid group practice program was there were no financial barriers to care and therefore people came in probably too often, when they didn't need it. Again, rather than just fretting about it he designed a way to try and do something about it. He decided to test it in a randomized way to see whether it would make any difference. His notion was that whenever any new people came to the Kaiser Permanente program in Northern California, at least in the Bay area of Northern California, they would be randomized into two groups. One group would be offered a new entry system that he called the total care program, something like that. Those people would be invited in for an examination by the nurse practitioner, would be oriented, their health risks would be evaluated, they would be offered health education, they would be offered information about how to use the program, and efforts would be made to integrate them into the program. Then over a period of years their utilization and experience would be monitored to see whether the people who were integrated this way, who had this sort of open-door policy for the program and were taught to use the program correctly would have different services than the people who had not.

Sidney died before that work was finally evaluated. Morrie Cullen told me very recently that he is finishing up the evaluation, that he had some preliminary results and they were very positive, but they were too positive and people really didn't believe them. They brought the accountants back in and they are calculating the costs. He expects that it will be published in the next year.

So their program developed out of the community services. There was in

Southern California, at various times, clinical research activities under the community services program. At one time there was a director of research named Joel Kovner who did some interesting things in the Southern California region. But the only two major research programs that have emerged are the Northern California Medical Methods Research and our program which began three years later in 1964, in the Oregon region.

WEEKS:

Are data exchanged between the different regional plans?

GREENLICK:

No there isn't any data exchange. Kaiser Permanente really is operated on the principle of regional autonomy. It was designed that way. I'm sure both Sidney and Ernie talked about how coming out of that Tahoe conference the notion was that there would always be a balance between the central program and the regions. Because the key concept is that of partnership at the major decision-making points and because each of the medical groups is independent, the regional manager and medical director really are major forces in the program. Therefore, things are only done centrally to the extent to which they need to be done centrally. The program is organized on the notion that if it wasn't invented in our region, it probably doesn't exist. Things need to happen in each region. Particularly relative to the Northern and Southern California regions. Recently with many new regions there is much more sharing of information and sharing of organizational technology.

When we began in 1964 it was really driven by Ernie's desire to create a research laboratory in our region and to develop an autonomous, academically oriented research program that would provide the research drive in the region. The medical care program would provide its major contribution by making itself

accessible to research and by providing some of the funds out of the community services program to help support the research center. He also intended from the beginning that the research center would be basically financed by federal grants and contracts. Out of this year's research center budget of \$6.5 million, we get about \$1 million from the community services program and about \$5.5 million comes from federal grants and contracts and foundations. The program emerged, as have many other things, just as Ernie saw it. He brought me to the program and turned me loose to design a population based research laboratory. Then he supported me in the system whenever I ran into trouble.

I was visiting with Kerr White also last night. Kerr was honored by the Association for Health Services Research last night for his career in the health services research. We were reminiscing about the first site visit we ever had at the research center in late 1965 or early 1966. The grant proposal was for the program that became our data base. Kerr, at that time, was chair of the health services research study section and chaired the site visit that came to the research center. We proposed a five-year project that would definitively produce the determinants of medical care utilization in a population. The study section thought we were perhaps a bit too ambitious and cut us down to a three year grant, but that grant became the basis of the outpatient utilization study (OPUS) that is still in existence now. We have been following that population for twenty-two years.

When we got into one particularly difficult point in the site visit on our proposal, Kerr pointed out that the youngest person on the site visit team was at least a decade older than the oldest person on our study team. I think pointing out that we were just a wee bit arrogant at that time, brash. It turned out that Kerr went back to the study section and really championed our

cause and argued that it was an opportunity to establish a long-term data base in a place where a prepaid medical program had made a commitment to research in the public domain. Ernie's original commitment to the investigators from the beginning was that all of our work would be in the public domain, that we had no censorship of any kind of our activities, that we could bring in good people and do honest research, take federal dollars whenever possible or necessary to do it and let the chips fall where they may. He had an extraordinary amount of confidence in his program.

WEEKS:

That's very important because the question has come up several times with other research groups where certain information is supposed to be privileged. That doesn't work out very well for anybody who wants to do real research.

GREENLICK:

Ernie's belief was that not only was it an obligation to create this laboratory but that if Kaiser Permanente wanted to best benefit by our research activity, the way to do it was to bring state-of-the-art research into the program, to get researchers who were tops in the field, to send their stuff out for peer review, then turn them loose and hang on. If in addition the researchers could translate their research to the program, then the program would be far better off. Managers understand what their day-to-day problems are, but they really don't have an underlying grasp of the field of medical care. They are very particularistic researchers, if they are smart and are doing research that can get funding, are right at the cutting edge of the field. His view was that the managers could learn from the researchers in the same way the researchers were learning from the managers. He really pushed that view.

By the time he left we had had a series of successes that gave us the momentum to keep going even after some very rough times. We began a project in 1966, about the same time we were starting the medical care utilization study, that asked the question "what happens if the Medicare benefits of home health and extended care were added to the total population?" We had done some work in 1965 looking at the object of assessment of post-hospital need that had come to the conclusion that Medicare was really underestimating the need for home health and extended care facility services. We published that and Agnes Brewster at HEW's Public Health Economics Branch said someday somebody is going to ask her that same question about the under-65 population. She gave us about \$400,000 to do a study on expanding the Medicare benefits to the whole population. We used that grant to help fund a wing of the hospital that Ernie had wanted to build by using it as an ECF for three years. We ran that as the first hospital integrated ECF in an HMO, sort of the progressive care concept that Bugbee and Brown had been talking about at that time. We also started a home health agency that I believe was the first home health agency inside an HMO that provided care for both Medicare people and the under-65 people. When that project ended in 1970 the home care benefit was integrated into the Kaiser Permanente program and they have run it ever since.

