Since 1954 the Regional Oral History Office has been interviewing leading participants in or well-placed witnesses to major events in the development of Northern California, the West, and the Nation. Oral history is a method of collecting historical information through tape-recorded interviews between a narrator with firsthand knowledge of historically significant events and a well-informed interviewer, with the goal of preserving substantive additions to the historical record. The tape recording is transcribed, lightly edited for continuity and clarity, and reviewed by the interviewee. The corrected manuscript is indexed, bound with photographs and illustrative materials, and placed in The Bancroft Library at the University of California, Berkeley, and in other research collections for scholarly use. Because it is primary material, oral history is not intended to present the final, verified, or complete narrative of events. It is a spoken account, offered by the interviewee in response to questioning, and as such it is reflective, partisan, deeply involved, and irreplaceable.

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It is recommended that this oral history be cited as follows:


Copy no. ______
FLEMING, Scott (b. 1923) Kaiser Permanente Lawyer

The History of the Kaiser Permanente Medical Care Program, 1997, xii, 222 pp.


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Background of the Oral History Project

The Kaiser Permanente Medical Care Program recently observed its fortieth anniversary. Today, it is the largest, one of the oldest, and certainly the most influential group practice prepayment health plan in the nation. But in 1938, when Henry J. and Edgar F. Kaiser first collaborated with Dr. Sidney Garfield to provide medical care for the construction workers on the Grand Coulee Dam project in eastern Washington, they could scarcely have envisioned that it would attain the size and have the impact on medical care in the United States that it has today.

In an effort to document and preserve the story of Kaiser Permanente's evolution through the recollections of some of its surviving pioneers, men and women who remember vividly the plan's origins and formative years, the Board of Directors of Kaiser Foundation Hospitals sponsored this oral history project.

In combination with already available records, the interviews serve to enrich Kaiser Permanente's history for its physicians, employees, and members, and to offer a major resource for research into the history of health care financing and delivery, and some of the forces behind the rapid and sweeping changes now underway in the health care field.

A Synopsis of Kaiser Permanente History

There have been several milestones in the history of Kaiser Permanente. One could begin in 1933, when young Dr. Sidney Garfield entered fee-for-service practice in the southern California desert and prepared to care for workers building the Metropolitan Water District aqueduct from the Colorado River to Los Angeles. Circumstances soon caused him to develop a prepaid approach to providing quality care in a small, well-designed hospital near the construction site.

The Kaisers learned of Dr. Garfield's experience in health care financing and delivery through A. B. Ordway, Henry Kaiser's first employee. When they undertook the Grand Coulee project, the Kaisers persuaded Dr. Garfield to come in 1938 to eastern Washington State, where they were managing a consortium constructing the Grand Coulee Dam. Dr. Garfield and a handful of young doctors, whom he persuaded to join him, established a prepaid health plan at the damsite, one which later included the wives and children of workers as well as the workers themselves.
During World War II, Dr. Garfield and his associates--some of whom had followed him from the Coulee Dam project--continued the health plan, again at the request of the Kaisers, who were now building Liberty Ships in Richmond, California, and on an island in the Columbia River between Vancouver, Washington, and Portland, Oregon. The Kaisers would also produce steel in Fontana, California. Eventually, in hospitals and field stations in the Richmond/Oakland communities, in the Portland, Oregon/Vancouver, Washington areas, and in Fontana, the prepaid health care program served some 200,000 shipyard and steel plant employees and their dependents.

By the time the shipyards shut down in 1945, the medical program had enough successful experience behind it to motivate Dr. Garfield, the Kaisers, and a small group of physicians to carry the health plan beyond the employees of the Kaiser companies and offer it to the community as a whole. The doctors had concluded that this form of prepaid, integrated health care was the ideal way to practice medicine. Experience had already proven in the organization's own medical offices and hospitals the health plan's value in offering quality health care at a reasonable cost. Many former shipyard employees and their families also wanted to continue receiving the same type of health care they had known during the war.

Also important were the zeal and commitment of Henry J. Kaiser and his industry associates who agreed with the doctors about the program's values and, despite the antagonism of fee-for-service medicine, were eager for the success of the venture. Indeed, they hoped it might ultimately be expanded throughout the nation. In September, 1945, the Henry J. Kaiser Company established the Permanente Health Plan, a nonprofit trust, and the medical care program was on its way.

Between 1945 and the mid-1950s, even as membership expanded in California, Oregon, and Washington, serious tensions developed between the doctors and the Kaiser-industry dominated management of the hospitals and health plan. These tensions threatened to tear the Program apart. Reduced to the simplest form, the basic question was, who would control the health plan--management or the doctors? Each had a crucial role in the organization. The symbiotic relationship had to be understood and mutually accepted.

From roughly 1955 to 1958, a small group of men representing management and the doctors, after many committee meetings and much heated debate, agreed upon a medical program reorganization, including a management-medical group contract, probably then unique in the history of medicine. Accord was reached because the participants, despite strong disagreements, were dedicated to the concept of prepaid group medical practice on a self-sustained, nonprofit basis.

After several more years of testing on both sides, a strong partnership emerged among the health plan, hospitals, and physician
organizations. Resting on mutual trust and a sound fiscal formula, the Program has attained a strong national identity.

The Oral History Project

In August 1983, the office of Donald Duffy, Vice President, Public and Community Relations for Kaiser Foundation Health Plan and Hospitals, contacted Willa Baum, Director of the Regional Oral History Office, about a possible oral history project with twenty to twenty-four pioneers of the Program. A year later the project was underway, funded by Kaiser Foundation Hospitals' Board of Directors.

A project advisory committee, comprised of seven persons with an interest in and knowledge of the organization's history, selected the interviewees and assisted the oral history project as needed. Donald Duffy assumed overall direction and Darlene Basmajian, his assistant, served as liaison with the Regional Oral History Office. Committee members are John Carpenter, Dr. Cecil Cutting, Donald Duffy, Robert J. Erickson, Scott Fleming, Dr. Paul Lairson, and Walter Palmer.

By year's end, ten pioneers had been selected and had agreed to participate in the project. They are Drs. Cecil Cutting, Sidney Garfield, Raymond Kay, Clifford Keene, Ernest Saward, and John Smillie, and Messrs. Frank Jones, George Link, Eugene Trefethen, Jr., and Avram Yedidia.

By mid-1985 an additional ten had agreed to participate. They are: Drs. Morris Collen, Wallace Cook, Alice Friedman, Benjamin Lewis, Sam Packer, Bill Reimers, Harry Shragg, and David Adelson, Lambreth (Handy) Hancock, and Berniece Oswald.

Plans to interview Dr. Garfield and Dr. Wallace Neighbor, who had been at Grand Coulee with Dr. Garfield, were sadly disrupted by their deaths a week apart in late 1984. Fortunately, both men had been previously interviewed. Their tapes and transcripts are on file in the Central Office of the medical care program. Similarly the project lost Karl Steil due to his lengthy illness and death in 1986.

The advisory committee suggested 1970 as the approximate cutoff date for research and documentation, since by that time the pioneering aspects of the organization had been completed. The Program was then expanding into other regions, and was encountering a new set of challenges such as Medicare and competition from other health maintenance organizations.

Research

Kaiser Permanente staff and the interviewees themselves provided excellent biographical sources on each interviewee as well as published and
unpublished material on the history of the Program. The collected papers of Henry J. Kaiser on deposit in The Bancroft Library were also consulted. The oral history project staff collected other Kaiser Permanente publications, and started a file of newspaper articles on current health care topics. Most of this material will be deposited in The Bancroft Library with the oral history volumes. A bibliography is located at the end of the volume.

To gain additional background material for the interviews, the staff talked to five Kaiser Permanente physicians in northern California, two of whom had left the program years ago: Drs. Martin Abel, Richard Geist, Ephraim Kahn, James Smith, and William Bleiberg. James De Long in Portland, and William Green, William Allen, and Dr. Toby Cole in Denver talked about the history of their regions. In addition, Peter Morstadt, formerly executive director of the Denver Medical Society, discussed the attitude of the medical society toward Kaiser Permanente's years in Denver.

The staff also sought advice from the academic community. James Leiby, a professor in the Department of Social Welfare at UC Berkeley and an advocate of the oral history process, suggested lines of questioning related to his special interest in the administration of and relationships within public and private social agencies. Dr. Philip R. Lee, professor of social medicine and director of the Institute for Health Policy Studies at the University of California Medical School, proposed questions concerning the impact of health maintenance organizations on medical practice in the United States.

Organization of the Project

The Kaiser Permanente Oral History Project staff, comprised of Malca Chall, Sally Hughes, and Ora Huth, met frequently throughout 1985 to assign the interviews, plan the procedures and the time frame for research, interviewing, and editing, and to set up a master index. Interviews with the first nine pioneers took place between February and June, 1985, and with the second group between February and December, 1986. The transcripts of the tapes were edited, reviewed by the interviewees, typed, proofread, indexed, copied, and bound. The entire series will be completed during 1987.

Summary

This oral history project traces, from various individual perspectives, the evolution of the Kaiser Permanente Medical Care Program from 1938 to 1970. Each interview begins with a discussion of the

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1Tapes of these interviews have been deposited in the Microforms Division of The Bancroft Library.
individual's family background and education--those tangible and intangible forces that shaped his or her life. The conversation then shifts to the interviewee's participation in and observation of significant events in the development of the health plan. Thus, the reader is treated not only to facts on the history of the Program, but to opinions about the personal qualities of the men and women--doctors, other health care professionals, lawyers, accountants, and businessmen--who, often against great odds, dedicated themselves to the development of a health care system which, without their commitment and skills, might not have resulted in the individual and organizational achievements that the Kaiser Permanente Medical Care Program represents today.

The Regional Oral History Office was established to tape record autobiographical interviews with persons who have contributed significantly to the development of the West. The office is headed by Willa K. Baum and is under the administrative supervision of James D. Hart, the director of The Bancroft Library.

Malca Chall, Director
Kaiser Permanente Medical Care Program
Oral History Project

23 January 1987
Regional Oral History Office
Berkeley, California

ADDENDUM

Following completion of the initial nineteen interviews in the Kaiser oral history series, the advisory committee expanded the project beyond the 1970 cutoff date. The aim was to document the medical program's evolution from the perspective of the Central Office through interviews with Scott Fleming and James Vohs.


In 1952, James Vohs began his career with Kaiser in labor and industrial relations with several different components of the Kaiser Company. In 1957 he joined the Health Plan in Los Angeles as employee relations advisor, shortly thereafter becoming Health Plan manager of the
Southern California Region. His career with the medical program moved steadily upward. Between 1974 and 1991 he assumed the helm of the Kaiser Permanente Medical Care Program as chairman, president, and CEO, positions he held until his retirement in 1992.

Both Fleming and Vohs knew the program and its key administrative and Permanente Medical Group personnel from its tumultuous "Lake Tahoe" days in the 1950s; through its expansion from three to twelve regions, with consequent growth of membership; the impact of federal regulations, including Medicare which Mr. Fleming had a hand in crafting; and the effect of competition among HMOs and Kaiser Permanente. They were on hand to witness the major changes in the health care industry with which Kaiser Permanente must currently cope. Their interviews broaden and add significantly to the history of the Kaiser Permanente Medical Care Program from its inception to the present.

Malca Chall, Director
Kaiser Permanente Medical Care Program
Oral History Project

July 1997
Regional Oral History Office
Berkeley, California
INTERVIEWS
KAISER PERMANENTE MEDICAL CARE PROGRAM

David Adelson
Morris Collen, M.D.
Wallace Cook, M.D.
Cecil C. Cutting, M.D.
Scott Fleming
Alice Friedman, M.D.
Lambreth Hancock
Frank C. Jones
Raymond M. Kay, M.D.
Clifford H. Keene, M.D.
Benjamin Lewis, M.D.
George E. Link
Berniece Oswald
Sam Packer, M.D.
Wilbur L. Reimers, M.D.
Ernest W. Saward, M.D.
Harry Shragg, M.D.
John G. Smillie, M.D.
Eugene E. Trefethen, Jr.
James A. Vohs
Avram Yedidia
Scott Fleming's oral history is the twentieth in a series, begun in 1985, on the Kaiser Permanente Medical Care Program (KPMCP). An attorney specializing in business and tax law, he joined the legal department of the Henry J. Kaiser Company in 1952. By 1955, he had moved to KPMCP's Central Office where he served as legal counsel and almost immediately became involved in the turmoil of the "Tahoe Period," a time in the mid 1950s when the regional Permanente Medical groups were at loggerheads with Kaiser Permanente Hospitals and Health Plan.

The Central Office was at the hub of this and other critical periods in Kaiser history. Thus Fleming can and does provide an "insider's" view of this and other events influencing the evolution of the organization. His viewpoint as an attorney can be fruitfully compared with those of physicians and administrators interviewed in this series. Readers might also be interested in comparing the "Kaiser model" of an HMO, as delineated by Fleming and the others in this series, with the "staff model" which Robert Gumbiner and colleagues describe in two ROHO oral history volumes on FHP, International, an HMO based in southern California and recently purchased by PacifiCare.

Fleming also tells of his two years in Washington (1971-1973) as Deputy Assistant Secretary for Health Policy Development in the Department of Health, Education, and Welfare, as it was then called. His vistas widened, he returned to Kaiser in July 1973, to become Senior Vice President and Regional Manager of the Oregon Region. Fleming's perceptions of the region during his tenure from 1973 to 1976 are a useful sequel to the oral history in this series with Ernest Saward, Oregon's first regional manager.

In 1977 Fleming returned to the Central Office as Senior Vice President in its Executive Department. In this position, he wrote KPMCP's national expansion policy and chaired the Kaiser Permanente Committee, where Kaiser's expansion was debated, formulated, and orchestrated. Mr. Fleming retired in 1989, but remains active as a Kaiser consultant, conservationist, and, with his wife Jenny, in the California Native Plant Society.

Oral History Process

Five interviews were recorded with Mr. Fleming in the Berkeley home he and his wife designed, which is surrounded by an exquisite garden of native California plants, also of their creation. Mr. Fleming spoke deliberately and without false starts or verbal mannerisms. Because of budget limitations, he generously agreed to write his early personal
history and also a section on the Hawaii Region. These sections are reproduced, without ROHO editing, just as Fleming wrote them. In addition, his office provided the final typing services.

The Regional Oral History Office was established in 1954 to augment through tape-recorded memoirs the Library's materials on the history of California and the West. Copies of all interviews are available for research use in The Bancroft Library and in the UCLA Department of Special Collections. The office is under the direction of Willa K. Baum, and is an administrative division of The Bancroft Library of the University of California, Berkeley.

Sally Smith Hughes, Ph.D.
Interviewer-Editor

June 1997
Berkeley, California
PERSONAL RESUME

SCOTT FLEMING

Born 1923 in Twin Falls, Idaho (parents' residence, Jarbridge, Nevada).

Grew up largely in mining country in Nevada, with some time spent in Los Angeles area in California, Brownsville, Texas, and farming and ranching country in Idaho.

Chronology—High School through Law School

Attended high school in Reno, Nevada, 1938--41.

Attended University of Nevada during academic year 1941--42, with journalism as intended major.

Attended University of California, Berkeley, fall term 1942 ending February 1943, with intended major in College of Commerce.

Military Service. Entered military service in March of 1943 and released from active duty in April of 1946. Commissioned Second Lieutenant Antiaircraft Artillery in November 1943. Assigned to administrative and training duties during spring of 1944. Retrained in Infantry summer of 1944 and assigned to predominantly administrative duties at overseas replacement depots, at Fort Meade, Maryland, Camp Adair, Oregon, and Camp Pickett, Virginia from fall of 1944 through release from active duty in April of 1946. Completed service as First Lieutenant assigned to the position of Regimental Information and Education Officer.

College and Law School. Attended summer sessions at University of California, Berkeley, summer of 1946. Entered University of Chicago Law School by examination fall of 1946 for one academic year. Attended summer sessions at University of California, Berkeley, summer of 1947 and entered University of California Law School at Berkeley (Boalt Hall) for academic years of 1947--48 and 1948--49. Did student writing for California Law Review 1947--48 and was member of Board of Editors of California Law Review 1948--49. Received A.B. degree from University of California in 1948 and LL.B. degree with honors in 1949.

Elected member of Order of the Coif (legal honorary society) on graduation in 1949.

Career History


Joined Legal Department of Henry J. Kaiser Company October 1951 and continued in that position through June 1955.

June 1955 through August 1971, served in several legal and managerial positions in the Kaiser Permanente Medical Care Program, with emphasis on organizational and structural policies, legal affairs, government relations, and long-range planning.

1955--60 Legal Counsel;
1961--65 Associate Manager, Assistant Secretary and Counsel;
1966--1969 Vice President and Counsel;
1970--71 Executive Vice President and Secretary.

Commencing in September 1971, Scott Fleming, at the request of Secretary Elliot Richardson and Assistant Secretary Monte DuVal, M.D., joined the Office of the Assistant Secretary for Health as Deputy Assistant Secretary for Health Policy Development, and continued in that position through June 1973.

In July 1973 Scott Fleming returned to the Kaiser Permanente Medical Care Program and assumed the position of Senior Vice President and Regional Manager of the Oregon Region of Kaiser Foundation Health Plan and Kaiser Foundation Hospitals--August 1973--December 1976.

He returned to the Central Office of Kaiser Foundation Health Plan and Kaiser Foundation Hospitals in Oakland, California as Senior Vice President, effective January 1, 1977.

Career-related Activities:

Member of the "Secretary's Committee on Hospital Effectiveness" appointed by HEW Secretary Gardner, 1966--67.

Member of American Hospital Association Committee on the Regulatory Process, 1976--77.

Member of the Board of Directors of the Group Health Association of America, 1974--81.

Member, Institute of Medicine of the National Academy of Sciences since 1973; member Health Services Research Committee, 1977--78
Member, National Chamber of Commerce Foundation Steering Committee for National Health Care Strategy Study, 1977--78.

Other Interests and Activities

Conservation: Life Member of Sierra Club, member National Audubon Society, Environmental Defense Fund, Natural Resources Defense Council, California Native Plant Society. Active in Sierra Club 1965--71; Chairman of Sierra Club River Conservation Committee 1969--71; member Board of Directors, Planning and Conservation League, since 1985.

Business: Member Board of Directors, Orcon Corporation, Union City, California, since 1983.

Political: Member Common Cause; Democrat.

Recreation: Skiing, hiking, backpacking, white-water kayaking, photography, scuba diving, windsurfing.
I was born in Twin Falls, Idaho, October 17, 1923. At that time our family home was in Jarbridge, Nevada, a mining town on the Jarbridge River (far north in Nevada), with a population of perhaps 500 persons, largely working in the major gold mine in that area and in supporting activities. There were, no doubt, a few independent, freelance miners in the area.

My father was the postmaster, and my mother was a school teacher. The nearest hospital was located in Twin Falls, about a three to four hour drive from Jarbridge with the automobiles and roads of that time. As far as I know, my grandparents had all died before I was born, and I know very little about them. I don't even recall much family conversation about grandparents, and they had no direct influence on my life.

My father described our family ancestry as "Scotch/Irish and English." The name "Fleming" derives from the "Flemish men." According to my understanding of the relevant history, a number of the Flemish men or "Flemings" joined the Duke of Orange in his adventures in the British Isles. I believe my ancestry on my father's side traces to that group. My mother's maiden name was Bascom. Her ancestry, I believe, was English.

I also have the impression that my ancestors on both my mother's and father's side had arrived in the United States quite early, although I do not have any specifics.

1In this biographical sketch, which I am doing independently (without an interviewer), I will try to follow the outline provided by Sally Hughes, the Bancroft Library oral historian who has conducted the other interviews.

--Scott Fleming
Parents

My father, John Benton Scott Fleming, who went by Scott Fleming, was born in Virginia in the post-Civil War period. According to my understanding, he had completed high school and had some tutoring beyond high school in Virginia before he came West. His career was mostly in mining. He was recognized as a self-taught "mining engineer," qualified in surveying and in assaying, with a practical knowledge of geology and a good understanding of mining and mineral refining practices. Before he was married he had pursued the occupation of mining in Alaska and British Columbia as well as in Nevada—and possibly other parts of the West.