One of our basic notions from the beginning is that when we do a research project, we publish the results. If it turns out to be feasible we turn it over to the medical care program and it becomes a part of the existing system. Later projects produced the first HMO dental program that now serves 80,000 people in Oregon and Washington. Our D.B.O. project resulted in the very early HMO Medicaid programs. The alcohol treatment program is one of a variety of Kaiser Permanente program features that we did first as research programs.

They allowed us to do the project as demonstratopms and then we spun them off into the program when the research project was over.

WEEKS:

You raised a question in my mind when you said that after you completed research if you find that it is valuable you turn it over to the medical care side. Who makes the decision whether to use the new information or not?

GREENLICK:

The management makes the decision at all times. What we have done in these situations is to give them the information that they require to make a management decision. For example, in that ECF home care program our research results indicated that the extended care facility could be integrated into our hospital with no net new costs for the under-65 population. Ernie decided at that time -- he was in charge of the system -- not to include ECF service as a health plan benefit, for a variety of reasons. He now reports that he was afraid to create an entitlement for long-term care for the under-65 in an increasingly competitive market. Also, it was the case that he had intended those beds to be acute care beds and because the medical care program was in the very rapid growth period I talked about earlier, the acute care beds were needed. The home care program, on the other hand, would create a net increase in premium, but a small and known increase. I remember the numbers, the net cost of the home health benefit was only about seven cents per member, per month. The management decided that since they were going to keep the home health agency anyway to do the Medicare home health service; it made sense to make that benefit available on a limited basis to the under-65 population.

It is always a management decision but because there was a research project evaluating the program explicitly, they had the data upon which to

make a management decision. In most cases if there is a successful research project the management knows how much the tested service costs, they know at least the proximate outcome if not the distal outcomes, it then gives them the confidence to make the decision.

WEEKS:

And they usually always do it?

GREENLICK:

Except for the extended care facility, I think they have integrated every successful research project we have ever had into the program. Some of them have made very significant impact. The management also have the ability to use the data from our five percent sample system to get comparable data to decide whether to do this.

We believed, and expressed very early, that in order to understand how to make management and policy decisions about health care you need to understand things about the basic underlying phenomenon in the health care system. You need particularly to understand patient and member behavior and physician behavior. Our outpatient utilization system was developed to provide the data to answer some of those basic underlying behavioral phenomenon.

In 1966 we took a five percent sample of all families in the health plan, identified the medical records of all the people in that group, and designed a system to sample five percent of all new families that joined the health plan. We trained a set of medical record technicians to abstract medical records in a research quality, reliable, valid way and have since gathered information on every single contact in the medical care system by that five percent sample. That sample system was designed in the summer of 1966. Sam Shapiro spent the summer with us. Ben Darsky spent the summer with us. My partner right from

the beginning, Arnie Hurtado, was the physician involved. He is still involved, managing that system twenty-two years later. We felt that we could create a data base that would eventually be unsurpassed anywhere. In fact, that data base is now the longest standing data base of population-based ambulatory care utilization anywhere in the country. The only thing that even comes close to it is the Mayo Clinic system which really isn't a population-based system anymore.

WEEKS:

Do you have any way of comparing your population with the general population?

GREENLICK:

We do compare it in a variety of ways, using things like the National Ambulatory Medical Care Survey and the National Expenditures Study. We've had several studies that have taken the national data and compared it with ours. We have a variety of ways to compare our data. Of course our data set is more reliable and more valid and more extensive than most other data sets. So it is very hard to find any comparable data.

WEEKS:

You were speaking of analyzing medical records. It occurred to me that this is a rather shadowy area too. In studies I have read about there have been many cases where medical records were not too exact.

GREENLICK:

The thing that makes a prepaid group practice different from other medical care settings is that all the providers write in the same medical record. So the normative system is that the medical records need to be pretty good, even when they are handwritten medical records, because you never know

when another physician is going to pick up that medical record in an emergency room and have to figure out what has been entered. My impression is that the medical records of our program are really superior to most ambulatory care medical records, even though they are still handwritten, free-format records. There are regular medical record audits of ambulatory medical records and there is a lot of social pressure on physicians who don't document things adequately. Furthermore, we have the opportunity to review the records over time. In the past we intercepted medical records the same day that they moved in and out of the record room so that if there was something missing we were able to take it back to the physician to check it. If there was unclear writing we were able to take it back to the physicians to check while it was still fresh in their minds. We don't do it that way anymore.

We also have a group of medical record technicians, about fifteen of them, that have been with us an average of nearly fifteen years. They are very familiar with those records, and they are very familiar with the physicians. And finally, we made the decision very early only to try and recreate the medical record. We can sometimes be looking over a case as a part of reviewing it and see something the physician hasn't picked out. However, unless there is an indication that a physician is treating a given disease, we do not record that disease. But we do record every single symptom that takes place in every single contact. We record all the morbidities that are noted in a contact. We tie all the morbidities and the symptoms together in episodes, both between and within visits. We keep track of all the drugs and ancillary services that tie to that contact. It is an extraordinarily complex system, now automated. We ran a paper system for a very long time. We have something like 7.5 million records recorded across this population

over this whole time period.

WEEKS:

Now you can retrieve them very readily.

GREENLICK:

Yes. It has been very valuable for specific projects. For example, we were one of the first seven OEO neighborhood health centers in the country which happened, again, partly through Ernie's ingenuity. Ernie and I were sitting in 1965 or 1966 at an APHA meeting when Lee Bamberger Shore of the office of health at OEO was talking about how she was going to build several thousand neighborhood health centers around the country so that poor people could get care in their very own neighborhood health center. Ernie turned to me and said, "Well, that's just plain stupid. That doesn't make any sense at all. We need to force the existing medical care system to be able to take care of the poor people. If we had the money and we could find the right way to leverage that, we don't have to have a separate medical care system for poor people. They should be integrated into everybody else's medical care system."

He went up to Lee after the meeting and said, "Look, we can provide medical care for every poor person in the city of Portland if you want to give us the money. We'll just form our own neighborhood health center."

She sort of scoffed at that, but it obviously made her a little bit nervous. Ernie turned to me and said, "Do you think you could write a proposal to do that?"

I said, "Well sure. I don't see any problem with that at all."

We went home and wrote a proposal, at that time under the OEO R&D section. It was before the neighborhood health centers even began. We sent

out a proposal that said we would take care of every poor person in the city. You give us a capitation arrangement and we'll integrate the poor people into Kaiser Permanente. At that time the only capitation arrangement for poverty medical care that we knew about in a group practice was Sam Shapiro's very early HIP program for taking care of old age assistance recipients in New York City. That was a brilliant pioneering effort. I have always admired Sam.

We, at that time, had about 85,000 people. We thought maybe another 10,000 would be no problem at all. We sent it to OEO and it obviously scared the hell out of them because they were at that time courting the AMA and so it was originally rejected. Then Robert Kennedy forced through, in the fall of 1966, the OEO Neighborhood Health Centers act, which ultimately lead to the funding of 30 or 40 neighborhood health centers. In the first round -- the announcement came out in December of 1966, I think, to start in March of 1967. Of course it was easy to develop a proposal for a neighborhood health center at that time, because we had one in the drawer. We just dusted out the old proposal, scratched out the number of the agency and send it back to OEO. After a lot of travail, we were one of the original round of seven OEO neighborhood health centers to be funded. Ernie and I went back to talk to the people about the concept of a capitation payment for poverty medical care which just confused and boggled the minds of the people.

We were invited back to a conference at OEO, a bunch of young, Kennedy-type staffers sat around the room. We were gathered in Washington. They gathered all these young, hotshot staffers around the table. I'll never forget the day in OEO around the table, with Ernie and I at one end and these fifteen young staffers about to change the world. One of them started off by saying, "Let me ask you a question. Do you mean to say that you are trying to

get us to pay you for these people whether or not they receive any care in your system?"

Ernie and I patiently launched in to an explanation of capitated health care and what that would mean for poverty population. As we started talking, people started getting up and leaving because they were so busy saving the world they didn't have time to sit too long. We explained it, with some questions, for a period of about a half an hour. By the time we finished we noticed that everybody who had been there had been replaced by somebody else. There was this other group of people going through so there was a completely different set of faces around the table now. One guy said, "Well, yeah, I've heard all of it, but I have one question."

We said, "What's that?"

He said, "Well, you mean you expect us to pay you for providing care for these people whether or not they receive care?"

We patiently launched into the same thing. We ultimately ran that discussion, in an hour and a half meeting, three times to three totally different sets of people because they were busy running in and out doing things at OEO. Since we had one of the live proposals, we were funded in that original group along with another HMO in Bellaire, Ohio -- a labor union HMO out of the miners' union. We were the first of the HMOs to accept a full capitation payment for poverty medical care which ultimately, then, became the basis of the Medicaid prepayment systems for HMOs. Bev Myers, two years after that, was the Assistant Commissioner for Public Welfare in New York State and asked whether we would help her write a model prepaid, capitated Medicaid system for New York State. So, working with her, I wrote that statute for New York State. We used the budget estimates of about a \$40 a member-month

premium for that, which was, as I remember, the OEO premium. So she made the New York State budget estimates by taking our Oregon premium and multiplying by the number of Medicaid people who were in New York State to calculate the savings on that. We ran that OEO program for seven years, then ultimately converted it into a capitation contract with the state of Oregon for AFDC population. We now have, I think, maybe 10,000 people or more in that program, so it was a very important program. There were all sorts of interesting trials.

Charlie Grosman, who is a physician identified with the welfare movement in Portland, was one of those physicians who left Kaiser in the battle with Ernie -- that original battle for control. Charlie fought Ernie and me tooth and nail through the community, arguing that Kaiser was a bad system and had all these things wrong with it. Ernie and I argued loudly that Kaiser maybe was a rotten system, but all we wanted was to give the poor people the same chance to choose Kaiser on an open basis that employed people had.

WEEKS:

The Medicaid people had a choice?

GREENLICK:

They had not had a choice up to that point. They actually didn't have much of a choice. They could stay in the Medicaid agency and have or are paid on a fee-for-service basis wherever they could get care, or they could join Kaiser and have us accept them as regular members of it. This was one of the examples where Ernie really had to pave the way for one of our research projects. There was a lot of opposition inside Kaiser Permanente to bringing in all these poor people. There was opposition from the administration; there was opposition from the doctors. It was a sort of harried business.

One of the deals we worked out for the poverty project was to let the four OEO poverty neighborhoods select the people who would be our indigenous, non-professional case workers. We had it organized on the basis of having a group of indigenous non-professionals who would go out into the neighborhoods and recruit the members. We recruited, I think, 6,000 members. They were just going to come right into Kaiser right away. They were going to be recruited in the neighborhoods, and indigenous nonprofessionals were going to be their caseworkers, helping them learn how to use the medical care system. We agreed to let the neighborhoods select the caseworkers who would become Kaiser employees. I had a deal with the hospital administrator who was in charge of personal at the time, Jim DeLong, to just let me hire people -- against all the Kaiser personnel policies. So we just hired twenty-four people. They were essentially welfare mothers, they were people who had never worked, they were, in many cases illiterate. We just hired them and put them to work, as they had been named for us by the neighborhood.

Jim DeLong called me one day and said, "You have hired all these people and we don't have employment applications."

I said, "Of course we don't have employment applications. We just hired who the neighborhood selected."

He said, "No. Our rules say you have to have employment applications."

I said, "Jim, I don't want to get employment applications. It doesn't make any sense. They are part of this project, we are paying them on project funds, we don't need employment applications." I said, "Furthermore, you just aren't going to like those employment applications. These are not ordinary people."