He died when I was sixteen. I recall him as a warm, friendly, and thoughtful person, an avid reader of political and current affairs information, and a very good father.

My mother's maiden name was Anna Laura Bascom. She was born in Ohio and came from a large family, mostly women who apparently came West together when they were fairly young. Because she died when I was eight, I have more knowledge and recollection of her sisters, many of whom I lived with at one time or another for various periods. These included Aunt Louise and Aunt Mabel, who together (with Louise as the dominant figure) ran a cattle ranch in Idaho, where I spent many summers in my childhood. Louise was a competent rancher. She kept a modestly successful ranching operation functioning throughout the Depression with a great deal of personal effort, toughness, and ability to be the boss in a predominantly male-type activity, with Old West cowboys as hired hands.

Aunt Georgia lived in Eden, Idaho, not far from Twin Falls, where her husband ran a general store. I visited her there as well as on Aunt Lou's ranch, which was considerably further north in a valley just to the north of the Lost River at the base of Mt. Borah, the highest mountain in Idaho, with an elevation exceeding 12,000 feet. Aunt Marian, closest in age and otherwise closest to my mother, lived in Rosemead, in the Los Angeles area, and I spent one or two school years with her and her husband, Walter, a carpenter, attending school at the Rosemead Grammar School.

Aunt Addie and her husband lived in Thermal, California, on a farm largely devoted to growing dates, although they had other crops as well. I spent some time at the farm in Thermal while I was living with Aunt Marian in Rosemead. The address for Aunt Louise was Chilly, Idaho. Both Chilly, Idaho, and Thermal, California, were appropriately named. Summers on the Idaho ranch were reasonably warm, but not hot. I also occasionally visited Aunt Georgia in Eden, near Twin Falls, Idaho.

As I've mentioned, my mother died when I was eight, and my recollections of her are rather vague. I'm not sure that I have any real recollections of living in Jarbidge. We left there when I was five to go.
to the Brownsville area in Texas, where my father's brother, my Uncle Earl, was starting a grapefruit growing enterprise and persuaded my father to join him. I have a few memories of the grapefruit farm—mostly of Mexican children, of people working on the farm, and of catching crawdads with my father from a bridge across an irrigation canal.

My father decided that the grapefruit farming venture was not promising, and we moved back to Copper Basin, Nevada (near Battle Mountain) after less than one year. At Copper Basin my father was the manager of a copper mine and mill in a mining camp with a population of fewer than 100 persons; all of the men worked in the mine or mill, and there were about a dozen children who attended the camp school which my mother taught. Indeed, some of my earliest recollections of my mother are of her as a school teacher.

I have pleasant recollections of my time in Copper Basin, particularly family picnics at Galina Creek a few miles away, where there was running water much of the year and trees providing a pleasant contrast to the pervasive sage brush, and pleasant shade in the heat of this semi-desert area. I also recall the winter when the mining camp was snowed in, and some dozen of the workers, mostly Scandinavians, fashioned skis from planks in the mine shop and skied into Battle Mountain about ten or twelve miles away to obtain provisions for the camp until the snow thawed sufficiently for vehicles to traverse the road. The children in camp inherited the skis and, despite their primitive nature and excessive size for children, we had wonderful fun skiing in that very hilly area. I acquired a fondness for skiing, which I retain.

The Depression of 1929 hit the mining industry within a couple of years of our arrival in Copper Basin, and the market price of copper dropped below the cost of production at this relatively small and inefficient underground mine which could not compete with the open pit mines in Utah and Montana and in other parts of the world. So the mine and mill closed and we moved some fifteen miles further south to a highly mineralized area known as Copper Canyon, where there was considerable gold to be found, as well as copper, silver, and several other valuable minerals.

My father mined gold, and some high-grade copper, in a number of different locations and situations while living at the mouth of Copper Canyon in facilities originally established for what had been the very rich Dahl Placer Deposit—then largely "worked out." I again have pleasant recollections of walks with my mother, making root beer which we cooled in a wet evaporative cooler in a long mine tunnel that had been part of the Dahl Placer operation, and family picnics in the adjoining canyon, Willow Creek, which supported a small year-round stream.

While living in this situation my mother contracted breast cancer and went to Reno, Nevada, for surgery. She died as a result of an embolism
incident to the surgery. Thereafter, my father moved to a mining shack farther up in Copper Canyon and continued to support the two of us with various gold mining activities. The one that I remember best involved mining placer ore from a "drift"--a tunnel extending laterally from a vertical shaft about 40 feet deep, windlessing the ore to the surface, and extracting the gold with a primitive gold mining device called a "rocker," which required water to operate.

At this time I was nine years old. Although I do not remember when I first started driving a car, I do remember driving our old Star roadster, in which the rumble seat had been converted to a pickup bed, up to the head of the canyon, filling two oil drums with water from the spring there, and hauling them back to where my father was extracting gold. Although this car started with a crank, and I couldn't crank it, some direction in Copper Canyon was always downhill, and the car started readily on compression. Thus my inability to turn the crank was not much of a problem. This was a remote and isolated area, and there were no police around to question my driving or lack of a license. Indeed I did considerable utilitarian driving both in Nevada and around the ranch in Idaho before I was twelve years old.

I attended school in Copper Canyon in a one-room, one-teacher school which at that time had twelve students, eight grades and a new young teacher. My mother's sisters were concerned that I might not be getting a proper education, so I went to Rosemead to live with Aunt Marian and attend school there. Probably because of my growing up in the mining camp situation, I was quite out of place and socially inept in the Rosemead School but, as far as the educational aspect was concerned, I was definitely ahead of the students in my class. As I was much happier in Copper Canyon, I returned there the following year after spending the summer on the ranch in Idaho. My recollection is fuzzy. I may have spent two school years in Rosemead. Probably because of growing up in such isolated and relatively remote circumstances, I feel that I was close to both of my parents and particularly to my father. Although my parents conceived a child who would have been an older sister, she died at birth.

Religion

My father regarded religion as mythology without any basis except human psychological needs. I do recall discussing religion with him, and I readily acquired, accepted, and have no doubt since elaborated upon his conviction of the implausibility and, indeed, the impossibility of the foundations of religious doctrine. Studies in anthropology make it clear that religion serves basic human psychological needs; over human history it has both served and dis-served human social needs. To me the fundamental is clear: man created God or, more accurately, mankind has created many
gods, not necessarily in man's image and likeness, but in the image and likeness of the things that men, in various cultures throughout human history, have believed that gods should be.

Financial Status

Prior to the Great Depression, I believe (based on vague recollections as noted above) that our family's financial status was middle class--adequate income for family support, a certain amount of travel, an automobile typical of the time, and in general no financial deprivation, although certainly no affluence. Following the closing of the copper mine and mill in Copper Basin, things became much more difficult in an objective sense. However I do not recall any significant change insofar as I was personally concerned.

Considering the relative isolation, the one-room mining shack with an out-house (indoor plumbing was not common during my early years, being available only in Rosemead, California and during my brief stays in Eden, Idaho), near-absence of children close to my age, and generally primitive circumstances, a social worker would probably have classified me as a deprived child. However, I didn't know this. As far as I was concerned Copper Canyon was just fine, and much better than the available alternative--Rosemead, California.

In 1936, my father barely escaped from his mine after a carbon monoxide poisoning episode and concluded that he should try to get out of the kind of mining he was doing. He and his sister, my Aunt Elizabeth F. Athey, who had been living in Washington, D.C., combined resources, including a moderate inheritance, and purchased a guest house in Reno, Nevada.

We moved there, as I recall, in late summer, 1936. Although the guest house operation was marginal, it did support the three of us. For a while my father ran a service station in downtown Reno, and I helped out there after school and during vacation time, etc. He could not provide the capital to improve the station, and the company (Shell) insisted on substantial improvements to what was a good gasoline dispensing location, so he gave that up. His health was declining. Although he sought other productive endeavor, including a small mining effort in the gold country of northern California, opportunities were quite limited during the Depression, and he never achieved any satisfactory occupation from the time he gave up the service station until his death from a heart attack in 1938.

Although the guest house provided basic support, it did not provide surplus cash. I earned a significant amount of money for those days in a combination of activities--delivering newspapers, working in service
stations based on the experience I had in my father's station, and working in the local Sears Roebuck tire shop.

I had become interested in photography and was fortunate in having two friends, both keenly interested in photography and both with parents who were advanced photographers and willing to loan photographic equipment. I worked for a time doing the film processing in a darkroom associated with a photo shop that had been inherited by a couple who knew nothing about photography. They were totally unable to continue the business without my part-time help.

On the basis of this experience I soon developed a very small part-time "business" in freelance photography--mostly photographing divorcees riding horses at various of the riding stables near Reno and photographing pets for the pet owners who could afford this service. (A fair portion of the Reno population was reasonably affluent.) The result was that, although I spent a lot of time working, it was reasonably pleasant and interesting work, and provided me with funds sufficient to more or less "hold my own" with my high school friends from more affluent families.

**Intellectual Interest**

Nevada mining country was not an intellectual Mecca. In the "intellectual" area I have three primary recollections: My father was an avid reader of periodicals concerned with current events and political matters. The one I remember most clearly was the Literary Digest--the predecessor of Time Magazine and Newsweek--which failed following a disastrous but simple statistical mistake. In polling for the 1936 Roosevelt v. Landon election, they predicted a Landon victory based upon telephone sampling. The only problem was that a very large percentage of the electorate in 1936--and the lower economic portion most likely to vote Democratic--did not have telephones.

In any event, during the years that I recall with my father and before that with my mother and father, I contrived to do a significant amount of reading in the Literary Digest. I don't really remember when I learned to read, but I do know that I was reading this and the newspapers that we got just about every week almost as far back as I can remember anything.

My father's interest in current news was keen. We had a radio more or less capable of picking up stations as far away as San Francisco. However, the reception was poor. I learned that I could often improve the reception by holding my hands around the radio in various positions. (I now know this was the condenser or capacitance effect with a physical explanation; at that time it was mysterious, but it worked.) Thus I
"hexed" the radio into producing clearer signals when my father was listening to the news. The result was that I also listened to the news, and my father explained, after each news session, a little bit about the places being reported on and what the news was all about. This, combined with the *Literary Digest*, probably reinforced my efforts at reading so that before we went to Reno in 1936, when I was twelve years old, I read quite proficiently at an adult level.

My first two years in Reno, the eighth and ninth grades in junior high school, were kind of "transition years," in which I was able gradually to overcome the social ineptness from a rather isolated childhood and achieve satisfactory relations with classmates. I was cautious during this period and picked friends carefully in three different areas so that when I entered Reno High School in the fall of 1938, I was well situated for a good social life with three distinct groups of friends: (1) some of the athletically inclined, who became the Reno High School ski team—a very good high-school level ski team in those days; (2) two friends who were avid photographers; and (3) a group—with some overlap—interested in debate, public speaking, and drama.

I also had some minor involvement in journalism—the school paper, the yearbook and a freelance young folks monthly that some of us produced. This, combined with photography, convinced me that the career I wanted was to be a photo journalist, *à la* Life Magazine.

Academically, junior high school and high school were a breeze. I maintained top grades with virtually no effort. In addition to a lot of compensated work as mentioned earlier, I was on the debate team, in extemporaneous speaking competition, and active in the drama club. I got much more than my share of good roles, not because of acting talent, but because I could learn the lines much more quickly than other students who were interested in those activities.

**Social Occasions**

Social life was limited in the Nevada mining country, and much of the social contact available was with adults. While living in Rosemead, we frequently visited relatives in the area, and a number of members of the extended family usually visited the ranch in Idaho for a period every summer. However, I don't recall a lot of what I would describe as social occasions.

In the guest house in Reno, my father and aunt and, after my father's death, my aunt alone served meals to the guests. I ate along with them in what tended to be a fairly large adult gathering—probably twelve people or so on average.
However, by the time I got to high school, I had a quite busy social life of typical teenage activities. Reno and environs, including the nearby Sierras, Lake Tahoe, Pyramid Lake and the ski country, provided a wonderful setting in which to be a teenager.

**Discipline**

Probably because of the isolated and somewhat unusual circumstances in which I grew up, and the predominance of adults rather than children my own age in my environment, I was something of a "goodie good" boy. I really do not remember discipline in the sense of punishment, even though fairly severe corporal punishment was the norm in the few other families with children in the mining camps.

My father talked to me about behavior and what not to do and why. However, this dealt mostly with matters of physical danger, such as being careful around mines and mining equipment, being alert to avoid rattlesnakes (which were fairly common in the area), and generally taking care of myself and avoiding dangerous or unhealthy circumstances.

As I recall, my Aunt Marian in Rosemead often nagged at me about something or other. Although I really didn't have very much respect for her, I tried to follow my father's urging to get along with her because she was trying to help me. I didn't really appreciate the help and would have much preferred to be in Copper Canyon with my father.

**World War II**

As the war raged in Europe, people of my age in the Reno area expected that the U.S. would become involved. With the prospect of military service in the future, I completed high school in the summer of 1941 and attended the University of Nevada during the academic year 1941-42. Although college work was much more interesting than high school, I did not, for the most part, find the courses particularly challenging. An introductory physics course proved to be the most demanding, but I handled it extremely well. The physics professor became somewhat interested in me and strongly urged me to transfer to the University of California in Berkeley, and major in physics.

On December 7, 1941, I was skiing in the Mt. Rose area near Reno. I swept past a group of people on top of a knoll listening to a bulky, wet-cell battery-powered, "portable" radio, and heard enough to gather that the Japanese had bombed Pearl Harbor; however, I was moving so fast that, before this fully registered, I was too far down the hill to climb back and
learn more. So I skied for a couple more hours before getting the complete story. I had turned eighteen in October and knew that military service was not far ahead. However, in the meantime, I continued in school, and life went on pretty much as usual until the end of the academic year in June 1942.

Then, with wartime construction active, and a major project at the Sierra Ordinance Depot north of Reno near Susanville, California, I got a construction job to earn more money to finance school at UC Berkeley until Uncle Sammy called. Initially hired as a laborer, I soon found an opportunity to transfer to a position as an "oiler," an apprentice in the operating engineers union servicing heavy construction equipment—bulldozers, carry-alls, compressors, etc. I worked six ten-hour days, for seventy hours pay per week while continuing to live in Reno and commuting with a senior operating engineer. He soon had me transferred to the position of oiler on a new state-of-the-art truck crane engaged in setting steel for ammunition warehouses. The oiler is the driver of the truck carrying the crane—a relatively easy job with nice new equipment and life was smooth, if busy. I earned about $150 per week—handsome pay for a college student in those days.

Then one morning, the operator of the crane informed me "we are going to Shasta." From the perspective of operating engineers at that time, operators and oilers were more or less attached to their equipment. It was assumed that the oiler would move with the rig. This was okay with me, so about the next day, after packing a few things, I drove the truck crane to the Shasta Dam project towing my early model Ford V-8 automobile.

Thus I spent from midsummer 1942 until about the end of September tending the truck crane (which was operating as a drag line) and a group of about eight dump trucks excavating and hauling gravel to a "batch plant." The gravel was crushed and mixed with asphalt to provide road surfacing material for the new highway over the Pitt River bridge above the waters rising behind Shasta Dam, which would overflow the prior highway.

Meanwhile, I had arranged by mail to enter UC Berkeley in October at the beginning of the fall semester of the three-semester system then in effect. I sought to enlist in the navy's V-8 or V-12 program, which offered some prospect of educational deferment for a period. However, I failed their color vision test and entered the army enlisted reserve corps.

After a most interesting and successful semester at UC Berkeley, I was called to active duty. I entered the army at the Monterey, California, reception center in March 1943. The first evening, after a day of test taking, I happened to meet an acquaintance from Reno at the post exchange—a man with significant physical handicaps who was in the army on "limited service." He held an administrative job in the personnel department. As a member of the enlisted reserve, I had the opportunity to select a branch of service and my selection would be respected if it happened to fit an army
need. I talked to my acquaintance about what branch of service to select. He would check my test scores and meet me at the post exchange the next evening. When we met, he told me "select anti-aircraft artillery and you will be on your way to Officer Candidate School in no time."

With no better source of advice, I followed his suggestion and it indeed worked out. After basic training at Camp Callan, near San Diego, California, I went to Officer Candidate School at Camp Davis, North Carolina, and graduated as an anti-aircraft second lieutenant in November of 1943.

My first assignment was to a "casual officers pool" at Camp Haan near Riverside, California. While there, I (1) married my girlfriend from UC Berkeley, Barbara Stayton, and (2) disregarding the army maxim "never volunteer," I volunteered for an assignment helping to conduct an intensive training school in "mines and demolitions"--a subject of importance because of the trouble our forces were having in North Africa with land mines and booby traps. My only qualification--and reason for volunteering--was that I was familiar with explosives from my boyhood around mines in Nevada, and was comfortable handling explosive materials.

Because of this assignment, which was no doubt the most useful thing I did in the army, I missed the opportunity to volunteer for desirable assignments, such as the army transportation corps. When the casual officers pool was closed out, the army sent me to an "infantry retread" course at Fort Benning, Georgia. (During the period between the midsummer of 1943 when I went to anti-aircraft Officer Candidate School and early 1944, the Allied Forces had gained air superiority in the European theater and there was no additional need for anti-aircraft artillery so A.A. officers were re-assigned to other branches of the service.)

After six weeks at Fort Benning, I was assigned as a "cadre officer" to the Army Ground Force Replacement Depot Number One in Fort Meade, Maryland, where my wife, Barbara, joined me at an off-post rental house in Linthicum, a few miles north of Fort Meade, near Baltimore, Maryland.

The function of cadre officers at an army ground force replacement depot was to "process" troops between basic training and shipment overseas as replacements of casualties in the fighting forces. "Processing" consisted of seeing that the replacement troops had the designated clothing and personal equipment, checking their immunization records, (and having them get shots for the umpteenth time because their immunization records were missing or not up-to-date), and filling any gaps in their designated training which had occurred because of illness or absence from particular aspects of training for any reason--usually kitchen police duty. Requirements included such things as throwing live hand grenades, going through infiltration courses with live machine gunfire close overhead, and certain rifle, automatic weapons, and mortar experience. Primarily it was
a record keeping and record checking game and one that was both boring and distasteful to many officers.

Because I was reasonably effective and conscientious, I soon became "indispensable"; thus even though cadre officers were supposed to rotate overseas after three or four months (which technically satisfied a "troop duty" requirement for officers before going overseas), the commanding general regularly went to the Pentagon--less than two hours away--and had selected officers removed from the rotation lists. After my absolutely final deferment at the commanding general's request, I took a pre-embarkation leave before assignment to combat duty in the European theater. By this time (probably January, 1945) the end was in sight in Europe.

When I returned from pre-embarkation leave, I received orders to transfer along with the commanding general and a select group of his preferred officers, to Camp Adair, Oregon, near Corvalis, to establish Army Ground Force Replacement Depot and my deferment from overseas assignment came to an end. I took another pre-embarkation leave expecting to go to the Pacific theater for the final assault on Japan--widely expected to involve the most ferocious fighting of the war. However, when I returned after about two weeks, the frenzied troop processing activity for the Pacific theater force build-up had come to a virtual halt. Within a few days, the commanding general was re-assigned to establish a replacement depot in Camp Pickett, Virginia, to process troops going to Europe for occupation duty replacing the bulk of the combat forces. Again the general was permitted to take a select group of officers experienced in the replacement depot game.

Somewhere along the line, I had been promoted to first lieutenant. Shortly after transferring to Camp Pickett, I became a regimental "information and education officer," responsible for trying to give the replacement troops some background appropriate to occupation duty. I remained in that position from midsummer of 1945 until my release from active duty in April 1946.

My wife did not accompany me to Camp Pickett; instead she returned to her home in Oakland, California, and then proceeded to enter the University of Chicago Law School in the 1945 fall semester.

Law School, 1945-1949

I had decided that I too wished to attend law school and visited Boalt Hall at UC Berkeley to see about admission prospects. At this point my academic credentials consisted of one year at the University of Nevada, one semester at UC Berkeley, and a few credits for some correspondence courses I had completed while in the army. At Boalt Hall the admissions
people told me in effect "go away little boy and come back after you have been to college."