Jim and I fought about it for a while. Jim knew Ernie would back me, and

finally said, "Okay, I'll work out a deal with you. You get the applications filled out and we'll just put them in the file and we won't even look at them. But we'll have them in the file."

So we literally had to shut down the project. We had to put all our professional staff -- it literally took us three days to get these twenty-four people to fill out these applications. They had never filled out applications, many of them couldn't write at all. But they were very smart, street-wise, really good people.

WEEKS:

Trusted by the community, I suppose.

GREENLICK:

They were well-trusted. They were terrific people, but their qualities were not what can be shown on an employment application. So, we filled them out and we sent the applications over to personnel. I got a call from Jim DeLong who said, "Do you know what you have done? You have hired a murderer."

I said, "Jim, you weren't supposed to read those applications. You promised me you wouldn't read the applications."

He said, "Well, I read the applications and you have hired somebody who has been convicted of murder."

I said, "Yes we did, but it wasn't murder, Jim, it was manslaughter. Yes, we did. But you weren't supposed to read the applications."

What had happened was we had hired someone, a black woman with many children, a really wonderful, tough woman, Ozella was her name. I remember her very well. She had a husband who was a drunk. He used to come home at night and he would beat up her and the kids. One day she said to him, "You S.O.B., if you come home drunk one more time and touch me I'm going to kill

you." He did, and she did. She was convicted of manslaughter and put on probation. She never even served any time. It was obviously a legitimate case. Jim said, "We can't hire people who have committed a crime."

I said, "Jim, we have hired her. There is no problem. She is really important to us out in the community. Nobody messes with Ozella. This really works very well."

"No, we can't do it."

So I said, "Well, I've done it. If you have a problem, call Ernie."

Jim calls Ernie and says, "Mitch hired a murderer." Of course Ernie knew all about this already. I had been filling him in through this whole debate.

Ernie said to DeLong, "Jim, some women kill their husbands one way and some women do it another way. Just forget about it." That was the kind of support that was very important because everything we did was risky. Everything we did was different. Everything we did was unusual.

I remember one of the physicians, Walt Berlin, a urologist, was really complaining loudly about how all these OEO people would be coming in and they were dirty and everyone would be different. One of the principles we had was that the poverty population had exactly the same card everybody else had. Nobody would know who they were. We believed they ought to be integrated. Ernie went out to Walt and said, "Well, Walt, I don't believe you can tell. I don't believe these people are different. I think it's a bunch of hooley. I think it's just a myth you are making up. I'll challenge you. Let's go out into the waiting room right now. You pick out who in the waiting room is an OEO person."

So Walt Berlin went out to the waiting room with Ernie, looked around. There was this scruffy guy sitting out there, shaggy looking, in old clothes.

He said, "That guy. That guy I am sure is one of the OEO people." They went over and it turned out it was a Portland State faculty person that he had picked out. So that sort of slowed down things.

Ernie knew that competition was coming in. He knew that at that time he had a big building planned, that he had built an extra wing of the hospital and that he had two clinics on the drawing board, and he wanted those 6-8,000 members. He wanted the money for them. He was quite willing. This was one more example of Ernie really wanting to be out front with the social philosophy and social experiment, but also knowing how to make that work in terms of a highly pragmatic management of the medical care program. It was that kind of moving back and forth between his social philosophy and his pragmatism that allowed him to be an extraordinarily successful manager.

WEEKS:

He must have been an unusual person for that job. He not only was medical director but he was director of everything, wasn't he? Wasn't he pretty much the final decision maker?

GREENLICK:

He only had the title of being medical director. There was a regional manager who he had appointed, a guy who he had moved up from being an ambulance driver in the shipyards. He had a health plan manager who was a really good salesman, and not a bad guy. He was entirely a salesman and did exactly what Ernie told him to do. He had a hospital administrator, Jim DeLong, who, in my belief, was one of the best day-to-day hospital administrators there ever was. He had worked up from the collection office. He had worked for Kaiser, gotten a degree at the University of Portland after the war, been head of the collections, and worked his way up. He really

understood the day-to-day management of the hospital. How to keep the laundry costs down, how to keep personnel happy. But it was not his job to have any vision. It was his job to do what he was told in terms of what the hospital was going to do as an enterprise.

Ernie only had his medical office. At the time I came it was off in a peripheral clinic. He had, outside the regional manager's office, a chair and an in-box. He would sit at that chair, at the in-box, read his mail and then give it to the regional manager's secretary to take care of. If he wanted to have a meeting he would throw the regional manager out of his office and have a meeting in there because these were his people. These were the people he had hired, he knew what was going on, they knew -- those people had been hired before there was a strong Kaiser central program. So Ernie was in absolute, total control of that region. He didn't necessarily have the title, but when Ernie said jump people asked how high. Just mentioning his name for two years after he left was all it took to get people to jump. He was absolute, 100% in control of that enterprise.

WEEKS:

This is, as I remember, one of the reasons he gave for his leaving. He found himself making all the decisions, doing all the things, yet he was being called away on consulting or helping start another Kaiser plan and the pressure became so great that he decided he wanted relief from it.

GREENLICK:

I never was exactly sure why he left. I'm still not sure I know why he left. That was his story even then. It is consistent, his view of the world. It really did seem to me strange that he all of a sudden had an insight that he had the seven dwarfs as a management team.

WEEKS:

He was there, what, twenty-five years?

GREENLICK:

He left, I think, in late 1970. So he was there twenty-five years. Actually it was more like twenty-seven years. He left an enormous hole. He did not plan for a normal succession. I guess if he had one flaw it was the flaw of the free-floating elitist form of pioneer. He really didn't plan for his succession in any way. He left the program in extraordinary bad management hands. The four or five years after he left were an extremely difficult period. He did leave the program in a very good financial position. It had financial reserves and was coasting those reserves. It had a big building plan. He had things organized. It did seem to me a bit irresponsible to simply just jump off the ship now and leave it sailing without building some succession. It seemed to me he could have spent three or four years bringing in managers of a different kind. It turned out that several of us at the second level literally had to run the program. It was an extremely difficult time. Extremely difficult time for the research center.

There was real question at that time whether I was going to stay. When Ernie left I was not willing to report to the regional manager, who, in my view at that time, was pretty much a buffoon. I was not willing to report to Oakland. So it was a real question of whether we were going to continue as a research center. We had an extraordinary meeting in Portland with the president of Kaiser and the vice presidents and Ernie and the regional manager and some of the people from the research center to try and decide whether or not we were going to stay. In a compromise, it was a very stormy meeting -- stormy inside and stormy outside -- it was finally agreed that we would form a

research policy committee that would be chaired by Arnie Hurtado who had been my partner and my associate. He would represent us in the medical group. The key people from Kaiser, the president and the vice president, and the regional manager and the medical director would all sit on this committee as would three outside people. It was Stoney Stallones who was at that time the dean of the School of Public Health at Texas. Ben Darsky joined that committee; as did Abrahm Yedidia who was a sort of Kaiser guru. They joined that committee with Art Weissman, Jim Vohs, Cliff Keane who was then president of Kaiser Permanente. Dr. Keane at one time had been medical director of the Willow Run auto plant. He was a surgeon who had graduated from the University of Michigan Medical School. They all served on this committee and the research center reported to this committee.

WEEKS:

When you speak of Kaiser do you refer to the Northwest Kaiser or as a whole?

GREENLICK:

Keane was the president of Kaiser Foundation Health Plan and Kaiser Foundation Hospitals. The key vice president, Art Weissman and Jim Vohs, were from the central office. They served on this committee with our regional manager, our medical director, and the three outside people. It gave the research center an independent reporting channel.

We got involved in an extraordinary internecine warfare. Ernie had left a controller in charge who was at best incompetent. I also didn't hold his personal integrity in high regard. He set out battling the research center, battling me and my allies, for control of the region. He lined up his set of allies, which at that time turned out to be the hospital administrator and the

health plan manager. I had, at that time, most of my allies in the medical group. We ended up with four years of bitter warfare where I spent a lot of my time trying to protect the research center and at the same time trying to do research. It ended up essentially with Kaiser finally putting in a new regional manager, Scott Fleming, who at that time had been Deputy Assistant Secretary of HHS. He came in and ultimately stabilized the situation. He slowly brought in new managers across the board.

By the time we got to, say, 1980, all the people who had been our enemies had been replaced and we had become institutionalized. We had become so institutionalized that we were just part of the program.

WEEKS:

Do you still have the board?

GREENLICK:

No, the advisory board actually just sort of atrophied. We report through the regular regional structure now. We report in two ways: our formal umbrella organization is the Kaiser Foundation Research Institute. All of our grants go through the Institute. Jim Vohs is the president of that. Paul Larson who is the chief medical advisor in the central office is the scientific director of KFRI. But we report in the region through the regional management structure. Most of the managers in our region have served on the staff of a research project at one time or another. I've become the senior, at least in terms of service, executive in the program. These things aren't an issue any more. It's hard to remember back in the days when our survival was viewed as a problem.

We continue to have a set of key successes. We were one of the original four Medicare capitation demonstrations, from 1978 to 1980.

WEEKS:

Would you like to talk about that?

GREENLICK:

Oh, sure.

WEEKS:

There aren't many successful stories in that lineup.

GREENLICK:

No. It's a tough field. This goes back again to Ernie's ideas, but also to some of the key people in the other regions of Kaiser as well.

When Medicare became law it wasn't really designed for group practice prepayment plans. It was really designed for the fee-for-service system. Starting from 1966 the people in the group practice prepayment plans were struggling with the people in the Social Security Administration to find ways to make Medicare work for HMOs. A marvelous story is told about Wilbur Cohen who was Secretary of HHS and was involved in the very high level fights to get Medicare to respond to the needs of group practice prepayment plans. Jim Brindle, Marty Cohen and some of the people from HIP were at a meeting with some of the Kaiser people, Bob Brickson and Scott Fleming, and some of the other group practice prepayment people. They were meeting with Wilbur Cohen. They were having just terrible arguments about it. The story goes that at one point Marty Cohen turned to Wilbur and said, "Goddamn it, Wilbur, it's enough to make you lose faith in socialized medicine." Perhaps Jim Brindle was the one who said that, not Marty Cohen. It is a story that's told in the HMO movement.

The fact is that HMOs had worked out a pseudo prepayment approach with Medicare. There was the Medicare group practice prepayment system for

shipping money out in an orderly way, but there was always the retrospective adjustments that ended up paying HMOs on a retrospective basis, for less than actual cost.

In 1969 and 1970, Ernie argued that we should submit a proposal for capitation under Medicare. Ernie was the person that invented the 93% of the AAPCC approach for paying HMOs. We had invented the ACR concept at that point. I reviewed the documents for an ACR study group that HCFA had done before 1970. It was interesting to me to review the 1968, '69, '70 proposals we had made to HCFA. We made two research proposals, one from the Southern California region, one from the Oregon at that time, to get a comparison group of Medicare people, matched with a Kaiser group of people to figure out how much it cost to take care of the comparison group and pay Kaiser 93% of this cost as a capitation rate. We had made a proposal in 1969-70 to do this that was rejected by the Social Security Administration.

So from the very beginning, the group practice prepayment plans were very anxious to try to find a way to get paid by Medicare on a capitation basis. When the 1972 amendments to Medicare were passed, there was the possibility to move toward capitation, at least to move towards a risk contract. Kaiser Permanente didn't like that approach because it also had a major retroactive adjustment in it.