However, I got a different reception at the University of Chicago Law School, mainly no doubt because my wife was a successful student there. At that time, the University of Chicago had a two-year Associate in Arts program, after which students could go on to more advanced training, including the University of Chicago professional schools. The acting dean arranged for me to take a solid week of tests given jointly by the U.S. Veterans Administration and the University of Chicago. The VA tests, available to all discharged service men, included extensive intelligence, aptitude, interest and similar tests; the University of Chicago battery consisted of "educational development" tests aimed at establishing whether applicants had an educational background substantially equivalent to that provided through the University of Chicago Associate in Arts program.

Although I turned page after page of some educational development tests without even being able to understand the questions, I did well enough--probably because I had read widely on an extensive range of subjects--that I was admitted to the University of Chicago Law School as a first year student in their four-year program for holders of the University of Chicago associate in arts degree.

After a very demanding but successful year, I again visited Boalt Hall with my Chicago transcripts. As a transfer student with excellent grades from a leading law school, I was eminently acceptable as a second year student in Boalt Hall's traditional three-year law program. Accordingly Barbara and I returned to California where I completed law school in the academic years 1947-48 and 1948-49.¹

My Chicago transcript had gotten me onto the Boalt Hall Law Review board of editors and I ended law school with an excellent grade point average in a virtual three-way tie for number one in class standing.

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¹In late spring of 1948, someone in the UC administration realized that I would be graduating from law school in June of 1949 without having an A.B. degree. The administration regarded this as highly inappropriate, so I received a call to discuss the subject with them. The result was that I took a number of summer session classes, and the administrative people (who were much more concerned about my lack of an A.B. degree than I was) granted me "in lieu" academic credit for my correspondence courses, my anti-aircraft artillery training, and one or two other things--possibly my duty as a regimental information and education officer. Thus, my official U.C. record shows an A.B. in 1948 and a J.D. in 1949, even though I had the equivalent of only about two academic years of undergraduate college courses.
Supreme Court Justice William O. Douglas had maintained the practice of taking a top graduate from Boalt Hall each year as a law clerk. Neither of my two top classmates was interested in that position, but I would have been delighted to take it. However, for some years representatives of Stanford Law School had been seeking to persuade Douglas that he should alternate clerkships between Boalt and Stanford. With the class of 1949, he decided for the first time to alternate between the two schools and it was clearly Stanford's turn. The individual who took the clerkship, that I otherwise would have occupied, was our current Secretary of State, Warren Christopher.

With the Douglas clerkship unavailable, I considered some positions in San Francisco, much more the center of gravity of legal business in northern California than it is now. Because I definitely did not want to join a big "law factory," the conventional route to success as a lawyer, I took a job with a small business and tax firm with an excellent clientele and quickly acquired a variety of experience that would not have been available in larger firms. Although my legal work was varied and interesting, and I was making good progress, I did not find traditional legal practice entirely satisfying.

Another lawyer who graduated one year behind me and whose work I had supervised on the Boalt Hall Law Review, had worked both during school and after graduation in the Henry J. Kaiser Company legal department in Oakland, California. At the time of my graduation and on several later occasions, he had urged me to take a job with the Henry J. Kaiser Co. legal department--a "house counsel" position which, in those days, was widely regarded as less suitable for "real lawyers" than a traditional practice career; thus, I was not much interested in his recruitment effort. However, after I had been in practice somewhat over two years, my then wife, Barbara, decided that she wanted to marry someone else. Although I would not have initiated a breakup, this decision on her part struck me as a wonderful idea and we had an amicable divorce. No children were involved.

This represented a major discontinuity, and although I was really not seeking to change my career path, I thought that I might as well interview the head of the Henry J. Kaiser Company legal department, Mr. William Marks. David Hardy, a very able attorney and then the "fair-haired boy" in the Henry J. Kaiser Company legal department, had pre-sold Bill Marks on hiring me. The result was a highly favorable offer which I accepted and joined the Henry J. Kaiser Company legal department in late September of 1952.
Re-marriage and Home Building

During this period, late 1952 until late spring 1955, while my primary work was with the Kaiser Industrial Companies, I met and in due course married Jenny Skinner, then a registered nurse who was working first at the University of California, San Francisco Medical Center, and later at the U.C. Berkeley Cowell Memorial Hospital. We had our first daughter, India, born in November 1954. Our second daughter, Hilari, was born in May 1956, while I was working exclusively for the medical program.

Also during this period 1951 through 1954, I built the home in the Berkeley hills where my wife and I still reside and plan to live until we can no longer negotiate the terrain—which is challenging. When I say "built the house," this is not in the usual sense of engaging a contractor to build it. Instead, I acted as the general contractor and did a large portion of the work personally, relying for help primarily on U.C. Berkeley students who assisted me evenings and weekends.
Hughes: Mr. Fleming, I think the logical place to start is with your arrival at the Henry J. Kaiser Company in 1952. Could you tell me how that came about?

Fleming: When I was in law school, I was on the editorial board of the Law Review. One of the Law Review candidates who did writing under my supervision was a man named David Hardy who, while he was going to law school, was also working as a law clerk in the legal department of the Henry J. Kaiser Company. We developed a relationship of mutual respect, and he tried very hard to persuade me to come to that legal department when I left law school. However, at that time, so-called "house counsel" jobs were generally regarded in the legal profession as substandard—not the sort of thing that real lawyers did. I had my choice, within very broad limits, of opportunities in San Francisco, so I had gone to work for a small but very high-quality tax and business law firm. However, during this period of time, I saw David Hardy now and then, and he kept trying to interest me in the Henry J. Kaiser Company legal department.

After about three years in traditional law practice in San Francisco, it began to lose its luster and I decided that I might as well consider the possibility of a change. David Hardy had talked up the Kaiser organization and the legal department very strongly. I had an interview with Bill Marks, who headed that legal department. I had been pre-sold by David Hardy, whom Bill

1### This symbol indicates that a tape or tape segment has begun or ended. A guide to the tapes follows the transcript.
Marks highly respected. It was quite an easy interview and ended with a job offer that exceeded my wildest expectations.

In those days, lawyers starting out in San Francisco law firms were treated as peons; put it this way: the attitude of the partners in those firms was, "We'd like to pay a newcomer what he's worth, but he has to live." It was a low compensation system until you'd been there long enough to establish client contacts, start generating business, et cetera. Thus I found the offer appealing and decided to make the change, which I did, effective at the end of September in 1952.

I had only been in the Kaiser legal department for a short time--a few weeks--when Bill Marks, head of the department, called me into his office. He was sitting behind his desk red-faced, obviously very worked up over something or other, and he pounded the table. "Those goddamn doctors! That goddamn medical program!" Then he explained that there'd been a board meeting of the organizations comprising the medical care program that morning. Henry J. Kaiser had been at the meeting and had blown his stack because Sidney Garfield came in with the agenda on the back of an envelope and little information to help the board make decisions. (He really just wanted a rubber stamp on what he was doing.)

Marks complained that he just didn't have time to do the corporate secretary's work for the medical program, that he simply had too many higher priority things to do. He was really quite apologetic about it, but he asked me if I would be willing to take on that set of responsibilities. He explained two things. First, he didn't regard it as real lawyer's work and it would be kind of a waste of my time but somebody had to do it. As I was the new one in the department and didn't yet have a full agenda of other projects, I was the logical candidate.

Hughes: Why didn't he consider it real lawyer's work?

Fleming: Well, that was his second point. The job was "corporate housekeeping"--the business of preparing agendas for board meetings, writing the minutes of the meetings, certifying resolutions, and generally doing the ministerial kind of work involved in having a proper set of records covering nonfinancial activities of the organizations.

He emphasized that for the medical program, my job was strictly the corporate secretary's duties, not legal work. He had a "treaty" with Thelen, Marrin, Johnson, and Bridges, the retained counsel for the Kaiser organizations. They were somewhat jealous of and concerned about the expansion of the
internal legal department which cut into the business that they enjoyed from Kaiser. His understanding with them had been that he would limit his work to the Henry J. Kaiser Company and its affiliated, profit-oriented companies, and would not do any legal work for the medical care program. I was to observe this treaty with care—and of course I did.

That is how I first became involved with the medical care program in the fall of 1952.

Functions and Key Personalities

Hughes: Shall we talk now about who was there when you first arrived?

Fleming: All right. When I first became involved, Sidney Garfield was acting as the chief executive officer of the medical program organizations that fell under the jurisdiction of Mr. Kaiser and his associates. That sounds like a fancy description, but it's important to recognize that the medical program had basically two facets. There was the medical facet, which was the responsibility of the Permanente Medical Groups, and there was for lack of a better term, the business facet that involved the corporations and trusts controlled by Mr. Kaiser and the key executives that he had selected for positions on the governing boards.

My responsibilities extended to that set of organizations but not to the Permanente Medical Groups--three at that time—one in each of what we subsequently came to call regions: The Permanente Medical Group in northern California; Southern California Permanente Medical Group in the greater Los Angeles area, including Fontana; and The Permanente Clinic in the Portland, Oregon-Vancouver, Washington area, which we now call the Northwest Region.

Hughes: Who had been doing legal work for the medical program before you arrived on the scene?

Fleming: The law office of Thelen, Marrin, Johnson, and Bridges had been doing all of the legal work for the medical program except in the Northwest, where another major firm--Davies, Biggs, et al.--was retained counsel. There had been no internal counsel until that time. The lead attorney for the medical program had been T. K. McCarthy, one of the partners in Thelen, Marrin. He later became an executive of the Kaiser Aluminum and Chemical Corporation.
George Link,¹ also a partner in Thelen, Marrin, had succeeded to the responsibilities that Tom McCarthy had carried. George Link's specialty was tax law, but he was the account executive, so to speak, for Thelen, Marrin on the medical program, although other attorneys in that office handled various parts of the work.

Hughes: I read into your remark about Dr. Garfield appearing with the agenda on the back of an envelope that Henry Kaiser and perhaps some of his colleagues were thinking that perhaps things should be done in a more businesslike fashion?

Fleming: Certainly many of them felt that things should be done in a more businesslike fashion. This was fairly early in the period during which Dr. Garfield became eased out of the central role in medical program management—a complex and prolonged transition.

I think I should try to give my perceptions of Garfield—a man that I did not know at all intimately. I think I knew him reasonably well in a business sense, but there were connections and relationships at higher levels in the medical program, as indeed I think in most organizations, that really transcend the business relationships. Garfield was never one of the people with whom I had a close personal relationship, or indeed any relationship outside of business, so I didn't know him as well as many people in medical program management did.

I have a little hierarchy: administrators are people who take things from the in basket and move them into the out basket and do something appropriate in between; managers are people who accomplish things through other people; and leaders make them like it. [laughter]

Garfield was a leader. He was not a particularly good administrator; he was a mediocre manager. I think it is reasonable to say that the program had grown to the point where Garfield's style was no longer adequate to the needs of the position that he held. I say this as objectively as I can and without an intention of being critical, because I think Garfield had done a truly remarkable job in bringing the program into existence at all and in keeping it functioning successfully through some very difficult periods. That I attribute to his vision and his leadership. I think vision is an important aspect of leadership. He also had an effective way of working with the leading physicians in the medical groups, particularly Dr.

¹See: George E. Link, The History of the Kaiser Permanente Medical Care Program, Regional Oral History Office, University of California, Berkeley, 1995. Hereafter referred to as the Kaiser series.
Raymond Kay in southern California and Drs. Morris Collen and Cecil Cutting in northern California. It's not clear to me that Garfield had a completely satisfactory relationship with Dr. A. LaMont Baritell, who was another very strong force in The Permanente Medical Group in northern California.

Hughes: Could you amplify?

Fleming: Well, Baritell was the distilled essence of arrogant surgeon. For assorted reasons of history, personal relationships, and respect, the other senior physicians, Drs. Kay, Fred Scharles, and Herman Weiner in southern California; and Drs. Collen, Cutting, and Neighbor in northern California—all of these doctors in the Permanente Medical groups in California, with the exception of Baritell, had close personal relations with and great respect for Garfield. Incidentally, Dr. Wallace Neighbor had been in charge of operations in the Portland-Vancouver area and had worked closely with Garfield there.

However it did not appear to me that Baritell respected anyone except Baritell. He was also not one of the old-timers in the sense that Kay, Cutting, and Neighbor, for example, were. While I really can't document this, I believe that Baritell's relationship with Garfield was less smooth and less respectful than the others.

I intentionally omitted Dr. Ernest Saward in the Pacific Northwest from this description because Saward was a different sort of person. He was also a remarkable man—a leader, a manager, and an administrator. He was probably the best single medical director that the Kaiser Permanente Program had until he left Oregon in 1970 to return to his alma mater, the University of Rochester.

Hughes: When you say that he was the best medical director, are you thinking in terms of administration?

Fleming: I'm thinking in terms of everything. I'm thinking in terms of a simple, direct, effective approach to routine administration, a very effective management style, a way of working with people to get what he wanted done by the people in the organization—both the non-physician staff and the physicians—and leadership in the sense of having the vision, having the charisma, having the capacity to mold the organization and move it in the direction that he thought it should go. He was also an excellent physician.

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1See the oral histories in the Kaiser series with each of these physicians.
with a deep understanding of and commitment to quality in medical care.

Hughes: Would you say that the relative lack of involvement of the Oregon Region—if it was called that at that point—in the turmoil of the fifties was due to more than just the geographic distance?

Fleming: It was clearly due to Dr. Saward. The geography was, of course, important, but other things were important. The Oregon Region, despite its small size, was economically viable. It was, for various reasons, not in a strong expansion mode, primarily because the Kaisers were not at that point inclined to finance expansion in the Northwest. It was well enough managed that it was not a source of trouble, and therefore benign neglect was due not merely to distance but also to the lack of problems getting beyond Dr. Saward's level. He really earned the considerable degree of independence that the Oregon Region enjoyed. He was on good terms with Garfield, but he was not "one of Garfield's boys," which in many ways Drs. Kay, Cutting, and Neighbor were, and to lesser extent some of the others were. His personality, management capability, and leadership strength permitted him to be independent of Garfield, and Garfield did not intervene in any major way in the affairs of what we now call the Northwest Region.

Hughes: I pulled you away from the discussion of Sidney Garfield. You want to say more, don't you?

Fleming: Garfield was a very charming person. He was a person who commanded great loyalty. He was by this time an in-law of Henry J. Kaiser--another layer of complication in the picture. I guess it's clear from other parts of this history.1 After Bess Kaiser's death, Henry J. married Alyce Chester, who had been Bess Kaiser's lead nurse during her terminal illness. According to the story that I have heard, though I can't document it, Henry J. Kaiser was the matchmaker between Sidney Garfield and Helen [Peterson] Garfield, who was Alyce Chester's sister. So there were involved in-law relationships as well as organizational relationships.

In the situation developing in the medical program, both Henry J. Kaiser and Edgar Kaiser (who was becoming increasingly influential in the organization as Henry J. grew older) were unsatisfied with Garfield as the chief executive of the organizations under their jurisdiction. On the other hand, they were so close to Garfield and had such good personal

1Mr. Fleming's oral history is the twentieth in the Kaiser series.
relationships with him that they weren't willing to have him out of the organization either. The result was a difficult and frustrating situation in which, although he was not nominally the chief executive during much of the pre-Tahoe, Tahoe, and post-Tahoe period, he in fact continued to exercise much of the authority of the office of chief executive. I don't recall the dates here, but I do recall the essence of what was happening.

Tensions within the Medical Program

Fleming: I believe it was in 1948 when The Permanente Medical Group, originally formed in 1947, reorganized without Garfield as a member of the group. The problems there related in large measure to the challenge from organized medicine—the American Medical Association, the California Medical Association, and the local county medical societies. They sought to discredit Sidney Garfield by actions which led to the case of Garfield v. The Board of Medical Examiners. The board commenced proceedings to revoke Garfield's license or otherwise impose discipline because of alleged violations of the Medical Practice Act.

Because Garfield was the focal point of much of the friction with organized medicine, and because he was the professional leader of the program, he was to a large extent a lightning rod for criticism. He felt, and the physicians in The Permanente Medical Group felt, that he should distance himself somewhat from the professional aspects of the program. At this time, he was still the organizational focal point for the Southern California Permanente Medical Group. The group as such had not yet been formed but was functioning to some extent as a medical group even though as a formal matter they were employed physicians of the sole proprietorship known as Sidney R. Garfield and Associates. Earlier the proprietorship called Sidney R. Garfield and Associates had been the employing organization for all of the physicians who subsequently constituted the Permanente Medical groups in California.

In the Pacific Northwest, Ernie Saward had taken the lead earlier in establishing The Permanente Clinic as a separate professional organization, with part of the motivation being the same organized medicine issues that propelled Garfield's separation from The Permanente Medical Group in northern California.

Some people believe that this was also driven, at least in part, by dissatisfaction on the part of some physicians with
Garfield's dual role as a member of the partnership and as the chief executive of the non-medical components of the program. This may have been true to some extent, particularly in the view of Dr. Baritell and perhaps Dr. Collen. However, the real motivations were two, and they were closely related.

One issue was the friction with organized medicine that focused on Garfield, and the other was the concern of the legal advisors to the non-physician components of the program about the dual role that Garfield had been occupying, and the feeling that there was at least potential for problems in the area of conflict of interest.

Fleming: Subsequently in the early 1950s, some of the leading Permanente physicians became quite concerned over what they conceived to be Garfield's systematic holding down of physician compensation in order to generate more funds for facility construction. Also many of them felt that Sidney was "Henry J.'s man" and therefore not reliable as a representative of the interests of the Permanente physicians. Thus we had this peculiar situation in which Garfield enjoyed enormous respect and affection among the old-time leaders of the Permanente Medical groups and at the same time was not entirely satisfactory from their viewpoint in the role of chief executive of the Health Plan and hospital components of the program.

In this framework, and because of the dismantling of the Kaiser Motors operation in Willow Run, Michigan, Dr. Clifford Keene entered the management picture. Previously, Keene had worked as a surgeon at the Kaiser Oakland medical center following his relief from active duty in World War II. He in fact was one of the "unlicensed physicians" whose employment was an issue in the case of Garfield v. Board of Medical Examiners. However, he had gone on to become the medical director of the Kaiser Motors operation at Willow Run, thus discontinuing active involvement with the medical care program.

He established a very good record as medical director at Willow Run and impressed Edgar Kaiser quite favorably, with the result that when things were unwinding at Willow Run the Kaisers

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1See Dr. Saward's oral history in the Kaiser series. For Dr. Collen's views, see his oral history in the Kaiser series.

2See Dr. Keene's oral history in the Kaiser series.
--both Edgar and Henry, Sr.-- persuaded Keene to come to California.

Keene understood that he was to become the chief executive officer of the Health Plan and hospital components of the medical program. I vividly recall that Keene visited Oakland in the course of deciding whether to take on this role, to familiarize himself with the medical program. Fairly early in 1953, as I recall, I received a call from Bill Marks telling me that there was this doctor from Willow Run who needed to learn about the medical program and asking me to meet with Keene and explain the medical program to him.

So Keene came to my office, which at that time was in the old Henry J. Kaiser Company headquarters building at 1924 Broadway in Oakland, condemned as uninhabitable in the October, 1989 earthquake. It was a distinct shock to Keene when I explained to him that Sidney Garfield was the chief executive of all of the medical program corporations and trusts. I explained to Keene the program structure and my instructions from Bill Marks (who was my main link to the board of directors) that the final decision maker on any medical program matters for presentation to the board—that is, the person who determined what would be presented to the board—was Sidney Garfield. Keene had apparently received a distinctly different impression of the nature of Garfield's role.

Hughes: Meaning that Keene would take precedence?

Fleming: Keene's understanding was that Edgar Kaiser, who was Keene's mentor or patron at that time, and Henry J. Kaiser, had selected Keene to become the chief executive of the medical program organizations. It also appears that they had not clearly informed Garfield of this decision. I do not know what went on behind the scenes; I've gotten glimpses from discussions with Keene and with a few other people, and I am probably oversimplifying something that was much more complicated. However Keene's impression was that he was to become the CEO. Keene told me that, in a personal meeting between Keene and Garfield, Garfield confirmed this impression and in fact urged Keene to accept the position.¹

From the behavior of Garfield in my dealings with him in regard to matters to be presented to the board of directors, Garfield never acknowledged that Keene had the CEO role either at that time or that it was understood mutually that he would assume

¹See Dr. Keene's oral history in the Kaiser series.
that role in the future. In fact, as far as the record is concerned, during this very awkward period preceding and leading up to the Tahoe impasse, Garfield was assigned the title of executive director, and Keene was assigned the title of regional director—clearly connoting that Keene's position was subordinate to that of Garfield. The title also carried the implication that Keene's role was limited to northern California, although we were not yet specifically designating northern California as a "region."

However, for a period of many months, continuing until the reorganization that followed the Tahoe conference, Garfield and Keene occupied those respective positions, at least as a matter of organizational form. This was a rather chaotic period in terms of organizational authority and responsibility, and a period in which, in fact, the only person generally accepted throughout the medical program as chief executive officer was Gene Trefethen, who was, of course, Henry J. Kaiser's principal deputy in running all Kaiser business affairs.

Hughes: My memory is that Dr. Keene's position even after the Tahoe conference remained ambiguous, that Garfield was definitely out. He was now designing hospitals. So it was clear that he was no longer in charge, but who was? You say Trefethen?

Fleming: Yes, but maybe we're getting a little bit ahead of the story here.

Hughes: Yes, we are.

Fleming: The situation with Garfield as executive director and Keene as regional director was awkward and ambiguous. There was no clarity as to Keene's authority or responsibility. For example, did "regional director" encompass the Northwest Region? Although Keene had a personally satisfactory relationship with Ernie Saward, he did not exercise a significant management role. He had no real relationship with the Southern California Region because Dr. Ray Kay adamantly refused to recognize that Keene had any role at all. The ambiguity diminished somewhat with the Tahoe conference and establishment of the Advisory Council, which was the output of the Tahoe conference.

During the Advisory Council period, only Trefethen was recognized as a chief executive officer with line authority to make program decisions. He became de facto CEO because of his position as Henry J. Kaiser's deputy and also because of his

1See Mr. Trefethen's oral history in the Kaiser series.
considerable leadership and managerial ability and his ability to function effectively in an atmosphere of extreme ambiguity. Trefethen wanted Keene to become the chief executive officer, and Trefethen relied on Keene for getting the information, making the recommendations, et cetera, that Trefethen needed in order to function as the CEO—as an incidental activity while he was running the rest of the Kaiser empire.

However, there was absolutely astounding acrimony toward Keene on the part of the physicians in the Permanente Medical Group leadership in both California regions. It was compounded of many things. Many of them had great loyalty to Garfield and were unwilling to see Keene supplant Garfield. They regarded Keene as an outsider who really didn't understand the medical program on the West Coast. Keene undoubtedly contributed to this because he had little tolerance for ambiguity and he was in an exceedingly ambiguous situation.

Keene's managerial and administrative background was in the armed forces, where he had been quite successful, according to my understanding, as a military manager of military medical facilities. In the very structured situation of the military in which formal rank is of overwhelming importance, Keene's management style was no doubt satisfactory.

However in the medical program, the structure was rapidly evolving and one of the few clear things was that the physicians were members of independent organizations which were independent focal points of power and not part of a corporate organization controlled by the Kaiser-dominated boards of directors or trustees. Hence, the military management style was entirely inappropriate. In addition, Keene put a lot of stock in perquisites and in symbols of office and authority; at that period he was unable to break through the formalities of management to deal effectively with the substance of management.

Hughes: Do you think that Dr. Keene appreciated the intensity with which the Permanente Medical Group insisted that medical matters remain in medical hands?

Fleming: I think that Keene, as a physician, understood the professional insistence on independence with respect to the practice of medicine. I think that Keene understood that, and I don't think that was really the issue. We were involved in a very complicated business in which the practice of medicine, although an important component, was only one component. Keene did not really understand the absolute refusal of the medical groups to have the non-medical aspects of the program managed by someone like himself who really had fairly good credentials in management
of medical functions, as he had in fact done in the armed services and at Willow Run.

Hughes: My understanding is that the argument from Henry Kaiser on down, simplified through Trefethen, was that medicine was a business that should be handled as a business. There were decisions made which the medical group argued were directly affecting their practice of medicine. I'm thinking particularly in terms of appointments that were made without the medical group approval. Mr. [Fred] Tennant was a real bone of contention at one stage. It was a question of where business ends and medicine begins, I think.

Fleming: Well, I think by any reasonable definition, the appointment of Fred Tennant as regional manager in northern California was not an intrusion into the practice of medicine. It was an intrusion into something else of great importance. It was a repudiation of the post-Tahoe understanding that there would be mutual acceptability of key personnel. This is a very important point that has unfortunately been honored much more in the breach than in the observance, at least with regard to a number of key personnel selections. Fred Tennant, of course, is one of the first and most conspicuous examples.

The physicians refused to accept Keene as the chief executive officer of Health Plan and Hospitals. Trefethen believed that, given a little time for the emotions generated in the Tahoe conflict to subside, Keene would become acceptable in that position. Trefethen subsequently did appoint Keene, first to the position of general manager and later to the position of president and chief executive officer.

However, this was over the objection or at best with the grudging acceptance of the leadership of the Permanente Medical groups. It was never accepted by Dr. Raymond Kay in southern California. He acquiesced in it, apparently on the ground that it was not anything worth fighting about at the time that it actually transpired. It was grudgingly accepted, or reluctantly accepted, by Dr. Cutting, who was the medical director in northern California. It was accepted by Dr. Saward in the Northwest, in large measure because it was virtually irrelevant in the Northwest. Dr. Saward was running the Northwest Region and he didn't have any strenuous objection to having Dr. Keene hold the nominal position of chief executive of the Kaiser Foundation Northern Hospitals as the corporate entity then was called. Keene was just fine in that role as long as Keene didn't do anything. That was how it worked in the Northwest.

[tape interruption]
Hughes: Mr. Fleming, we've been skirting around the tumultuous Tahoe period. Could you summarize what you see as the major causes of stress?

Fleming: Well, I can try. This was a complicated set of circumstances, and I'm sure that everyone involved would have a little different view and a little different emphasis. I guess I would start with a major discontinuity in the life of Henry J. Kaiser, namely the death of his wife and his marriage to Alyce Kaiser who had worked in the medical program and was keenly interested in it. As a result of this marriage, and perhaps also as a result of his decreasing involvement in the affairs of the industrial companies, Mr. Kaiser came to take a much greater degree of interest in the medical program than he had previously.

One characteristic of Mr. Kaiser was that he tended to dominate those things that he was interested in. As a matter of fact, he'd been known to say, "If I'm in it, I run it," or words to that effect. During the prior history of the medical program, Henry J. had been interested in it, enthusiastic about it, and had done much work intended to support it. Although people would vary in their views as to how useful some of his interventions in the area of relations with organized medicine, et cetera, were, nonetheless he had been a strong advocate for the medical program but had not been substantially involved in setting program direction or operating policies. He had really relied on Sidney Garfield, so that the program had been a physician-run program, with Sidney Garfield being the key physician in running it. However, the physicians in charge of the various components had been the effective executives of the regions, facilities, et cetera. I emphasize that it had been a physician-run program.

As Henry J.'s interest increased and his involvement increased, he began to assert himself in various ways, some of which were troubling to the physicians. Sometimes he didn't successfully assert himself but tried to. For example, he felt that the medical groups were getting too big and that the program would function much better with smaller medical groups organized around each of the major facilities and, at least to some extent, competing with each other. Henry believed strongly in the stimulus of competition. This was heresy to the leaders of the medical groups.

He was, in his fundamental nature, a builder. He was interested in building things. His interest in the medical program focused largely on facilities. He was never happier than when he was directly involved in constructing something that he thought was worthwhile, as in his running around in his aloha T-shirt straw bossing the construction of the Hawaii hospital, to
the great consternation of the contractor responsible for the job. Nonetheless, that hospital got built between February and mid-November 1958, which must be some kind of a record for constructing such a complicated facility. That I attribute in large measure to Mr. Henry J. Kaiser's regular presence at the job site.

Mr. Kaiser was neither accustomed nor inclined to power sharing. Although he cooperated with other construction contractors on the major construction projects that they undertook, the pattern was that--

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Fleming: --one "sponsoring contractor" or "managing partner" ran the project. The idea of sharing power with the medical groups did not fit with Mr. Kaiser's way of doing business. This resulted in what the medical groups called "unilateral acts"; that is to say, decisions made by the hospital and Health Plan organizations without consultation with and approval or acceptance by the medical groups.

One significant example which contributed to the pre-Tahoe stress involved the Walnut Creek hospital. Although I was not personally involved, as I understand, it was Alyce who selected Dr. Wallace Cook\(^1\) to be the medical director of the Walnut Creek hospital, a gross usurpation of authority from the Permanente Medical Group viewpoint. In fact, the entire construction of the Walnut Creek hospital was an affront--particularly the construction of an advanced and, for those days, a quite expensive facility, at a time when The Permanente Group leadership perceived much higher-priority resource needs in San Francisco, Oakland, and other areas where facilities were inadequate. They greatly resented the large investment in Walnut Creek, an area they regarded quite low in relative priority.

Hughes: I also understand that there was a question as to whether another hospital was really needed in Walnut Creek.

Fleming: Well, I guess you could almost always raise that kind of question. In fact, the demographic projections thoroughly justified the Walnut Creek hospital, and they've been abundantly confirmed by the unfolding of history. However, an objective analysis of the situation might well have given San Jose priority over Walnut Creek. But Walnut Creek was the area in which Mr. Kaiser and Alyce lived at that time, as I recall, and an area of

\(^1\)See Dr. Cook's oral history in the Kaiser series.
keen interest to them. It was also the area to which Edgar Kaiser moved when he returned from Willow Run. Thus, personal, extra-rational considerations dictated the decision, a factor that greatly disturbed many Permanente physicians.

Another example of a unilateral act was the change of names of all the medical program organizations from "Permanente"--the name with which the doctors were familiar, had embraced and felt comfortable with--to "Kaiser." This was part of a Kaiser-wide process--renaming all Kaiser organizations and adopting a new logo--a stylized version of the name "Kaiser." As far as I know, the governing boards made this decision without any notice to or discussion with Permanente Medical Group leaders.

I recall at the time--this was while I was performing the duties of the corporate secretary's office--that I took this subject up with Bill Marks and explained to him that the name change would generate a strong adverse reaction among the Permanente Medical Group physicians. Marks's attitude, typical of most Kaiser executives on the medical program governing board was, "That's what the boss wants so that's what we're going to do." The idea that Permanente Medical Group views should receive serious consideration on a "non-medical" matter was not an acceptable notion, even though I made the point, as strongly as I could, that the decision would be inflammatory. The "name issue" may seem like a trivial matter; however, it helped give credence to the point made by critics in organized medicine that the Permanente physicians were simply part of an industrial complex. There were other events of this kind, but this is adequate, I think, to illustrate the "unilateral action" problem.

Another point of friction involved Garfield, who despite his ambiguous position, was nonetheless effectively the chief executive officer. The Permanente physicians felt, perhaps with some justification, that Garfield was holding down their incomes in order to have more money for facility investment. Thus they felt that they were subsidizing the capital needs of the medical program in an inappropriate manner. They could make a fairly good case because of the difficulty of recruiting physicians at that time and the highly attractive economic opportunities available to physicians in traditional practice. Ultimately, these were all symptoms or aspects of the key underlying issue: the issue of control. Mr. Kaiser's attitude was that if the physicians would just take care of patients and behave themselves like good employees in the aluminum company, for example, and let businessmen run the business, everything would be all right. The doctors, of course, held a rather different view: if Henry J. and his associates would simply provide money for facilities like wealthy philanthropists are supposed to do and let the doctors
run the program—as they had in fact been running it from its inception—then everything would be all right.

Thus the bottom line, to use current jargon, in the Tahoe impasse was simply control. The control issue was exacerbated and brought to the front by "unilateral decisions" on the part of Mr. Kaiser and his associates and by the physician income problem. Main Kaiser concerns included the unbusinesslike way in which many aspects of the program were being conducted under Garfield's management, and the serious uneasiness that Mr. Kaiser, Gene Trefethen, and the other Kaiser executives on the governing boards felt about financial matters.

The program could borrow for facility construction only because of the Kaiser name and a fundamental understanding between the Kaiser organization and the Bank of America. It had been dramatically evidenced in other situations that "the bank would not lose money on a Kaiser loan."

At this stage, to my knowledge, none of the credit extended by the Bank of America was explicitly guaranteed by the Henry J. Kaiser Company or the industrial complex under Kaiser's control. Nonetheless the bank financing was realistically a responsibility of the Kaiser organizations collectively—even though there was no legal basis on which the bank could have asserted any claim, for example, against the Kaiser Aluminum and Chemical Corporation. So the "Kaiser side" had legitimate concerns that the medical program should function in a businesslike manner and about the ability of the program to generate funds sufficient to meet all operating requirements and repay facility loans. One key element of the pre-Tahoe impasse was that Mr. Kaiser decided that there would be no more financing raised except for completion of projects under way, until there was a satisfactory arrangement with the Permanente physicians.

This, I think, lays the basic groundwork for the Tahoe affair. It was compounded by personality matters involving Keene, for example, the attitude of some of the Permanente physicians toward Keene, and by a feeling on the part of some Permanente physicians that selection of non-physician personnel assigned to the medical program was not necessarily being handled in the most professional human resources management fashion. In fact, some of the physicians maintained, I think, with some degree of validity, that in the period after World War II for at least a few years, the medical program was something of a dumping ground for loyal Kaiser industries and Kaiser-affiliated company personnel who could not be placed in one of the Kaiser industrial companies.
The Tahoe Conference and its Aftermath

Fleming: A whole array of issues all came to a head in the spring of 1955 and led to the "Tahoe conference." I should explain, in the interest of historical accuracy, that the Tahoe conference is something of a misnomer. There were several key high-level meetings that occurred in the spring of 1955 between Permanente Medical group leaders and Mr. Kaiser and his associates, including Trefethen, Keene, Garfield, and a few others. These were all part of a continuing process that culminated in a crucial meeting at the Kaiser estate at Lake Tahoe. Thus the Tahoe conference was actually a series of meetings of which the last took place at Lake Tahoe.

Despite its prominence in Kaiser Permanente folklore, realistically, the Tahoe conference didn't resolve anything. It produced a document called Decisions of the Working Council. It also produced an agreement to establish a body called the Advisory Council. This consisted of the key medical group and Kaiser leaders: Drs. Cutting, Collen, Baritell, and Neighbor from northern California, Drs. Kay, Scharles, and Weiner from southern California, and Dr. Saward from the Oregon region represented the physicians. Henry J. Kaiser, Edgar Kaiser, Gene Trefethen, Bill Marks, A.B. Ordway, Sidney Garfield, Clifford Keene, and George Link from Thelen, Marrin, Johnson, and Bridges, represented the Kaiser side. This body became the forum for attempting to resolve the impasse which, despite the Decisions of the Working Council, had not been resolved in any meaningful sense by the Tahoe conference, except to the extent that instituting the Advisory Council process might be regarded as a resolution.

Hughes: Mr. Fleming, perhaps the next step is to talk about in some detail the Tahoe conference itself.

Fleming: Well, I can't tell you many details of the Tahoe conference because I wasn't there, although it was a key factor in my becoming fully assigned to the medical program. As noted earlier, starting in the spring of 1952, I'd been handling the duties of the corporate secretary's office--using probably about 5 percent of my working time. In the spring of 1955, probably April or early May, I got another call to Bill Marks's office and we went through the routine again about the "goddamn doctors" and the "goddamn medical program."

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Marks explained that there was this row developing with the doctors—which of course I knew—and that he, Trefethen, and Henry J. had decided that a lawyer should be assigned full time to work with the medical program to help resolve these problems. Again, he was very apologetic because he didn't think it was very sensible to waste a real lawyer on the nonsense of the medical program. However, as I was the only one in the legal department beside himself with any knowledge of the medical program, I was the obvious choice. So he asked me if I would be willing to undertake the assignment of working full time with the medical program until the problems were resolved. He estimated that might take six months or so. I was quite willing. First, the boss wanted me to do it, and second, I had become quite interested in the medical program in the course of my limited involvement up to that time. I arranged to phase out my activities for the Kaiser industrial companies during the late spring of 1955, and commenced working increasingly on the medical program issues.

By around the first of July, I'd made a pretty complete transition and was working full time for the medical program at the time that this portion of the Tahoe conference occurred. As I was a newcomer on the scene, I was not actually invited to the meetings at Tahoe. However I was briefed on them rather extensively and assigned, along with a few other people, to work full time on trying to resolve the medical program problems.

The other people primarily involved included Joe Reis, a key financial executive of the Kaiser organization. There was a financial man from the Northern California Region by the name of Karl Palmaer (no relation to Walter Palmer, who later became the chief financial officer for the medical program). Arthur Weissman, a medical economist engaged by Mr. Kaiser some years earlier to develop statistical information systems for the medical program was another key staff member.

Reis, as the senior member of the group, was the chief of staff. Weissman, Palmaer, and I were the full-time staff working for Gene Trefethen, who had the assignment from Henry J. to find some way to resolve the issues with the Permanente Medical Groups. We prepared agendas for the meetings of the Advisory Council. Incidentally, I think you have the minutes of the Advisory Council, and they're certainly an important part of the archives that should be related to the oral history. Reis and Palmaer concerned themselves with financial analysis and financial projections. Art Weissman and I concerned ourselves

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1The minutes are on deposit in The Bancroft Library.
with the more general problems of the organizational and managerial structure and relationships between the non-physician components of the program and the Permanente Medical groups.

For the summer and fall of 1955 up until about Thanksgiving, we went through an intensely busy wheel-spinning exercise. We prepared enormous amounts of material for the Advisory Council. The Advisory Council meetings were time consuming, intense, acrimonious, and by and large ineffective. Incidentally, the Advisory Council minutes themselves constitute, I am sure, the best history of this period, July, August, September, October, and maybe part of November, of 1955. They show a lot of turmoil and no progress.

In late November, near Thanksgiving as I recall, Gene Trefethen called his staff together. I've identified Reis, Palmaer, Weissman, and myself as the full-time staff. Others including Garfield, Keene, Paul Steil from southern California, Hal Babbitt from northern California, and Bill Price who oversaw the controllership functions, were involved in various ways but did not have this as a primary assignment.

Actually, the full-time staff really did almost all of what was done. The others, (although Dr. Keene was an advisor to Trefethen, and Garfield looked at what was being developed), had very limited involvement. Garfield lacked credibility with Mr. Kaiser on these kinds of issues because Henry J. regarded Garfield as largely responsible for things developing to the point of an impasse. Keene's views were automatically rejected by the physicians, especially in southern California, so his role had to be very low-key. Hence Joe Reis and Karl Palmaer did the financial analysis, and Weissman and I did the conceptual work on how to resolve the impasse.

As noted, Trefethen called the staff together in late November, 1955. I don't remember who all were present at this particular meeting. (Indeed, we might have had more than one meeting.) But there was one key meeting at which Reis, Palmaer, Weissman, I, and probably Keene were present. I'm not sure whether anyone else was present. Trefethen opened the meeting by saying, in effect, "Look, this Advisory Council process is not getting us anywhere; it's just wasting a lot of time and creating a lot of frustration and not producing any progress."

"We're not getting anywhere. Let's just brainstorm this problem for a while. Let's put ideas on the table for consideration." So we had a bit of a brainstorming session. I don't recall a great deal of that part of the session, but I do recall that Art Weissman and I urged the necessity for respecting
the professional independence of the physicians and for coming up with some kind of a solution that gave them a feeling of professional independence and assurance of their professional integrity.

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Fleming: Trefethen concluded by saying in effect: "What I want you to do," referring to the staff, "is to go off on your own somewhere and develop a proposal that addresses all of the issues that have surfaced in our Advisory Council meetings. Figure out what you think is a practical way for the non-physician and medical parts of this program to live together.