The story of how the Nixon administration got interested in HMOs and became committed to an HMO strategy as their cost-containment approach is, of course, well known. But we began then to push the Nixon administration to allow us to do some research on a capitation program in group practice prepayment. We were involved in several study commissions. We were really pushing them to issue an RFP to do a capitation prepayment program.

An RFP was issued early in 1978. At that period the Research Center worked entirely within the Northwest Region. We did not do things for the national KP program. When the RFP came out I really sat back and waited because I was not interested in taking any initiative in this area unless there was some overall program support for our effort. I knew the initiative to move in this area couldn't come out of the research center alone. I was able to initiate most research at the research center and then turn them over, if they were successful, but here was one area of research that the program really needed to support.

The KP central staff tried first to get the Northern California region and then the Southern California region to respond to this RFP. They both refused. Ten days before the RFP was due the Northwest regional manager, Dan Wagster, was asked whether he would be willing to have me do a proposal for Medicare capitation. This was the spring of 1978. We had ten days to respond to the RFP.

I remember at the time that I was the principal investigator of our center for the multiple risk factor intervention trial for heart disease prevention. I had a group of people scheduled to arrive the next day from all over the country for a retreat. I was organizing the effort to write the next phase of the MRFI intervention program. What we did was to take computers off to our retreat center. Sara Lamb, who was the project administrator for the Medicare was there and Ted Carpenter, who was the director of planning and medical economics of the region joined us. At the breaks in the retreat I was chairing, and in the evening, we went off to the other room and wrote our response to the Medicare capitation RFP. We only had ten days to get it in. We ultimately got that proposal in and were named as one of the first seven

centers to do a Medicare capitation demonstration.

We had resources at that time, a million dollars in grant and contract money. So we could use the resources for the planning and design and for the evaluation of the project. With the OEO project we had used the 5% sample to compare the utilization experience of the OEO group with the remainder of the population. We added them to the 5% sample system on a 100% basis so we had 100% of their utilization and the comparison sample's utilization. We asked what differentiates the medical care of poor people from the medical care of regular health plan members when you take away the economic barriers. We used that data to determine that utilization differences generally disappeared once people are in the same system and taught to use the system. We proposed the same approach for studying the utilization of Medicare beneficiaries newly enrolled in our capitation demonstration. We put 25% of Medicare members into the outpatient study.

There were several elements in that project that were fairly complicated. At the time we began this we had just under 15,000 Medicare members in the Northwest Region. We were proposing to add 4,000 new risk contract members by going out in the community and bringing them in, almost on an instant basis. We were worried that we would be accused of skimming the population if we really didn't have a mass campaign to enroll a broad-based population. At that time, however, Kaiser had never advertised in any way. Doing an advertising campaign really scared the Kaiser Permanente Program. We had to take every step of the development of the campaign to Oakland for approval. And we had to work with the policy makers to make sure the financial mechanisms we were inventing made some sense to them.

It was a delightful experiment because Dan Wagster, who was the regional

manager really wanted to see it succeed. He had been a health plan manager and had been struggling with Medicare all that time. He really made it clear to the region that they were to cooperate with the research center. We brought people into an operations committee and met weekly for two and three hours for six months just learning about how everybody dealt with Medicare. We got everybody attuned to the capitation Medicare concept. We had a variety of task forces, all headed by project staff people. We really carefully planned that process. We planned it from late 1978 to the spring of 1980. There were only four of the seven programs that went on to the second phase; Marshfield Clinic in Wisconsin, Fallon Clinic in Massachusetts, and a set of experiments in Minnesota. We kicked it off with a giant advertising campaign. We ran 95 television slots in a television advertising campaign that I personally worked on with the advertising agency. We had 4,000 new people enrolled in about four to five weeks. We called the program Medicare Plus.

Medicare Plus was very successful. Kaiser had been having some membership problems and were very startled by that result because many believed that old people wouldn't leave their doctors to join HMOs. But we offered a program where they could get; Medicare covered services free of co-insurance or deductibles. Where they could, for \$18 per month, get total medical care, including pharmacy, dental, hearing aid, and vision services. For \$6 a month they could get a drug benefit in addition to Medicare covered services. It was an enormous bargain. We went on television and enrolled 4,000. The health plan proposed that we enroll some additional members, so we ran the spots again and enrolled another 1,500. We enrolled 5,500 people into the Kaiser Foundation Health Plan in a period of about ten weeks. On a one-for-three basis we added another group of people that we converted from the

Kaiser membership. I think we ended up with 7,800 altogether, 5,500 new and 2,300 conversion people.

WEEKS:

So for \$18 a month at the most, a person could have total benefits.

GREENLICK:

Total benefits, including full dental coverage, full drug, full eyeglass, hearing aid.

WEEKS:

How did this work out? Financially, for Kaiser.

GREENLICK:

We calculated an ACR, adjusted community rate, which took the basic community rate for the year and multiplied it by the utilization factors that we expected in the over-65 population. The federal government paid us on the basis of 95% of the AAPCC, the actuarially adjusted per capita cost, which was a rate book estimating what each of the people would have cost the government had they stayed in the fee-for-service community. The difference between that 95% of the AAPCC and our adjusted community rate was known as savings. These savings went directly back to the beneficiary to offset the cost of the premiums for the co-insurance and the deductibles and for the extra benefits.

So, KP was paid on the basis of the adjusted community rate which is what it felt it needed in order to provide the quality medical care services. The beneficiaries got the benefits of the savings.

WEEKS:

Now this Medicare program is still in existence?