"I'm not really establishing very many limits on what you can do here, but a few things are important. First, we have to have a line management system. We're not going to have this management by committee, which is what the Advisory Council and related things amount to. Second, we must have a financial arrangement that assures that the hospitals and Health Plan will be able to service their debt and generate funds for additional facilities which are clearly needed. Finally, Mr. Kaiser wants the doctors as employees, but that's not right. We don't want the doctors as employees, we want them as partners."

That is all I recall of his directives to the staff, except he also said that, as a subsequent step, we need to have a retirement plan for the physicians "that is as good as KSRP." KSRP was the Kaiser Savings and Retirement Plan for personnel of the Kaiser industrial companies. Gene regarded KSRP as a standard for an acceptable retirement plan. He knew this was exceedingly important because, under the tax laws at that time, self-employed persons--and the physicians in the Permanente partnerships were self-employed--were heavily disfavored as far as accumulating retirement benefits was concerned.

Hughes: What happened?

Fleming: We spent the period from late November through the holidays and January developing a proposal. I was the draftsman on the proposal, and I think that I have a copy of it in my files. That should also probably be an appendage to this interview because it is a very important document. However it was a working document and as such it didn't get preserved in the way the Decisions of the Working Council and the Advisory Council got preserved.

Hughes: Now, does this contain the eight points?
Fleming: I don't know what you mean by the eight points, but it did contain the outline of the reorganization that ensued. I guess it contained the "eight points"; I'd never counted them quite that way.

Hughes: Your history makes a big point of the eight points.¹ I think we're talking about the same thing.

Fleming: No, I don't think we are. My Program History reflects much evolution after the Tahoe conference period, and perhaps what you call the "eight points" grew out of that evolution. The proposal which resolved the Tahoe impasse included a structural reorganization to simplify the organizational structure. We removed The Kaiser Foundation—which had been important back in the World War II days but had ceased to have much importance—from the medical program structure. This was the main structural simplification. We also proposed a revised management structure, and several financially related policies.

These included the per capita method of compensation to the medical groups in lieu of the percentage of revenue system, previously in effect, that had never worked particularly well. We proposed pooling of all revenue from all sources, at least conceptually, into a single pool to support the entire program. We also proposed the essential features of new medical service agreements that we subsequently fully developed to define Health Plan-medical group relationships, and a counterpart mirror-image agreement to reflect the Health Plan-hospital relationships.

I guess I need to add one other thing into Trefethen's marching orders for the staff, which was that he also very much desired to have some kind of an incentive compensation system for the physicians so that there would be a financial incentive for efficiency, economy, productivity, et cetera.

At any rate, in the period from late November '55 until roughly the end of January '56, Reis and Palmaer developed the financial implications and parameters for the proposal that we were working on, and Art Weissman and I developed the remaining aspects of the proposal. We presented this to Trefethen and others probably in late January of 1956. We formally presented it to a meeting of the Advisory Council in February of 1956. Incidentally, there had been no Advisory Council meetings during

this period of developing the proposal, which I referred to in
the history that I wrote as the "Trefethen Initiative."

Hughes: That was your coinage?

Fleming: Yes. It didn't have any name. It was just what we were doing. I called it the Trefethen Initiative because it grew out of the meeting at which Trefethen decided that the Advisory Council process was fruitless and assigned us to develop a proposal. Also, as we were finishing the proposal and preparing to submit it to the Advisory Council, we had another meeting at which Trefethen concluded, after discussing the problems of working something out with the medical groups, that we should concentrate on the Southern California Region for several reasons: There was no significant problem in the Northwest Region; Ernie Saward was continuing to manage that as in the past, and it was doing okay.

There was so much infighting among the leadership of The Permanente Medical Group in northern California, with Collen and Baritell contending for the position of chief executive officer and using denunciations of the Health Plan and the Kaisers as their principal campaign material, that Trefethen felt it was then hopeless to try to deal with the leadership of The Permanente Medical Group.

He correctly perceived Ray Kay as the undisputed leader of the group in southern California, and a person with whom it was possible—though difficult—to negotiate. Also, the Southern California Region was the most desperate for facilities and the most anxious to unplug the stop on financing, imposed due to the Kaiser-Permanente impasse. So we presented the proposal to the Advisory Council meeting in February of '56. Then we embarked upon an intense series of negotiations with the leadership of the Southern California Permanente Medical Group. Indeed, I was commuting to Los Angeles along with Weissman and Trefethen.

Keene went to most or perhaps all of the meetings at which we were attempting to sell the leadership of the Southern California Permanente Medical Group on the proposal. The attitude of The Permanente Medical Group in northern California was that they didn't want to have any part of it, but if the southern California Permanente leaders were inclined to pursue this, it was okay with the northern California physicians.

This was an intense, difficult, tumultuous series of negotiations. I said we were commuting to Los Angeles; it's also true that the physician leaders in southern California were commuting to Oakland, because we had a number of meetings in Trefethen's office in Oakland. But as time went on and we worked
the ideas and issues through numerous meetings, the Southern California Permanente Medical Group accepted the key elements of the proposal. Indeed, I do not recall any major departures from the proposal that we had presented in February, but there was a very extensive educational process because Dr. Kay and his associates approached this with a great deal of suspicion. Only with considerable difficulty did we overcome their suspicion and resistance, and reach the point of mutual recognition that we were trying to solve a mutual problem and not trying to gain some sort of legalistic advantage.

By late spring, 1956, the SCPMG accepted the proposal in principle; however, we needed several months to complete all the details including the organizational changes, a new Medical Service Agreement to reflect all specifics implicit in the proposal and development of the Physician Retirement Plan promised by Trefethen. The revised arrangements became fully effective January 1, 1957.

Hughes: Did you have any model or models for the various points within the proposal?

Fleming: Basically, no. There was, to my knowledge, no other similar organization. The Health Insurance Plan of Greater New York, with, I believe, thirty-two independent medical groups all within the greater New York metropolitan area, had enormous organizational and structural problems and certainly was not a model that we intended to follow. The Ross-Loos Medical Group in Los Angeles, one of the first prepaid group practice programs that now continues to exist in at least some form, was a physician-owned and managed program, and it was not a model. The others were mainly consumer cooperative plans: Group Health Cooperative of Puget Sound, Group Health Association of Washington, D.C., and Group Health of St. Paul. There may have been some smaller ones, but they weren't significant. These consumer cooperative programs were not a model acceptable either to the Kaiser management or the physicians. The only other prepaid group practice plans were labor-sponsored plans—clearly of an entirely different nature and not suitable models for us. So we were developing a model that had not previously existed.

**Northern California Adopts the Plan**

Hughes: I understand that there was something like a year's delay before The Permanente Medical Group signed the medical service agreement. Were you part of those negotiations as well?
Fleming: Oh, certainly. The situation in northern California was really quite simple. Drs. Baritell and Collen were contending for the position of chief executive of The Permanente Medical Group, and both used the Health Plan and the Kaisers as their whipping boys in attempting to outdo each other in finding things wrong with the proposal that we were developing in southern California. Basically they rejected any kind of a solution other than complete physician control of the program. That was the horse they were both riding, and as long as Collen and Baritell were contending for leadership of The Permanente Medical Group, there was no apparent way of getting them to take a more moderate view. Only after they neutralized each other and Dr. Cecil Cutting became the acceptable compromise executive director of The Permanente Medical Group did progress become possible.

When that happened, there was really no issue remaining. Dr. Cutting found the pattern developed in southern California acceptable. The lawyers engaged by The Permanente Medical Group really could not find anything of any substance wrong with it. They made a few minor technical points which I characterize as salting and peppering the medical service agreement liberally with the term "professional"; however, they did not raise anything that affected any key aspect of the medical service agreement or the related changes.

Many people emphasize the medical service agreement because it's an identifiable document. However actually the whole reorganization was the important thing. The medical service agreement was only one part, and by no means the most important part, except to the extent that the medical service agreement embodied some of the concepts that were crucial in the total reorganization.

Hughes: I understand that one of the stumbling blocks was how the ancillary revenue was going to be disbursed. Apparently the Health Plan wanted to appropriate it, and of course the physicians didn't like that.

Fleming: Maybe you don't understand this issue; we were dealing with irrationality. The Health Plan did not seek to "appropriate" the ancillary revenue. Rather we insisted that ancillary revenue be pooled with a prepaid "dues," and with all other revenue, to permit a workable financial arrangement, in which total revenue from all sources was available to meet all needs of the program in a systematic fashion. The Permanente leadership in northern California, and particularly Dr. Collen, strongly objected to pooling the ancillary revenue with the Health Plan dues. Dr. Collen's mantra was, "The doctors like to hear the cash register
ring." He put great stock in having the ancillary revenue be totally medical group revenue.

In addition, he and perhaps other physicians in northern California raised an alleged ethical issue to the effect that pooling ancillary revenue with prepaid dues was too much like the Health Plan receiving fee-for-service revenue, an arrangement that would have infringed on some interpretation of some concepts of the code of ethics of the American Medical Association.

The ancillary charges were not fees for service; they were simply payments in lieu of higher prepaid dues that the program utilized in order to be able to offer lower prepayment rates to groups that could not or would not afford the full comprehensive prepayment rate. They were trade-offs intended, insofar as possible, to generate equal total program revenue from groups paying lower monthly payments and higher point-of-service charges and groups preferring higher prepayment and lower point-of-service charges—or none at all.

In my opinion, the objections to the Health Plan pooling the ancillary revenue along with dues were quite irrational. However, because of at least a shadow of an argument on the ethics issue, we accomplished the pooling, not by having the revenue in question collected directly by the Health Plan at the outset, but by having it collected by The Permanente Medical Group and offset against the payment that the medical group would otherwise receive from the Health Plan. Thus in financial effect it was pooled with the prepaid revenue, although at that time it was actually collected by The Permanente Medical Group as an organization.

Honestly, I don't know whether that is still the system or not. It was a meaningless issue; the proof of how meaningless it was is that I don't know what's being done and it really doesn't matter. The crucial thing is that, in concept and in all significant respects, the ancillary revenue is pooled with the prepaid dues and other miscellaneous revenue, such as parking lots and vending machine income, to support the total program. The matter of what account it first goes into is pure mechanics.

Hughes: Do I understand, then, that the medical service agreements in the north and the south are slightly different?

Fleming: Oh, the medical service agreements in all of our twelve regions are slightly different. The medical service agreement is a very detailed document. Among other things, it defines service areas, and obviously, the service areas are different in every region.
There are numerous differences, but in fundamental concept they are similar.

Hughes: You said that you didn't consider the medical service agreements to be the most important part of the restructuring. Would you like to expand on that?

Fleming: I'll expand on it first by saying that in the actual day-to-day operations of the program, I don't think that regional managers and medical directors look at the medical service agreement more than once a year on the average. That occurs when they're redoing the financial components—an annual exercise. I know that when I was regional manager in the Northwest Region, I only looked at the medical service agreement when it was significant in connection with making some changes in the manner in which we compensated certain allied health personnel who were operating under the direct supervision of the physicians and were to some extent physician surrogates.

The medical service agreement documents some very important things in the relationship between the Health Plan and the medical group, but the financial provisions which need to be revisited annually are the only parts receiving continuing attention. Continuing financial review and annual "re-negotiation" of payments to the medical groups are key aspects of our budgeting and rate-setting process. This is essential because of all of the changes that are constantly occurring in medical practice and in the requirements for various facets of program operations. However, these ongoing financial reviews and annual payment changes deal with amounts of money to meet changing needs, not principles of the agreements and relationships.

Other parts of the medical service agreement do get amended from time to time because of legal changes in the states in which we operate, and because of other extrinsic factors. However what emerged from the Tahoe conference and subsequent reorganization was a way of operating this program as a partnership between the physician and non-physician components in a constructive and effective manner.

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Fleming: In the Kaiser Permanente program, Health Plan and medical groups succeed or fail together; neither can succeed independently. Wise leadership of both Health Plan and medical group components must recognize the legitimate needs of the other component and must approach the problems of physician compensation, other costs of operating the program, and Health Plan rates as problems to be
solved by mutual effort and accommodation, and not by either party trying to "get the best of a deal."

Hughes: To whom would you give most credit for working out the relationship?

Fleming: Well, I guess I have trouble answering that question. I think that Art Weissman and I shared conceptualizing the overall plan and developing the rationale and the arguments that ultimately led to it being accepted. I was the draftsman; Trefethen was the manager in charge. At the outset in November, he had sketched out some general parameters for an acceptable resolution, had reviewed progress at one or two interim meetings, and then reviewed and approved the final product. As I recall, Trefethen found it pretty much acceptable as we presented it. I don't recall that we made any significant changes after his final review. He did not get into conceptualizing or resolving specific issues that came up along the way. Art and I felt that we owed him a finished product, not an "options paper."

The few changes made in subsequent negotiations with the medical groups were not in any sense fundamental. They were--I hardly know what term to use--they were more honorific, to increase the respect and recognition of the medical group and physician roles as expressed in the documents; they did not involve changing the essence of the proposal.

Hughes: To what extent, if any, do you credit the success of the medical program to the relationship worked out in this period between the physicians' groups and Health Plan and hospitals?

Fleming: I think--and I think that most people closely involved would agree--that the manner in which we resolved the Tahoe impasse was critically important to future program success.

Obviously, we had to work out a mutually acceptable relationship. It was quite clear that the medical groups were not going to accept anything analogous to employee status in a program dominated by non-physician components. It was equally clear that the Kaiser side was not going to turn over total control of the program, including the tangible assets which belonged to the non-physician components of the program. They were not going to turn those over to the medical groups for many reasons: legal reasons, reasons of the responsibilities of directors or trustees of nonprofit organizations, and reasons of the nature of Mr. Henry J. Kaiser and the Kaiser organization.

The fact that Kaiser Permanente has thrived for nearly forty years without major alteration of the basics then worked out
testifies that the resolutions of the impasse were quite sound. I guess there were three options. The program could have continued indefinitely in a very ambiguous and unsatisfactory state, which would probably have led to dissolution or at least to ineffectiveness. Financing of tremendous subsequent growth was simply not going to happen without a resolution satisfactory to the Kaiser side.

So the options were (1) to decide the whole thing was a bad idea and give it up, (2) to continue staggering along, or (3) to find some mutually acceptable resolution. By definition, a resolution had to be satisfactory to both the physicians and to the Kaiser side. There were some discussions in the inner offices, with Trefethen and a few of the key staff, of simply calling a meeting of all of the physicians and laying it on the line: "We are willing to have this kind of an organization; those of you who want to go with it, sign the roster when you leave the meeting, and those of you who don't, 'good-bye'." That's maybe a somewhat over-dramatized version of what we discussed as the alternative to reaching some kind of a resolution that the leadership of The Permanente Medical Group would accept.

These discussions were in the northern California context because they occurred after we had our resolution in southern California, at a time when we felt that the resolution in southern California was very constructive and should be acceptable in northern California. We were all quite frustrated by the apparent impossibility of making any progress in northern California.

The Physicians' Retirement Plan

Fleming: One aspect that I mentioned only briefly because it is somewhat peripheral has to do with the Physicians' Retirement Plan. One of the specifications that Trefethen had laid out as a key element in a satisfactory resolution was a retirement program that would provide Permanente physicians with benefits comparable to those provided in the Kaiser Savings and Retirement Plan of the Kaiser industrial companies. This was legally difficult in 1955 and 1956. Subsequent legislation that authorized retirement plans for the self-employed had not yet been enacted, and the Internal Revenue Service was vigorously fighting any legally devised schemes to achieve a tax-sheltered retirement plan for self-employed persons. I believe they fought to preserve a gross inequity because of what they conceived to be a very drastic—or highly exaggerated--effect on the federal revenue.
We had really only two models to look at for tax-sheltered retirement plans for self-employed persons. One of those was based on the retirement plan developed for the physicians associated with the Health Insurance Plan of Greater New York, which involved a trust to which HIP made contributions, and distributions from the trust, post-retirement, by formula based upon compensation and length of service of the participating physicians.

This plan worked in the Health Insurance Plan of Greater New York, in part because as far as I know, it was never seriously challenged by the Internal Revenue Service. One reason that it was never seriously challenged was that the Health Insurance Plan of Greater New York was a nonprofit organization, so it filed information returns, not income tax returns. Thus the question of the deductibility of contributions by the Health Insurance Plan of Greater New York to the retirement plan never came up.

However, at that time, and despite my arguing for several years that the Health Plan should apply for tax-exempt status, the Health Plan was a taxable organization. (The means of avoiding the income tax burden was by limiting the Health Plan's net income to $50 per month per region, or a total of $1,200 per year in California.) The structure was different in the Pacific Northwest.

Although I had been satisfied that the Health Plan was entitled to a 501(c)(4) tax exemption, Bill Marks, who headed the Kaiser legal department, would not approve submitting an application because he was concerned that the scrutiny that such an application might bring could lead to questioning the tax-exempt status of Kaiser Foundation Hospitals. That was important in the estate planning of the Kaisers, a complex matter that I won't try to explain at this point. For legal reasons, the additional five percent that could be deducted in donations to hospitals was an important adjunct in the planning of the Henry J. Kaiser Family Foundation and the personal estates of Henry J. Kaiser, Edgar Kaiser, Henry Jr. during his life, and some other key Kaiser executives.

It was not until subsequent to the resolution of the Tahoe affair that I was able to persuade Bill Marks that the Health Plan should apply for tax exemption, and since it took several years to obtain that exemption, we did not have the benefit of exempt status at the time we were trying to set up the retirement plan for the Permanente physicians.

The other model that we could have followed was the "Kinter Association," as it was called, based upon the court decision
involving a Dr. Kinter and others in the Western Montana Clinic. The tax case involved a medical group in Missoula, Montana, which had established a corporate-type retirement plan on the grounds that they were an "association taxable as a corporation," under the Internal Revenue Code. Although being unincorporated, as was required by medical practice acts at that time (before professional corporation laws were enacted), they were able to organize themselves as an unincorporated association with sufficient corporate attributes that the court handling the case decided they were taxable as a corporation and as such were entitled to the benefits of the tax-sheltered retirement arrangements for employees then available to corporations.

I strongly argued for the Kinter route, but Dr. Raymond Kay was unwilling to accept that approach because it would have required a reorganization of the Southern California Permanente Medical group from a partnership into an unincorporated association. Dr. Kay entertained serious doubts as to whether he would be able to preserve his leadership through such reorganization. In fact, during this period, his leadership was seriously challenged at one point—a story which we might get to later. It explains the departure of Paul Steil from the medical program and his continuation of his Kaiser career through Kaiser Jeep Corporation.

At any rate, the Kinter Association method, which was legally sounder, was unacceptable to Southern California Permanente Medical Group, so we followed the HIP model but without the protection afforded by tax-exempt status for the Health Plan. Thus retirement plan contributions had to be deductible by Health Plan. This created a fundamental issue. The physicians appropriately insisted on security and were unwilling, at that stage in relationships, to rely on the unsecured promise of the Health Plan to pay the retirement benefits. The tax law made it very difficult to create a plan in which the benefits were secured without being currently taxable to the recipients.

We gave it a noble try through a structure that involved a trust fund separate from the Health Plan, thereby securing the benefits, but so arranged that the benefits, although earned by the participating physicians, were technically not vested. It was clear as a matter of tax law that a benefit that was both secured and vested was currently taxable; however, there was a good argument that if it was either not secured or not vested, it was not currently taxable. Out of lack of any other alternative, we established the physicians' retirement plan initially in the Southern California Region and subsequently extended it to the
Northern California Region and the Northwest Region as a secured but nonvested benefit.

However, the Internal Revenue Service challenged this when they audited the Health Plan's tax return, and questioned the deduction for the contribution to the physicians' retirement plan. They concluded that the Health Plan was correct in taking the deduction but that the income was currently taxable to the participating physicians because it was secured and the lack of vesting was such an illusory restraint on their benefits that it was not sufficient to preclude current taxation. The Health Plan felt morally and practically bound to protect the physicians so we incurred a significant obligation as a result of taking the unsatisfactory HIP alternative.

On the other hand, Ray Kay did maintain very successful leadership of the Southern California Permanente Medical Group. The tax loss actually entailed, as a result of the unfavorable decision in the tax case, was of relatively small magnitude in terms of the total resources of the program and became a matter of little consequence in the broad scheme of things. I should note that the quite modest tax cost finally incurred resulted from outstanding work in tax law accomplished by Jerry Phelan, the second lawyer that I recruited into the legal department, and a superb legal thinker.

Hughes: Thank you.

Post-Tahoe Restructuring

[Interview 2: August 9, 1990] #

Hughes: Mr. Fleming, last time we talked about the Tahoe period, and I think today we should go into the aftermath of Tahoe and how the restructuring was implemented in the three regions. Could you first say whom you consider to be the main players in implementing the new policies?

Fleming: Well, of course, we started out with agreement in the Southern California Region. Dr. Raymond Kay was clearly the dominant figure in the Southern California Permanente Medical Group. At the outset, Paul Steil occupied the position that we came to call regional manager in the Southern California Region. However, during the Tahoe conference turmoil, Paul had become frustrated trying to deal with Dr. Kay and had become involved in an effort by a Dr. Marvin Shapiro, then with the Southern California
Permanente Medical Group, to supplant Dr. Kay. Dr. Shapiro, who subsequently had a distinguished career and became head of California Blue Shield, was also frustrated with Dr. Kay's leadership and attempted to foment a palace revolution.

Hughes: What was the contention?

Fleming: Well, I can't identify a specific problem. I think the problem from Paul Steil's viewpoint—and probably from Marvin Shapiro's viewpoint, although I never had any contact whatsoever with Shapiro so I am only inferring from other circumstances—was Dr. Kay's management style. Dr. Kay carried participative management to a fault. I have referred to it as the "mother hen" style of management. He was always running around talking to "my guys." (Women's lib hadn't made itself felt at that time, and although there were female physicians in the Southern California Permanente Medical Group, Ray always said "my guys.") He was spending a tremendous amount of time talking to the physicians at the various facilities, attempting to be sure that he had a consensus supported by the group.

The superficial result of this, from the viewpoint of Paul Steil, and I think Marvin Shapiro and a number of other physicians who supported Shapiro, was the appearance of weak and vacillating leadership. I don't believe that was true; I believe that Ray Kay was a firm manager with a clear idea of where he wanted to go. However his way of getting there was very different from the American ideal of the strong executive. I am really not aware that Shapiro and his supporters had any marked difference in objectives or attitudes towards what the program should become; rather that they were frustrated by what they conceived to be an inordinately slow and indecisive approach to getting to the objective.

Hughes: Any objective, you mean.

Fleming: Yes, I am saying that there was not to my knowledge a big difference in objectives. The Shapiro group wasn't trying for some radically different outcome but was, if my reading is correct, simply frustrated by the interminable discussions involved in getting there.

At any rate, the result of this was that Paul became unacceptable to Ray Kay and was transferred (I believe by Gene Trefethen) from the medical program to the Kaiser Jeep Corporation. Paul's brother, Karl, then Health Plan manager, succeeded to the position of regional manager of the Southern California Region. This is covered from Dr. Kay's viewpoint in
the history that he wrote of the Southern California Permanente Medical Group.¹

Hughes: Did you in the Central Office see it basically the same way as he recounts in the history?

Fleming: I've read the history and I don't recall having any major difference in viewpoint. Ray Kay, of course, went into it in considerably more detail than I have and discussed internal group politics at a level that I knew nothing about.

The Central Office

Hughes: Did the Central Office--which directly after the Tahoe conference was not yet referred to by that term--look upon itself as the organizing force in the restructuring that had to occur in the three regions?

Fleming: Well, the story of the Central Office is a somewhat peculiar one. It was referred to as the Central Office particularly by Dr. Kay, who frequently said, "There's not going to be any Central Office." [laughter] The Central Office, not officially recognized, at least not by the Permanente Medical Groups in California, de facto consisted of Gene Trefethen, Dr. Keene, Art Weissman, and myself. I guess at that time we would have included Joe Reis and Karl Palmaer. That was about the size of it.

Of these people, only Dr. Keene had a career orientation toward a Central Office role. Art Weissman's base had been in the Northern California Region. Although he clearly felt that there should be a programwide statistical and medical economics system, he was working on this in a low-key way from his position in the Northern California Region. He was not, as I recall, advocating a Central Office--although I think everyone involved on the non-physician side recognized that some organizationwide functions needed to be handled in some manner.

I was on loan from the Henry J. Kaiser Company legal department, and the assumption was, until well after the

settlement with the Southern California Permanente Medical Group, I would return to that department when the problems in the medical program were resolved. Thus I had no stake in the Central Office.

Joe Reis was approaching retirement, and his fundamental position was as a senior statesman in the financial area for the Kaiser organization, so he had no commitment to a medical program Central Office. Karl Palmaer was out of the Northern California Region in much the same position as Art Weissman. Hence there was not much "corporate politics" driving in the direction of a central office. Gene Trefethen, however, continued to insist to Ray Kay that, "I have to have a staff." The situation was one in which there needed to be some kind of central organization. There had been a modicum of a central financial organization because the program, through Mr. Kaiser and Gene Trefethen, did its borrowing at least on a California-wide basis through Kaiser's overall relationship with the Bank of America.

Bill Price in the Northern California Region, whom we would now call regional controller, maintained a set of programwide books of account (the "Home Office" books), which we needed for bank relationships, tax filings, and other financial reporting.

However there was no particular thought of a strong central management structure (except perhaps in Dr. Keene's mind), but rather--and this, I think, was Gene Trefethen's viewpoint--the minimum necessary to have the organization function in a somewhat unified manner. Gene had no objections to the concept of regional autonomy and lots of independence for the regions. He did think that there needed to be some consistent policies, some coherent direction, and most particularly, that, from a financial viewpoint, the program had to function as a single unified program. He was cognizant of the potential for expansion, the demand for facilities, and the desirability of functioning as a single unit in the financial markets.

Hughes: This is a real simplification, but would you say that the Central Office essentially became a larger Sidney Garfield? That in the early days, Sidney Garfield was the liaison between the medical groups and Kaiser Industries?

Fleming: Well, Sidney Garfield had been the "Central Office" prior to the events leading up to the Tahoe conference and continued to be effectively the central executive of the organization until the spring of 1955. However, my view is not that the Central Office was a continuation of Garfield's role. Garfield's management style was unique, highly personal, and really involved his relationship with the leading Permanente physicians. Rather, the
Central Office emerged out of necessity. I've already explained a little bit about the necessity from the viewpoint of capital financing.

Previously, the medical program representation in Sacramento had been through the law firm of Stanton and Johnson, which was actually more of a lobbying firm than a law firm. Gardiner Johnson in Stanton and Johnson was the brother of Gordon Johnson of Thelen, Marrin, Johnson, and Bridges. The firm's traction lay primarily with conservative members of the California senate, so they were pretty well able to block legislation that there were plausible grounds for opposing.

My concern was that exactly the senators, (and members of the assembly also), that Stanton and Johnson heavily influenced were the same ones who were quite responsive to the California Medical Association. Thus I feared that their representation would not be effective in relationship to the California Medical Association and the California Dental Association, which was the nominal sponsor of a bill which would have rendered operation of the Kaiser Permanente program illegal. The net of it was that I obtained approval from the Northern California Region and from Gene Trefethen to place direct health plan representation in Sacramento. Gibson Kingren was successful in gaining support. I will cover the government relations function, an important central activity, in the section on Kaiser Permanente and Public Policy.

Henry J. Kaiser's Role ##

Hughes: Henry Kaiser was fond of proclaiming the Kaiser Permanente model as an alternative to national health insurance. Was he taken seriously?

Fleming: Mr. Kaiser made his statements and appeared at congressional hearings, et cetera, in which he advocated the extension of prepaid group practice nationwide. Almost all of this occurred before I was directly involved with the program or indeed involved with the Kaiser Permanente organization at all, so I don't have firsthand knowledge. Because of the underlying political situation at the time, I don't think that organized medicine took Mr. Kaiser very seriously. I think they regarded it as more in the nature of a political stunt, although I'm sure that from Mr. Kaiser's viewpoint it was not intended as a political stunt. But I don't think that his advocacy of the Kaiser Foundation Health Plan model as something for nationwide
emulation ever had enough reality, during his lifetime, to make it a matter of much significance one way or another to the leaders of organized medicine.

Hughes: What role did Henry Kaiser play after the Tahoe conference, excluding the Hawaii situation?

Fleming: I was going to say that his role really involved the Hawaii situation, which I will discuss at another time.

Because of Henry J. Kaiser's close association with Dr. Garfield and Dr. Garfield's keen interest in facilities, his impact was most significant in connection with some aspects of facility design and some influence on facility development. But I don't really believe that his influence on the medical program outside of Hawaii was very significant after the Tahoe conference, except on extreme rare occasions such as his strong intervention when The Permanente Medical Group considered a venture in San Diego. [This subject is discussed in a later section. --ed.]

Hughes: Had Kaiser turned over the responsibilities of the medical program to Trefethen and pretty much dropped out of it, except for the Hawaii episode?

Fleming: I think that's reasonably accurate. I would put it this way: although Trefethen persuaded Henry J. Kaiser to accept the resolution of the health plan/medical group impasse that I described earlier, Mr. Kaiser's acceptance was reluctant and grudging. A consequence of that, I think, was that Henry J. sort of washed his hands of involvement with the medical program in California and Oregon, except for playing facility games with Garfield. Instead he focused his attention on Hawaii until things went bad in Hawaii, after which his direct participation in medical program matters declined further.

Hughes: Yet he maintained throughout his latter life that the medical program was his greatest achievement.

Fleming: Yes, he maintained that and I think he was probably sincere. However, Henry J. always had a keen sense of public relations and understood the public relations value of identification with the medical field and with the nonprofit rather than profit-oriented portions of the empire he created. But I believe that he did have a sincere and deep interest in the medical program. I think his declining involvement reflected in part his unwillingness or reluctance to accept the shared power situation that emerged from the Tahoe conference. Sharing power was not in Henry J. Kaiser's nature. Also, he was getting older and his phenomenal energy was
His inclination to participate actively, I believe, was also diminishing, especially after the problems in the Hawaii region that caused it to revert pretty much to the mainland model.

**More on Post-Tahoe Restructuring**

Hughes: Is there more that you care to say about that immediate post-Tahoe period and the effect that the agreement that came out of the Tahoe conference had on the structure of the three regions? I guess it's only two regions that we're talking about, because if I understand correctly, Oregon was really not much affected by what occurred at Tahoe.

Fleming: Let me talk about this for just a minute. The revised organizational structure, medical service agreement, financial arrangements, management structure, the whole thing, was accepted in southern California in 1956 and became effective the beginning of 1957.

Hughes: Are you talking about the medical service agreement?

Fleming: It was a lot more than the medical service agreement. Some of these things became effective along the way. The revised medical service agreement, as a true prospective agreement, first took effect in the beginning of 1957 in southern California. The Northern California Permanente Medical Group had continued to resist for reasons related to internal medical group politics that I think I discussed earlier. A year later, after Dr. Cecil Cutting became the executive director of The Permanente Medical Group, a very unfortunate thing occurred in northern California--unfortunate in the evolving health plan-medical group relationship picture.

At the urging of a key labor relations executive by the name of Walter "Sonny" Farrell, Gene Trefethen appointed a man named Fred Tennant, whose background was in labor and industrial relations, to the position of regional manager in northern California. I believe I was the alternate candidate for that position, but Farrell, who had a systematic policy of trying to place labor relations people in management positions and had substantial influence on Gene Trefethen, persuaded Trefethen to select Tennant.

Hughes: Who had put your name forward?
Fleming: Probably Cliff Keene, or probably Trefethen himself. Internally, there were very few plausible candidates, and I think I was one of these. Some people might say that I wasn't a plausible candidate because of the lack of prior management experience, but I had clearly been in the center of medical program management since the middle of 1955.

At any rate, Tennant had no particular qualifications for the position. Although he had the appearance and the air of an executive, he didn't, in my opinion, have the substance of one, and he was not acceptable to The Permanente Medical Group. Possibly because I'd been an advocate in the Tahoe confrontation, I was not acceptable either, although I am not at all sure that this was an issue that could not have been resolved by some discussion among the people involved.

Hughes: You make it sound, or at least that's my reading, that it was to some degree a question of personalities. But wasn't it also the fact that one of the understandings that came out of the Tahoe conference was that key positions in either Health Plan, Hospitals, or in the Medical Groups were to be reviewed by the other side before the appointment was made, and that did not occur in the case of the appointment of Fred Tennant?

Fleming: Yes, that's exactly the thing I was getting to.

Hughes: Oh, okay. [laughter]

Fleming: I don't know that The Permanente Medical Group took the explicit position that Tennant was unacceptable. I do know that the acceptance was at best very reluctant and that the view within the medical group was that Trefethen had "forced Tennant down our throat." Nonetheless, Cece Cutting worked in good faith, at least from all I could see, to function in an appropriate relationship with Tennant. There was no overt split, although there was continuing dissatisfaction. What finally led to Tennant's removal was neither Medical Group objections nor incompetence, but rather the fact that he engaged in what would now be called "sexual harassment" involving a female secretary in the regional office. This came to Edgar Kaiser's attention, and Edgar insisted that Tennant be fired, which he was.

Hughes: And that pacified the Medical Group?

Fleming: Well, I don't think it pacified the Medical Group, because just as they felt they were entitled to be consulted and have their views respected on the selection of key personnel, they also had the same view on discharge of key personnel. At the same time, I don't believe they regarded Tennant's removal as inappropriate.
Hughes: Wasn't there a similar problem with Felix Day? A disagreement between the Kaiser forces and PMG about the appointment and lack of review?

Fleming: I'm not aware of a parallel situation involving Felix Day. The thing is, Felix Day was not brought in from the outside. He was already there in the pre-Tahoe period. Although I believe many of the physicians had reservations about him, there was no situation in which, to my knowledge, there was an explicit issue about his acceptability under the "mutual acceptability" understanding that emerged from Tahoe. Also, the selection of Tennant was regarded by the leaders of the Medical Group as a failure on Trefethen's part to respect the "mutual acceptability" aspect of the Tahoe understanding.

Moreover, and most important, the "mutual acceptability" has in fact only worked in one direction. There's an inconsistency between the concept of the Permanente Medical Groups as autonomous, self-governing organizations and the concept of mutual acceptability. In fact, the Health Plan has been very sparing in its attempts to influence the selection of medical directors, both because of the conceptual inconsistency between the "mutual acceptability" concept and the concept that the medical groups are autonomous, self-governing organizations, and also because any interference in internal Medical Group politics could prove counter-productive.

Hughes: Is that enough on the subject of restructuring?

Fleming: I guess I was going to go on to note that following Tennant's removal, Trefethen selected Karl Steil, regional manager of the Southern California Region, to take Tennant's place in northern California. I am quite sure that at that time I was the alternate candidate, and in terms of management development I believe the program made a mistake in not having a second regional manager. However, Karl Steil had established himself as able to work with Ray Kay in a partnership mode, and it was generally expected that he would be able to function in the same mode with Cecil Cutting, and this was an important aspect of the job.

When Karl became regional manager in northern California as well as southern California, he moved to northern California and selected Jim Vohs, who had been the Health Plan manager in southern California, to be assistant regional manager. Subsequently, of course, this relationship was changed so that Jim became the regional manager in southern California and Karl continued as regional manager in northern California.
Hughes: Because the job was too big?

Fleming: It really didn't make any sense to have one person being regional manager in two regions. That was simply a temporary expedient because Karl Steil had the credentials insofar as medical group relationships were concerned. Although I was not involved in the discussions, I'm sure that both Trefethen and Karl Steil wanted to see Jim functioning in an acting capacity before giving him the full responsibility.

I guess I should mention briefly what was going on in Oregon. The organizational structure was of course the same in both California regions and was what had emerged from the Tahoe conference. However, historically the situation had been different in Oregon. There had been one corporation, originally Northwest Permanente Foundation, subsequently renamed Kaiser Foundation Northern Hospitals, which handled both Hospital and Health Plan functions, and The Permanente Clinic, a partnership of physicians which provided professional services only. By contrast, in the California regions we had a separate hospital corporation and separate health plan organization and the medical group in each region, which employed non-physician personnel in all of the "non-hospital" functions. That is to say, the nursing and support personnel whose responsibilities were strictly inpatient were on the payroll of Kaiser Foundation Hospitals, whereas all other personnel, those in the medical offices and those such as X-ray and lab, for example, that served both the inpatient and outpatient functions, were on the medical group payroll. This is a matter of no great consequence in the big picture but has been subject of extensive debate and argument within the program.

In the Oregon Region, which we now call the Northwest Region, the professional-services-only arrangement between the medical group and the corporate organization had worked very well and indeed was a simplifying arrangement in many ways because the relationship with the Medical Group concerned only physician services uncomplicated by all of the other personnel problems and related concerns. Also, the Hospitals and Health Plan were in a single corporation, which was a less complicated arrangement, although again, the matter was not of great consequence.

However, with the post-Tahoe reorganization and Mr. Kaiser's desire to establish a health plan in Hawaii, there arose the matter of financing the Hawaii hospital, and concurrently, the need for a hospital on the Portland side of the Columbia River. This need had long been apparent, became more immediate because of the obvious question of why invest in a hospital in Hawaii when the Oregon Region desperately needs one? In addition, we
had been operating at essentially a break-even basis in the Northwest Region and there were substantial operating loss carry-forwards, so the tax exemption, although valuable for many purposes, was not necessary as a shelter from federal income tax. However, everyone anticipated that this would change dramatically when the region had a hospital on the Portland side of the Columbia River. Thus, the question arose about continuing the Oregon Region corporate structure or changing it to the California pattern.

At this time, I, along with George Link, tax attorney at Thelen, Marrin, Johnson, and Bridges, had been in discussions with the Internal Revenue Service regarding a tax exemption for the Health Plan under Internal Revenue Code Section 501(c)(4) as contrasted with the traditional hospital exemption under IRC Section 501(c)(3). We discussed this matter with the exempt organization's branch of the Revenue Service in Washington and were advised that "we understand how you are functioning in California, and we believe that is the proper way to function." Having obtained our tax advice from this impeccable source, we reorganized the Oregon Region to follow the California pattern with a separate hospital corporation and a separate health plan corporation, but continued with the Medical Group contracting with the Health Plan for professional services only.

Hughes: Was Dr. Saward giving his blessing to these changes? Or had he gone on to Rochester by that point?

Fleming: No, Dr. Saward was there. Dr. Saward was very happy with the existing organizational structure with a single corporation. However, he recognized that the addition of another corporation really didn't make a lot of difference and was quite willing to accept advice from George Link and myself to the effect that this was the safe and sound way to proceed. There was no objection from the Medical Group in Oregon. Also, the Oregon pattern with a contract with the Medical Group for professional services only was the pattern that we followed in setting up the program in Hawaii and is indeed the pattern that we have used in all of the newer regions, so that only the California Regions involve the medical groups with the employment of non-physician personnel.

Hughes: I suppose it's impossible to pinpoint exactly when the term "Central Office" became current. But when did you begin to realize that yours was not just a temporary assignment, and the Central Office was an entity that was going to endure?

Fleming: Well, my initial assignment had been to work on resolving the issues between the medical groups and the Kaiser side of the program. However, being an attorney and being active in the
medical program on a full-time basis, I soon commenced to get involved in lots of other legal matters and the "treaty" that had reserved the medical program legal work for Thelen, Marrin, Johnson, and Bridges had really ceased to be pertinent. As a routine practical matter, I commenced handling an increasing number of medical program legal problems, however, calling upon the Thelen, Marrin office whenever anything of sufficient magnitude or substance came up. For example, I always worked with George Link on federal income tax matters concerning the medical program. Concurrently, as noted above, we commenced a government relations activity under my direction, so my job had in fact expanded significantly, and everywhere I looked, there were more problems that needed dealing with, either in the legal arena or the government relations arena.

I don't know when it became clear to me that I had an attractive career opportunity as legal counsel for the medical program, but this probably emerged in 1959 when we suddenly had a very major government relations issue: namely, the Eisenhower administration proposal for extending health care coverage as a fringe benefit to federal employees. I will discuss this in the section on Kaiser Permanente and Public Policy.