GREENLICK:

Oh, yeah. Once we got over the first few months, it was a major problem

to integrate 5,500 new aged people onto the medical care system. We did have 270,000 people at the time. It was not a small system, but going from 15,000 aged to more than 20,000 aged in a period of three months was described by our medical directors as similar to a boa constrictor swallowing a whole pig. He said it left a very big lump that ultimately worked its way down the snake and out. We really did have a lot of support in the system and a lot of help. But there was a lot of screams of pain and anguish by the physicians. We did get over that. We had a new entry system which helped orient people how to use Kaiser Permanente. We did a health survey on all the people before they came into the program so we could screen them for needs and could arrange appointments for members who needed them. We kept one appointment available in the morning and afternoon of every internist for the first four months of the program we could add these people into the schedule. We had telephone tapes that members could call to find out about a variety of subjects. We prepared the most complete orientation program for new members that Kaiser had ever used. These materials are now used routinely. We really taught Kaiser a lot about how to integrate new people. And it worked very well. Our early success in this demonstration stimulated Congress to include capitated Medicare in the 1982 TEFRA regulations. We testified before Congress, showing them it was possible to get old people to join HMOs, showing them our membership satisfaction surveys, and showing them our utilization experience. Our story was very persuasive, I think.

We have moved now beyond that demonstration to the Social HMO, one of my current projects which is adding long-term care benefits to the Medicare benefits financed by a 100% AAPCC and universal premium contributions. But we have now about 35,000 Medicare beneficiaries in our region. So we have gone

from 15,000 in 1980 to 20,000 in 1981 to now 35,000 in 1987. We have almost 5,000 in our social HMO.

WEEKS:

Would you like to discuss the Social HMO?

GREENLICK:

That is one of the two things I am currently spending my time on. I spend half my research time on that, and half my time in a project to reduce dietary cholesterol in kids eight to ten years old. I split between my health behavior, cardiovascular, epidemiology habit and my gerontology habit.

Social HMO is a very exciting project. You may hear more about it as time goes on. It is a project to make available as an HMO benefit long term care services, particularly community-based rather than institution-based long-term care services. It was an idea originally started by Brandeis University. When I heard they had a HCFA grant to select sites to try this thing out, I contacted them and HCFA. It seemed to me the very next logical step after our Medicare Plus project. As I talked with the Medicare members I kept hearing about nursing homes and their fear of nursing homes. Our doctors kept saying, "Okay, you brought us all these old people and it's really nice for them to have Kaiser Permanente. But we don't have anything on the long-term care side. What do we do when they have long-term care needs?"

We were ultimately selected as one of the original four Social HMO sites. We are in at the beginning, as you notice, of all those kinds of things. There is one site in Brooklyn, called Elderplan, which was a geriatric institution trying to start an HMO; one in Minneapolis which was a joint partnership between Group Health Incorporated and Ebenezer Society, a long-term care institution and an HMO in Minneapolis. And there was one started by

the senior citizen action network in Long Beach which was a community action senior citizen group trying to start an IPA HMO backed by a hospital; and there was us.

To my mind the concept is really very simple. It takes Medicare Plus and adds to it a long term care benefit. We call it Medicare Plus II to point out its transition. The long-term care benefit is a simple one, in concept. It provides reimbursement of \$1,000 a month for long-term care services in the home for people who might otherwise be in a nursing home. Members have to be certified for entry into a nursing home using the State of Oregon criteria. The member can also receive reimbursement up to 100 days of ICF care. But the basic benefit provides \$1,000 a month of in-home support services for people who become eligible, using the very strict criteria. It is a benefit designed to serve 5% of the population at most, at any one time. The average cost for those services is about \$600 a month. The premium for this benefit as a part of the overall premium package is about \$30 a month. The premium that people pay for the total coverage is \$49 a month.

We have been selling it in the community at \$49 a month. The beneficiaries get the Medicare Plus package (which now costs about \$33) a better pharmacy benefit, plus this long-term care benefit. We have been at it now nearly two years serving more than 200 members a month with our expanded care benefit. The cost of this benefit is about \$25 a member month. We are keeping people out of the nursing home mostly, serving them in their own home. It is a very exciting thing. It looks like it's going to work.

WEEKS:

Are you doing this home care work with your own staff or are you contracting with visiting nurses or something?

GREENLICK:

We are doing it both with the Kaiser Permanente Home Health Agency and with some community resources. The KP Home Health Agency has become a very traditional Medicare home health agency. They now have about 125 employees and they are very busy. One of the problems in long-term care is that skilled, acute home care agencies really aren't used to dealing with long-term care services such as homemakers and personal care aides. So we use them for maybe a third of our cases, but in the other two-thirds we are buying services from community agencies that supply personal care aides, or homemakers, or chore service.

I've also started an adult day health program in the research center to support the day treatment needs of the population. We now have a census of twelve people in that program. I have the resources and can do things like that. I've learned it is always easier to get forgiveness than it is to get permission. So I just go ahead and start things. And, having had the funds available to do it, I just started this in the research center. But I am mostly buying outside services for homemaker, personal care aides and so on. I've got a team of about seven resource coordinators who do the assessments in the home. These are research quality assessments, because our agreement among the four sites is we will have a common assessment protocol.

WEEKS:

I am sure you have done research on the satisfaction level.

GREENLICK:

Yes. We do a lot of membership satisfaction stuff.

WEEKS:

I assume that most of the patients would much rather be home than in a

nursing home.

GREENLICK:

Much rather be home. Not necessarily all the families. Of course, our program is really dedicated to keeping the informal support system in tact so we really require family cooperation. What we are trying to do is to support system working well. It is a vital piece of the social home approach.

WEEKS:

Are you trying in hospice service?

GREENLICK:

We are tied to the hospice, to a full range of things.

WEEKS:

Are there things that you would like on record?

GREENLICK:

I think those are the key things.

WEEKS:

Have you thought of congregate living at all?

GREENLICK:

That's very much next on my mind. I believe medical care should be tied to housing in a much different way than is usually considered. I would very much like to find ways to tie medical care to congregate living. What I would also like to tie in aged medical care retirement planning. I'd really like to get people to begin paying for their retirement medical care, at perhaps age fifty. And I think programs like KP should be able to offer people, whenever they decide to retire, options for the rest of their life for medical care that include very comprehensive options. I would like them to have the resources available in something like IRAs or annuities, to pay for very

comprehensive options. I hope to organize approaches for early retirement planning, to be able to build very comprehensive retirement benefits, and to get people saving earlier to finance a very comprehensive medical care program or use their resources some other way when they decide to retire.