More on the Central Office ##

Fleming: Insofar as my career and the development of the Central Office are concerned, the government relations effort involved in the Federal Employees Health Benefits Program, the fact that this was bound to continue at the regulatory level as a vitally important ongoing activity, and the accelerating number of things requiring attention in the areas of government relations and legal affairs, together with my deep involvement in and personal interest in the medical program, caused me to see my future in the medical program rather than in the Henry J. Kaiser Company legal department.

My friends in the legal department advised that going with a nonprofit organization was not a wise thing to do because the pay wouldn't be as good and other opportunities would be more limited. As it turns out, the careers of many of my associates in the legal department were cut short by the unraveling of Kaiser Industries Corporation, so that I was the only one from the Henry J. Kaiser legal department to complete my career in an organization spawned by Henry J. Kaiser and his wide-ranging activities.
Hughes: Would you like to say something about the reasons behind the tensions that existed within The Permanente Medical Group in reference to the Central Office?

Fleming: Going on with the Central Office theme, I dealt with this in the history that I wrote of the Kaiser Permanente Program\(^1\) under the heading, as I recall, "Emergence of the Central Office." The picture I see includes no clearly identifiable point at which a Central Office was created, but rather a continuing process which can be traced back to Dr. Garfield's role, and that developed and accelerated over time. The Central Office grew in response to needs for some central point of focus and coordination. I will explain how the government relations function developed, grew, and was necessarily centralized because the program needed to speak with a single voice on government relations issues. I might put in an aside here and explain how I handled this in the early days.

I would send a memorandum to regional managers and medical directors as well as appropriate Central Office personnel, identifying government relations issues that we needed to deal with, articulating a proposed position and course of action, and inviting their comments and suggestions. I took silence to be approval--of necessity because many of these items wouldn't wait for explicit responses from busy people who found many of the issues I presented to be legalistic and probably, from their viewpoints, unimportant.

The result was a centralized function with continuing liaison with the management in the regions, but achieved in a fairly low-key, unobtrusive way. Occasionally there were differences of opinion from personnel in the regions regarding the position and course of action that we should take, but as I recall, I was always able to negotiate some acceptable reconciliation of the different viewpoints. Because our government relations efforts were generally fairly successful, acceptance within the operating regions was quite sufficient for a unified voice.

I neglected to mention one aspect of centralization that had preexisted the Tahoe conference because it was administrative in nature and not of overwhelming importance. The entire group of Kaiser-affiliated or -associated organizations, including the medical program, had centralized services from a Kaiser company,

\(^1\)Scott Fleming, Evolution of the Kaiser Permanente Medical Care Program: Historical Overview, Oakland: Kaiser Foundation Health Plan, 1983, pp. 38ff.
called Kaiser Services, whose stock was owned by all of the Kaiser-affiliated companies, but not by the medical program. This organization provided a lot of personnel and human resource-type services, including negotiating and administering group life and disability programs, the retirement programs, and related activities. They also operated the transportation services for travel reservations, et cetera, and a number of other routine administrative-type services, most of which I can't recall and would need to do a little research to identify.

These were all characterized—or almost all—characterized by being largely administrative in nature and not key elements of what the line management of an organization needs to manage. There was, however, one significant and occasionally troublesome exception: namely, the centralized labor relations function. Labor relations had been vitally important to all of the Kaiser-affiliated companies and they had generally maintained a reasonably congenial relationship with organized labor—though in some cases probably at excessive cost. Because the leadership of all the unions does communicate fairly closely, the industrial relations managers and indeed the top managers of the Kaiser-affiliated companies were very much concerned about labor relations in anything carrying the Kaiser name, including the medical program. The result was that the Kaiser Industries industrial relations people became involved whenever there were tense labor relations problems within the medical program.

I don't claim enough expertise in labor relations to evaluate the pros and cons of this situation. My impression is that the Kaiser Industries industrial relations people were occasionally quite helpful to the medical program, and on other occasions interfered in a manner that was probably detrimental to the medical program as such but may have been beneficial to the total Kaiserwide industrial relations activities. This was one centralized function that the regions resented but that had simply been inherited from the past as part of being a Kaiser-related organization. Despite a certain amount of grumbling over excessive costs and interference, it was not really a fundamental issue in program management and existed as an element of the Central Office that became more explicit as the program grew, as the Kaiser-affiliated companies unraveled, and as the Central Office assumed the functions that had previously been obtained through Kaiser Services.

Hughes: Why did the Permanente groups object to the labor relations aspect of the Central Office?

Fleming: First, it was not the labor relations aspect of the Central Office, it was the labor relations aspect of Kaiser Industries.
Just to take an example—and this is a sort of a generic example because I don't recall the details of a specific situation—suppose that the management in the Southern California Region believes that the demands of some labor union are unreasonable and should be resisted even to the point of a strike. The Kaiser Steel Company and Kaiser Aluminum Company feel that a strike in the medical program would be detrimental to their negotiations with their unions. The result could be pressure, which medical program management might find inappropriate, to settle on an unduly expensive basis.

Examples that people closer to the labor relations front would give could range from major to trivial, but it was things of this sort that caused the regions to resent the Kaiser Industries labor relations influence. When that role was assumed by the Central Office through transfer of Andy Gensey from Kaiser Services to the medical program, the element of external interference diminished greatly. But line managers in any organization often resent intrusion from "headquarters," and there are often issues on which, as the lawyers say, "reasonable men can differ" between what regional personnel and Central Office personnel might believe to be most appropriate.

The tension between the regions and the Central Office is not fundamentally different from that which exists between the headquarters and the field operations in any large business organization. Because of the historical high degree of autonomy enjoyed by the regions, there was, in the early days, late fifties and sixties, much greater sensitivity on the "regional autonomy" issue than there is now.

Hughes: You mean as an aftermath of the tensions of the Tahoe conference period?

Fleming: More or less. I've noted that Dr. Kay's position was that there wasn't going to be any Central Office, and the Permanente Medical Groups in California were particularly sensitive to what they conceived to be any intrusions into their autonomy from Central Office personnel. In addition, there was the controversial role of Dr. Keene, who was deeply resented by physician leadership in both of the California regions and whose appointment to the position of vice-president and general manager and later president by Gene Trefethen were regarded as gross breaches of the "mutual acceptability of key personnel" understanding. Dr. Kay, at least, in southern California, never would have accepted Dr. Keene in that role, and Dr. Cutting in northern California did so only grudgingly.
Hughes: Now, how much of that was Keene and how much of that was the position?

Fleming: I think the valid answer is a lot of both. Dr. Keene came into an impossible position. As I understand the story, he had been led by the Kaisers and Trefethen to believe that he was coming in as chief executive of the medical program organizations that were under Kaiser management, as contrasted with the medical groups. However, Dr. Garfield never got this message, or at least that's the way it would have appeared to observers. Because of his close relationship, including in-law relationship, with Henry J. Kaiser, Garfield had an inside track that Dr. Keene was never able to match. Dr. Keene initially had strong support from Edgar Kaiser, but apparently that support eroded over the years.

Hughes: Why?

Fleming: Well, to be brutally honest about that, I believe that Dr. Keene was a rather inept manager in a number of ways and that his ineptness had consequences that fed back to Edgar Kaiser, who had many personal acquaintances among the leaders of the Permanente Medical Groups.

Keene was a reasonably competent administrator. He was not a particularly good manager, and he was certainly not a leader. Garfield, on the other hand, was a very mediocre administrator, a moderately good though quite limited manager because of reluctance to delegate, but an outstanding leader. As I’ve said, Keene put a great emphasis on the perquisites of office. He liked the things associated with being a chief executive, even though he never really functioned as a chief executive.

Hughes: You mean even after his position became solidified and he actually had a title?

Fleming: Well, in the Kaiser Permanente Medical Care program, a title does not signify anything to the Permanente physicians, and they are a vital part of the medical care program. Keene gained increasing acceptance as time went on, particularly after the retirement of Dr. Kay, who was his most committed and dedicated enemy. He also built fair relationships with the medical group in Hawaii and developed a satisfactory relationship with Ernie Saward in Oregon--because Ernie was not really concerned about Keene's limitations as a manager as long as Keene didn't interfere with Ernie, and Keene didn't. He also achieved a greater degree of acceptance in the newer regions. Still, in my estimation, he never became a true chief executive officer.
He always was constrained by the reluctance of the medical group leaders to respect his position, which reluctance was, of course, communicated to the regional managers and other personnel so that Keene enjoyed token respect; but with the exception, perhaps, of a relatively small number of individuals situated in various places in the program, he rarely enjoyed real respect. His role, even after he was designated president, was much more ceremonial and formalistic than substantive. Indeed, Ernie Saward explicitly characterized him as a ceremonial president. The fact that Keene enjoyed very limited respect was the product of history and of management style, not of basic ability for in many ways Keene was a quite able man.

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**Fleming:** My own dealings with him were generally satisfactory. He was entirely gentlemanly and quite able and willing to deal with issues on the merits. I think he had the same kind of relationship with Arthur Weissman. The two of us spent endless time counseling Dr. Keene on the manner in which he could best handle his awkward and ambiguous role. If you take the standard widely used in the corporate world of evaluating executives by the results achieved under their stewardship, you would have to rate Keene as a considerable success in his role in the medical care program. However, many knowledgeable individuals would maintain that the success was achieved despite rather than because of him.

**Hughes:** I keep pulling you back to the Central Office, but there seems to be one other major function, and that's the financial, which I understand was very important in the relationship with banks. The legitimization of the medical care program in the eyes of the financial world was certainly something that the Central Office was trying to do, was that not true?

**Fleming:** I had referred to this. The initial financing through the Bank of America had depended upon Henry J. Kaiser and Gene Trefethen and their relations with the bank. The overall capital financing and financial policy roles continued to reside in the Central Office. The quality of the financial management was very high under Trefethen's direction, and the internal capability increased dramatically with Walt Palmer's promotion to vice president for financial matters.

I think that I should scan the Central Office a little bit more broadly regarding its evolving functions and its emergence as a major component of the organization. Arthur Weissman had started the medical economics function. Because of his own low-key but very effective management style, he gained widespread
acceptance for that function. His successors have carried it on excellently. The financial management function has been extremely well handled, and the current chief financial officer, Susan Porth, is outstanding, as is Dick Anderson, the current head of medical economics.

The personnel function grew rapidly with the increasing size and complexity of the organization and the addition of small regions that required more central support than the large regions, which indeed could have been entirely autonomous in all of their functions, at least in terms of their size and resources. The legal and governmental relations functions, which I started, have continued to be well led and well managed and are, I believe, generally respected throughout the program.¹

As the program has grown, both in size and complexity, with the addition of new regions, and as marketing has become more complicated, with interrelations between the regions on marketing issues, the Central Office has also been obliged by circumstance to assume a marketing function which did not exist at all in the immediate post-Tahoe period. It indeed was first manifested—although we didn't think of it that way—in the Central Office role with the Federal Employees Health Benefits Program, where the Civil Service Commission insisted upon dealing with a single program rather than with a collection of regions. Thus Bob Erickson—the first lawyer I added to the legal department—was put into what was in fact a key marketing role even though it was not explicitly so recognized. Bob Erickson, who succeeded me as head of legal and governmental affairs, has been absolutely outstanding.

Concurrently, the development of the computer age and telecommunications generated the need for some common oversight in the area of communications and computerization, which has been effectively handled for the first time by Tom Fisher. So the centralization, a very important matter, was the product of circumstance and necessity rather than the execution of some preexisting plan to establish a strong Central Office.

Hughes: Do you think that fairly well covers the Central Office?

Fleming: I think so. I'll no doubt think of another thing or two.

¹As I review this Oral History in the Summer of 1994, legal and government relations functions are undergoing reorganization.
The San Diego Venture

Hughes: As I see it, the next step is a few words on San Diego. What were the circumstances that led to the San Diego venture?

Fleming: The circumstances, in brief, were that San Diego was a big and growing market, and insofar as prepaid group practice is concerned, it was only served by the San Diego Health Association (SDHA), formerly the Complete Service Bureau, which was not a particularly effective organization and was grossly undercapitalized so that it really couldn't make a dent in the San Diego market within any realistic period of time. So we collectively, the program, especially the Southern California Region, were continually pressured to expand into San Diego because groups that we were serving in other areas, and especially in the Los Angeles area, were also major factors in San Diego.

However, the Southern California Region was running as fast as it could to stay still, so to speak, and did not have the resources to make a commitment in San Diego when there were so many unmet needs in the immediate Los Angeles area. The Permanente Medical Group in northern California was not really satisfied with the post-Tahoe arrangements. Although under Cutting's direction these arrangements had been accepted, they were still accepted only grudgingly, and leaders in the Permanente Medical Group, including A. L. Baritell and Morrie Collen as well as Cece Cutting, continued to hold the belief that a prepaid group practice program would function better under exclusive medical group management. Thus, they saw San Diego as an opportunity for them to demonstrate how prepaid health care should really be handled.

Probably in part because Collen was somewhat restive after having failed to win the position of executive director and would have liked another sandbox to play in, he--and no doubt others, although I don't know the specifics--continued to agitate for Permanente Medical Group sponsorship of an independent physician-dominated prepaid group practice program. San Diego was an obvious opportunity, and when they found a hospital for sale, they took advantage of the circumstances and purchased the hospital with the intention of establishing a physician-managed, physician-owned prepaid group practice for the San Diego area.

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1This subject is discussed in several oral histories in the Kaiser series. See specifically Dr. Collen’s.
Although the Southern California Permanente Medical Group had not yet accepted the numerous invitations to expand to San Diego, they regarded it as part of their natural territory and took exception to the move by The Permanente Medical Group. Dr. Kay's position was firm but conciliatory; he thought it was all right for The Permanente Medical Group to start a program down there, with the understanding that it would be assimilated by the Southern California Region or the Southern California Permanente Medical Group when the time was right. This, of course, was not what The Permanente Medical Group had in mind, because they intended to demonstrate their ability to establish and operate a superior prepaid group practice program and were not intending to keep the throne warm for either Ray Kay or the Southern California Region.

Hughes: Did they make that clear at the time?

Fleming: Although I have no firsthand knowledge of discussions within Permanente leadership, I think The Permanente Medical Group intentions were clear. I believe that Dr. Kay also made his view clear. However, Dr. Kay had a way of going about things that could have left it ambiguous. He had this thing that I referred to as a "mother hen" style of management and often did not speak in totally straightforward ways. Ambiguity is sometimes a good lubricant. Kay was perfectly capable of being quite clear on occasion.

However, Kay's aim, I think, was to avoid a controversy with The Permanente Medical Group at the time because he thought prepaid group practice under Permanente or Kaiser leadership should be in San Diego and was not yet ready to make the commitment to divert resources from Los Angeles. However, he never relinquished the claim to San Diego as appropriate expansion territory for the Southern California Region. He also counseled Cutting (I can't document this, although I am confident that it's true) or perhaps more accurately, Collen and the other PMG leaders as well as Cutting, that this would be an affront to the Kaisers and would be totally unacceptable as a violation of the partnership concept.

However, there wasn't much time for speculation because Henry J. Kaiser entered the picture and made it unequivocally clear that, insofar as he was concerned, sponsorship by The Permanente Medical Group of an independent medical group-owned and -operated program in San Diego was totally unacceptable and would represent a repudiation of the post-Tahoe understandings that Henry J. had accepted, albeit grudgingly.
Meanwhile, the San Diego Health Association was experiencing increasing financial difficulties which they attributed—probably not entirely accurately—to the fact that they did not have hospital facilities. I'm not sure that I have the details straight, but I believe they acquired a nursing home in La Mesa and converted it into a small general hospital. The capital investment involved, together with the burden of operating a hospital in addition to outpatient facilities, was moving SDHA rapidly toward bankruptcy, and these problems were compounded by internal friction within the management and sponsorship of SDHA, leading to a proxy fight for control of the organization.

Meanwhile, Fred Tennant had been recruited by SDHA to become their chief executive officer based upon his Kaiser Permanente experience. It's not clear to me that Fred had learned much about running a prepaid group practice program from his Kaiser Permanente experience, but at least insofar as his resume was concerned, he had the credentials. He entered what was probably an impossible situation and was not able to achieve the changes necessary for financial viability, so quite reluctantly, but on instructions from his governing board, he approached the Kaiser Permanente program about a "merger," fully realizing that this would be an acquisition rather than a merger and that SDHA had in reality very little to sell and essentially no bargaining power.

The program leadership decided that we should explore the acquisition of SDHA and, barring--

Hughes: "We" being the Central Office?

Fleming: The program. It was not Central Office, it was Southern California Region, Central Office, and others; so it was just "we" collectively. We decided to explore it, and barring any unforeseen adverse findings, were inclined to take over the SDHA operation.

Working with Jim Baldwin in the Los Angeles office of Thelen, Marrin, Johnson, and Bridges, which provided legal services to the Southern California Region, I explored the legal ramifications. Walt Palmer, regional controller in southern California at that time, explored the financial situation, and numerous others—physicians, facility management personnel, Health Plan personnel, et cetera—explored all other aspects of the operations.

We concluded that we should not, because of the fear of undisclosed or unknown liabilities, including possible malpractice liabilities, take over the SDHA structure but should simply purchase assets and assume responsibility for continuing
service to the membership. That was the first time I'd dealt in depth with Walt Palmer, and I was absolutely amazed at the quickness and accuracy with which he got a grip on the financial circumstances of SDHA.

Within the period of less than a week, during which we conducted our exploration, he understood their financial circumstances better than they did and had a better grip on their valid membership enrollment than they did. Among other things, their enrollment records included a lot of people who were no longer premium-paying members but were what we called "phantom members."

At any rate, we were inclined to take the program over but had a few more details to work out. When a payroll was becoming due and the issue arose as to whether the San Diego Health Association's bank would advance money to meet the payroll, I remember a conversation on the telephone with an officer of the bank in which he was attempting to persuade or coerce me into agreeing that Kaiser Permanente should put up the funds to meet the payroll. I told him that I was not able to guarantee meeting that payroll and was not able to guarantee that the program would in fact take over SDHA. I assured him that if we did take it over, a clearly identified bank debt, including the advance for the payroll, would be paid, but that if that payroll was not met and we were not able to acquire a going concern, I could virtually guarantee him that the bank debt would not be paid. The result was that the bank advanced the money to meet the payroll and we assumed responsibility for the continuing operation of the program, including assumption of designated liabilities relating to the conduct of the business.

Hughes: So you think that pretty well covers it?

Fleming: I guess I might add that most of the physicians then serving the membership continued temporarily with the program. As I recall, the Southern California Permanente Medical Group sent Dr. Harry Shragg to manage medical services in San Diego. He soon weeded out a number of the physicians who had previously been there. However, he retained several, including Herbert Sorensen, who was an excellent physician and manager and subsequently had a distinguished career with SCPMG.
III DEVELOPMENT OF THE KAISER PERMANENTE COMMITTEE

[Interview 3: November 29, 1990] ##

The Physician-Administrator Forums

Hughes: Mr. Fleming, I thought today we'd start with the physician-administrator forums which I believe Dr. Keene set up. Were those indeed Dr. Keene's idea?

Fleming: Yes, I believe they were. Dr. Keene, as I think is apparent from the many interviews in the series, was in quite an awkward position, being a chief executive in name only and not having much acceptance of his leadership or management role, particularly by the medical groups. The historical origins of the program, what we call "regional autonomy" and the great resistance to any central authority on the part of both the California medical groups, but especially the southern California group, precluded central direction. We functioned with reasonable coherence because of commonly held values, not central direction. Keene was striving for some way in which he could bring the program together and provide some central direction. This was a highly appropriate objective--passing for the moment the question of whether Keene was a good selection for providing central leadership.

As one part of this effort, he conceived the idea of the physician-administrator forums. These may have started out on a slightly different tack with his so-called "Quo Vadis" meeting down at Monterey. The basic idea was to get the program leadership together to talk about the program and matters of

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common interest. The medical groups were a bit reluctant even to do this, because they perceived it, quite correctly, as at least a tendency toward some degree of centralization. But the meetings were quite innocuous, and we held a number of physician-administrator forums. They were not on any regular schedule, and I don't really recall how many there were, but from the early 1960s up to about 1967 there were several.