WEEKS:

One of the things you may run into and have undoubtedly thought about is the marketing of this idea. Assume that you come up with a very good congregate living plan then when you approach people of 65 or over, or 70, they will say that is a fine idea but I'm not quite ready for that yet. "I'd like to be able to do it in my own home."

GREENLICK:

We just applied but we didn't get into the first round of the life-care community at home project. I think you can integrate congregate living with populations of people living at home. I think you can have buildings, but I think you need to tie programs in buildings with programs for the community based population. You need to tie people to the program long before they retire. My intention would be to have a program in a much broader context, including good housing facilities linked to good medical care facilities. But to bring people together even if they choose not to move into some kind of facility. I don't think people want to give up their houses.

WEEKS:

No. That could be part of a progression.

GREENLICK:

Exactly. Facilities could be available if that's what you want or need, but services could also be available in the home.

WEEKS:

You said something about socialized medicine. What is coming down the line?

GREENLICK:

Well, I'll tell you, you mentioned Ig Falk before. I made myself very unpopular at an APHA meeting at one time in the late 1960s as a commentor on a paper where Ig Falk presented his vision that we were going to have national health insurance in the late sixties or early seventies. As you know, there was a sort of universal agreement in the early seventies that we were going to have national health insurance. I argued we were not going to have national health insurance at that time. I didn't believe we would because I didn't believe the problem was insurance. I believed the problem was the organization and delivery of health care services. I believed we were moving towards de facto universal entitlement and I thought it silly to think we were going to get government mandate for universal entitlement. I was very much in the minority, and I was very unpopular among my left of center friends.

I have now begun to look at the question in the medical care system and I think the opposite is currently true. The entitlement is going down about as fast as it can possibly go. Things that are happening in the industrial arena are reducing entitlement. Large, old employers are going out of business leaving people without entitlement at retirement and even before retirement. Employers are behaving in a very anti-social manner. They are trying to find new ways of freezing people out of health benefits as a part of their fringe benefit program. And rise of the for-profit enterprise in health care is destroying the social mission of the health care system. Currently even the non-profit organizations like Kaiser Permanente that are competing with the

community are doing anti-social things. Like moving away from community rating, moving away from the social mission that they once had.

The result of all this is that more and more people are becoming disentitled and insurance coverage is declining at an alarming rate. Things are going to intensify that in the next couple of years, and I believe for the first time that we are headed for national health insurance. I have talked with other people who are beginning to have that idea. Wilbur Cohen believed it because he believed in seventeen year cycles and thought we were headed for that phase in the seventeen year cycle. But I think that perhaps as early as the 1988 campaign, but absolutely by the 1992 campaign, we are going to have national health insurance as a major part of our national debate. I think we will be moving towards a program that will create a national entitlement. I think it will be based on mandating employers to cover health insurance as a part of employment, as is currently proposed in the Kennedy-Waxman bill. Even Ford Motor and other companies are beginning to argue for mandated coverage so they can get cost-shifting expenses out of their fringe benefit package and put the burden on companies that aren't providing coverage.

So, I think we are moving toward national health insurance. Consequently, I think the challenge for the future is to continue to understand the underlying phenomenon in the health care system so that we can help organize services correctly in a system that has universal entitlement in it. I think the work we have been doing inside the universal entitlement of an HMO will really help us, but it seems to me now critical, more critical to understand the basic behavioral phenomenon. As we create this universal entitlement, we must be able to help the policy makers predict the result of their decisions. We can only achieve that goal through really basic health

services research, studying underlying phenomenon.

I am very excited about the future of health services research because we are beginning to illuminate some of the basic underlying principles of the organization of medical care. As the policy makers really get to the tough decisions, and I think they are going to in the next four to six years, then we really have a challenge.

WEEKS:

I wonder if you agree or disagree with me that we are going to face a new means test idea. In fact, my income is sufficient to pay most of my bills and so forth, why shouldn't I pay part of my health service costs? As long as I can afford to pay for it, why shouldn't I pay for it? Let the people whose incomes are low and who have trouble paying their bills of any kind, why shouldn't they benefit before I do?

GREENLICK:

Because Sy Axelrod taught me that it is really dysfunctional to charge at the point of service for medical care expenses. I believe it should be done as a part of the tax system. I believe that if you have income and resources you should pay more, but you should pay for it out of the tax system. For example, I really do favor the idea of taxing the Medicare benefits. Include the Medicare benefits as income and tax it. That makes a lot of sense to me. But I hope as a part of universal entitlement we will move away from the means test as we create universal entitlement.

WEEKS:

I can see your point. As an example, at the present time if you are on Social Security, receiving Social Security benefits and your income is \$35,000 or more, you begin paying tax on your benefits.

GREENLICK:

That is totally appropriate. I'd also like to see taking the lid off of Social Security tax as it is in terms of employed workers. Claude Peppers' proposal would take the tax limit off the Medicare piece. So individuals would continue to pay FICA taxes on the health insurance piece, whatever the income.

WEEKS:

It seems every now and then someone refers to the new things that are coming.

GREENLICK:

I have just written a chapter for the new edition of Freeman and Levine's Handbook of Medical Sociology -- I wrote the chapter on adult care. I didn't start it this way, but the more I wrote about the things that are happening in the adult health care system, the more I became convinced that we are moving towards national health insurance. It was very interesting that that was not where I started writing, but it was the conclusion of my social policy analysis of the current events in the health care system.

WEEKS:

It seems when you reason this thing out and you come to the end you say there is only one conclusion you can make.

GREENLICK:

It surprised the hell out of me to find that that was indeed my conclusion.

Interview in Ann Arbor

June 16, 1987

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