The format was largely based on presentations by financial people. Howard Spaulding led the financial part of it to look at what the program was doing financially. Keene's interest, stimulated somewhat by Henry J. Kaiser, was comparative financial analysis. However the regions strongly resisted comparisons, maintaining with considerable justification that there were too many essentially non-comparable aspects of program operations to have comparable financial analysis be meaningful or useful. Even though the examination of the Regional Economic Analysis Program, as it was called, was sort of the excuse for the physician-administrator forums, they spread out from there to encompass other matters of mutual interest throughout the program. They were strictly information exchange activities, no decision-making being countenanced by the medical groups. However, there was some low-key consensus building.

**The United Auto Workers' Medical Plan, Detroit**

Hughes: Would you regard them as a predecessor of the Kai Perm Committee?

Fleming: In a sense, yes, although something significant intervened. Edgar Kaiser was a good friend of Walter Reuther, who headed the United Auto Workers Union, which had sponsored a prepaid group practice plan in Detroit. It was intended for UAW members and other union workers in the Detroit area. The UAW plan was having a lot of trouble and generally losing money, certainly never doing well financially, whereas the Kaiser Permanente program on the West Coast was highly successful. As a result, Walter Reuther attempted to persuade Edgar Kaiser to have the Kaiser Permanente organization take over the Detroit plan.

When Edgar pressed this upon the leadership of the Kaiser Permanente program, we had two meetings devoted to this subject. They were not exactly physician-administrator forums but they were somewhat similar in composition and came naturally because of the physician-administrator forums. I can probably determine the dates of these. I don't remember offhand, but probably one of them was in 1967 and another in 1968.
A team had been selected to study the Detroit situation, and we met to review the report. After receiving the report and discussing it at length, the consensus within the group that attended the meeting was that the Kaiser Permanente program should not take over the United Auto Workers plan in Detroit.

Hughes: Why?

Fleming: There were a number of reasons. The program was expanding very rapidly in the existing regions. The demand for capital and for other resources—physicians, managers, everything you need in terms of personnel—was hard to satisfy. The one strong sentiment was that, as long as we were running as hard as we could to keep up in the existing operations, we didn't have any business taking on something new in a different part of the country in a different economic and sociological environment, and one that we really didn't know much of anything about.

Hughes: Yet two years later, 1969, Kaiser Permanente did move into Cleveland and Denver.

Fleming: The reconciliation is something we will get to, but at that time, the considerations just noted were a set of reasons against taking on the Detroit plan. Another strong reason was the fact that the Detroit plan was clearly dominated by the United Auto Workers Union. Many people in the leadership of the Kaiser Permanente program were quite uncomfortable with the idea of becoming involved in a situation in which the United Auto Workers were such a dominant factor. Because of the nature of industry in Detroit, they were almost certain to continue to be a dominant factor.

Some of the doctors in particular were concerned that there would be intrusions into professional prerogatives and a degree of consumer activism that concerned them seriously. The combination of resource limitations, concern about, broadly speaking, major cultural differences, concern about the problems of a "one-industry town," and the dominant role of both the big auto makers and particularly the United Auto Workers Union, precluded achieving any consensus in support of that expansion.

Origin of the Kaiser Permanente Committee

Fleming: I need to check the facts, but I think at the first meeting on Detroit, the idea of the Kaiser Permanente Committee in its ultimate form began to emerge. There was consensus that the
participants should be much different from those who had attended
the physician-administrator forums. The meeting should be
limited to the key leadership of the program. By consensus this
was recognized to consist of the medical director of each medical
group, the regional manager of each region, and some key
personnel in the Central Office. At that time these included Dr.
Keene, Art Weissman, and myself. I'm not sure whether there were
any others at the outset--possibly Bob Erickson, my key
assistant. I don't think Walter Palmer was in the Central Office
at that time, and I don't believe that anyone from the financial
side was officially a member of the group, nor do I remember
whether we called it the Kaiser Permanente Committee at that
meeting. If not, we did at the subsequent meeting which was held
at the request of Edgar Kaiser. He wanted Kaiser Permanente
leadership to reconsider the Detroit decision.

Hughes: Was the Detroit business the impetus that actually got the Kai
Perm Committee off the ground?

Fleming: There were some parallel threads here. Without checking the
records, I can't say exactly how they played into what finally
happened. One of the threads was the now generally accepted need
for some kind of a central forum to deal with programwide issues.
An important part of that was dealing with the frequent requests
to provide consulting services to plans that were having trouble
or were trying to get started. A third thread was the Detroit
situation--a specific embodiment of the generalized issue of
helping plans that requested help.

Hughes: Was the committee also seen to legitimate the Kaiser Permanente
operation in regard to the banks and other financing
organizations?

Fleming: I don't really think so. The financial relationships had de
facto been centralized for historical reasons and for the very
practical reason that the program was a much more creditworthy
organization as a single program than as a collection of separate
regions. The financial relationships were really handled under
Gene Trefethen's direction. Even though the physician leaders
who objected to any centralization were not entirely comfortable
with this, it's the way things had been and there were practical
reasons for keeping it that way. So the Kaiser Permanente
Committee did not play a role with regard to the general program
financing.

It did play a vital role in another aspect, namely achieving
consensus on financing expansion, which was a difficult problem
because all of the regions were able to make good use of all of
the financial capacity that they could amass, and there was
strong resistance to diverting resources to any activities outside of the existing regions.

**Expansion Fund**

Hughes: Would you like to say something about the expansion fund? We should also talk about the role of the Henry J. Kaiser Family Foundation.

Fleming: Let me step into this by noting that even though there was no consensus supporting taking over the United Auto Workers plan in Detroit, the process of considering that plan revealed that there was considerable support for expanding "under the right circumstances." There was a missionary zeal within the program leadership. I think almost without exception the people in the leadership group felt that prepaid group practice was the best health care financing and delivery system in sight. They had something of an evangelical attitude toward expanding prepaid group practice, tempered, however, by the very real constraints of limited resources and intense demands upon those resources.

Hughes: Was there ever an either/or situation set up? The decision could have been made to expand, but to expand within the existing regions and just do it more intensively.

Fleming: Expansion within existing regions was a given. Each region wished to, and to the extent that there was any central policy on the subject, had a programwide mandate to extend services within its geographic area. That was never an issue.

Hughes: But if the money that was eventually pumped into out-of-state expansion had been turned back into the regions, expansion within the regions presumably would have occurred at a faster rate.

Fleming: Yes, no, or maybe. Money isn't the only constraint on expansion. The whole business of designing facilities, getting land, getting permits and legal clearances, and getting the construction done and so forth was in itself a significant limit on the rate of expansion--not to mention recruiting and developing human resources. In fact, our history shows that none of the proposed projects within the regions moved as rapidly as the plans called for. I say none of them did; there may be exceptions, but the general pattern was that things took longer than expected. The delays eased the financing requirements to some extent.
I think that very few people on the Kaiser Permanente Committee viewed it as a simple, straightforward matter of "either we build a hospital in Orange County or we go to Cleveland." There developed a recognition—I think I espoused and to some extent sponsored it, though I was by no means alone—that the entire program could be strengthened by expansion into other geographic areas.

One of my responsibilities was government relations. It was quite clear to me that the more widespread our political bases, the stronger the program would be in dealing with health policy issues on the national scene.

In addition, there was a challenge enunciated by the health care world east of the Rockies, along this line: "Well, your plan seems to work in California where all the nuts and flakes are, but it would never work in the eastern part of the country." The program leadership felt that the fundamentals were sound and would work anywhere given circumstances that were not too negative.

Henry J. Kaiser Family Foundation

Fleming: In addition, the program had two financial resources that were not regional. The Henry J. Kaiser Family Foundation, which of course was entirely independent and under separate management, was nonetheless, at that time, sympathetic to the expansion of the Kaiser Permanente program. The Family Foundation had provided the capital financing necessary to start up in Hawaii and to build the Bess Kaiser Hospital in Portland, Oregon, which permitted the Northwest Region to emerge from stagnation and become a vital, successful operation. They had quite substantial resources, and it was generally understood that, under the right circumstances, the Family Foundation would provide some assistance for Kaiser Permanente expansion.

Incidentally, at that time there was some overlap between the foundation trustees and the board of directors of Kaiser Foundation Health Plan and Kaiser Foundation Hospitals. There was a very businesslike sense that the trustees of the Family Foundation would not make a commitment to support Kaiser Permanente expansion unless the program itself made a commensurate commitment.

The other nonregional financial resource consisted of stock of the Henry J. Kaiser Company and later of Kaiser Industries
Corporation that had been donated to Kaiser Foundation Hospitals by members of the Kaiser family and by certain other senior Kaiser executives. These donations were stimulated by the fact that hospital organizations were eligible for larger tax-deductible contributions than were other kinds of organizations eligible for tax-deductible donations.

Because of the nature of tax law at that time, one of the most beneficial ways of utilizing Kaiser Industries stock by those persons who had acquired it early at a very low price was to give it away. A share of stock that had been purchased for, or had an adjusted acquisition cost, of ten cents could produce a $20 tax deduction, and roughly a $10 or more current saving on income taxes. Hence the Kaiser family members and key Kaiser executives who held low-cost Kaiser stock had a strong financial motive to make donations to Kaiser Foundation Hospitals as well as to the Henry J. Kaiser Family Foundation.

### Fleming:
As a result, Kaiser Foundation Hospitals had a significant amount of Kaiser Industries stock, by no means a huge amount, but an amount that was significant in relation to the estimated costs of expansion at that time.

The result was that, when we seriously considered expansion to Cleveland and to Denver, the Kaiser Permanente Committee was able to reach consensus on an expansion fund to be derived in part from the Henry J. Kaiser Family Foundation, in part by selling the Kaiser Industries stock held by Kaiser Foundation Hospitals, and in part by ongoing contributions from the established regions. We started out, as I recall, with one cent per member per month, and this gradually increased by one cent each year until it topped out at five cents per member per month. With the membership that existed in the late 1960s, this yielded about $150,000 per year to start; this amount increased rapidly to about $1.5 million per year by 1973.

**Opposition to Expansion**

Hughes: Apparently there was some opposition to expansion. You, Dr. Keene, and Mr. Weissman were very much in favor of expansion, but Dr. Keene talks in his interviews about a memorandum that he received from Edgar Kaiser in 1964, which essentially stopped the momentum gathered for expansion.
Fleming: Do you have that memo?

Hughes: I have the complete memo in the car, but here's a portion of it. Edgar Kaiser's memorandum stated: "Both Gene [Trefethen] and I recommend against any time or effort being put in on eastern areas. We do not believe it is necessary to inaugurate a health plan in the Middle West or the East for purposes of demonstrating that the plan will work in an area other than the four areas in which we are currently operating."

It's dated October 9, 1964. The way Dr. Keene expressed it, it came as a bolt out of the blue.

Fleming: Would you go get the memo? I'd like to see the whole thing.

[tape interruption]

Hughes: Mr. Fleming, do you recall why Edgar Kaiser and Gene Trefethen would have been opposed in 1964 to expansion?

Fleming: You just showed me Edgar Kaiser's memo to Keene, and a concurrence from Henry J. to Edgar in the fall of 1964. Although I am familiar with those memos, I still find it a little bit confusing because in the early 1960s and certainly until 1967 or so, I'm not aware of any serious consideration of expansion outside of the existing regions. Undoubtedly there'd been some casual conversation on the subject, and we had repeated requests from the Health Insurance Plan of Greater New York for a merger. Indeed we had sent a team there to explore the situation and make recommendations on it.

There was never any great interest within the program leadership in a merger with HIP because of a widespread perception that theirs was not a high-quality operation, the tremendous problems of their organizational structure, with more than thirty independent medical groups in the New York City metropolitan area, and the intensely politicized nature of New York state and New York City. We did hold some courtesy discussions with the HIP leaders and indeed sent a team. I believe I was a member of the team. At least I was in many of the related discussions to explore this, but it was never anything that Kaiser Permanente leadership was interested in doing.

I don't recall any serious consideration of expansion at that time, although no doubt it was something that Dr. Keene

\(^1\)See Dr. Keene's oral history, p. 91.
talked about with Trefethen and the Kaisers. I don't know what situation prompted Edgar's memo, aside from whatever his discussions with Dr. Keene might have been. The program was only beginning to get comfortable with the revised organizational and management arrangements that had emerged from the Tahoe conference. The attitude of Gene Trefethen and Edgar Kaiser and probably Henry J. was that the Kaiser organization as a totality was responsible for the borrowings of the medical program.

There was no such legal responsibility, but I believe at that time we were still borrowing primarily from the Bank of America and there was a fundamental relationship between the Kaiser organization and the Bank of America that has many interesting aspects, including very un-bankerlike things that the Bank of America had done to assist the Kaiser organization in the earlier days. It was understood that "the bank will never lose money on a Kaiser loan," and Gene was still not entirely comfortable with the assured long-term capacity of the medical program to service its indebtedness. I think that Gene's concern with financial prudence was an important factor.

In addition, the very traumatic Tahoe conference period was not far in the past; moreover, Henry J. Kaiser was personally not satisfied with the performance of the medical care program and particularly not satisfied with the outcome of the Tahoe conference which had greatly diminished if not virtually eliminated his power to direct the program anywhere except in Hawaii. There his personal presence and personal relationships gave him much influence. Realistically it was not a time to consider expansion seriously.

The only surprise to me about that memo is that there was an occasion for Edgar to issue it, because I don't think there was any serious thought, within program leadership, of eastward expansion in 1964.

With respect to Washington, D.C., I do not recall any serious proposal that would have involved establishing a program in Washington, D.C. at that time. In my position in charge of government relations, I personally advocated the view that it would be highly desirable for the program to be effectively situated in the nation's capital area. However, the Group Health Association of Washington, D.C., a pioneer prepaid group practice plan, was functioning there with at least reasonable success; at that time I would not have advocated entering that market in competition with them. It is possible that they had extended some feelers relating to a possible merger, but I do not personally recall any. My contacts with the leadership of the Group Health Association plan were probably as good as those of
practically anybody within Kaiser Permanente management, with the possible exceptions of Arthur Weissman and Avram Yedidia.

Hughes: When a few years later there was a definite move towards expansion, criteria for expansion were set up. Would you like to comment on those?

Fleming: I don't remember any specific explicit criteria until the Kaiser Permanente Committee adopted an expansion policy in the early 1980s, although I remember extensive discussion within the Kaiser Permanente Committee and undoubtedly participated in developing whatever criteria we then had. We were concerned that any expansion be solid and successful. We also needed to differentiate any expansion proposal from the Detroit situation in which the Kaiser Permanente Committee, to the displeasure of Edgar Kaiser, had declined the expansion opportunity. One thing that played into the criteria issue was the need to have some standards that answered the question: "If Cleveland, then why not Detroit?"

Support of Expansion

Hughes: Why had the climate of opinion changed to even be considering expansion to Cleveland and Denver?

Fleming: As I've indicated before, there was an evangelical element in the psyches of the Kaiser Permanente leadership.

Hughes: Among the leadership, were there individuals that were particularly anxious to propose Kaiser as a model that might be duplicated everywhere in the country?

Fleming: Of course, Henry J. himself in testimony before Congress in the 1940s and fifties had advocated prepaid group practice as a model for the country. The question is, "Among the true believers, who was the truest believer?" I think that Ernie Saward was one of the more articulate. I believe I also articulated the advantages of expansion in a persuasive way. Dr. Kay, who was, on the one hand, most strongly opposed to diverting resources from existing regions, was concurrently one of the strongest evangelists because of a keen personal belief that prepaid group practice was really the best system for doctors, patients, and the country.

I don't think anybody on the Kaiser Permanente Committee opposed the idea that prepaid group practice was the best solution, nor the idea that we were best able to implement the
Hughes: prepaid group practice concept. However, there were many pragmatists who were keenly concerned about both resource limitations and the resource needs of the existing regions. It was only, I think, through prolonged and repeated discussion of the subject, both in the formal Kaiser Permanente Committee context and also, perhaps more important, in informal discussions among people in leadership positions, that there finally did develop a consensus in favor of limited expansion under suitable circumstances.

Hughes: Do you have any comment to make on Henry Kaiser's various proposals for Kaiser as a national model, which I believe he offered as an alternative to some of the national schemes that were being put forward?

Fleming: Well, of course, organized medicine by and large regarded the Kaiser Permanente system as an abomination and as a threat to all that was holy in American medicine. I believe they were, quite correctly, never sufficiently seriously convinced of an imminent threat of "national health insurance" to believe it was timely to consider a less objectionable alternative.

Expansion to Cleveland and Denver, 1969

Hughes: Were you equally involved in both the Cleveland and Denver expansions?

Fleming: Yes, I think so. As my position was a Central Office position, I guess in a theoretical sense I had a little more involvement in Cleveland because, on a strictly informal basis, I had provided some assistance to both Ernie Saward and Avram Yedidia, who were highly instrumental in developing the Community Health Foundation in Cleveland.

I was acquainted with some of the key personnel there, particularly Gene Vayda, who was the equivalent of what we would call a medical director, and Glenn Wilson, who was what we would have called regional manager. I felt that there was importance in preventing the failure of that plan, which was one of the very few prepaid group practice plans then functioning in the country. However, I didn't hold any particular brief for Cleveland as compared with other possible expansion opportunities. I knew they were on the verge of failure and felt that their failure would be a black eye for prepaid group practice with at least some--probably not serious--residual negative implications for prepaid group practice.
With respect to Denver, the impetus for that came from some elements of academia/labor. The United Mine Workers had a regional headquarters in Denver as I recall. We had longstanding relations with the United Mine Workers through the Kabat Kaiser Institute, later the Kaiser Foundation Rehabilitation Center, (which incidentally had once had a location in Washington, D.C.), and through the Kaiser Foundation Utah Hospitals, which was a donation from United States Steel Company to Kaiser Foundation Hospitals as part of a settlement of a strike in the coal mining industry in Utah. Thus we had fairly deep and cordial relations with the United Mine Workers. Some of their personnel and supporters had been involved in a symposium in Denver relating to establishing a prepaid group practice plan in that area. That put Denver on the playing field, so to speak, as an expansion possibility.

Denver had a number of attractions. We felt that it was more western in terms of culture than Cleveland or areas east of the Mississippi, and felt that gaining receptivity for something new would probably be somewhat easier in Denver than it would have been in many of the places in what we now call the Rust Belt. The dynamics were that the Cleveland plan was approaching insolvency and was very anxious for an affiliation which they of course realized meant a takeover. There was significant sentiment in Denver, not in the business community as far as I know, but in the labor/consumer community for a prepaid group practice plan.

It would have been eminently reasonable to select one expansion target and concentrate on it. However, this ignored the tension between the two California Permanente Medical Groups. Because of size and resources the Northern California Region would logically lead an expansion effort. Essentially, when it came down to the decision point, the Southern California Permanente Medical Group would support expansion to Cleveland only if, as a tradeoff, they were awarded the leading role in the expansion of the medical component of the program into Denver.

We replayed the same record many years later when Bruce Sam's price for supporting expansion into Raleigh-Durham, North Carolina, was concurrent approval of program expansion into Atlanta, Georgia.

Hughes: If there were rumblings of dissent in the regions, were the two expansions at almost exactly the same time?

Fleming: The decision was at exactly the same time.

Hughes: And they became operational at the same time?
Fleming: No, we took over in Cleveland, effective January 1, 1969. The Denver plan became operational July 1, 1969. However the decisions were both made at the same Kaiser Permanente meeting. The reason for the different timing was that the Cleveland plan was running out of money, and that transaction needed to be concluded while the plan was still viable. A new start in Colorado was in many ways a more demanding problem. There was much more to do in Denver. There was an existing plan, and all of the essentials to function existed in Cleveland, whereas in Denver we were starting from scratch.

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Fleming: Also in Colorado there was a legal inhibition that would be resolved by the effectiveness of the Colorado professional corporation law which was enacted in the spring of 1969, but did not take effect until July 1, 1969.

Hughes: Was there indeed an outcry from the regions when the Kaiser Permanente Committee recommended expansion to Denver and Cleveland?

Fleming: There was no outcry that I heard. The outcry had occurred several years earlier, and in the intervening period there had been gradual evolution toward a consensus that limited expansion was a reasonable thing to undertake. The expansion fund, calling in resources from the Henry J. Kaiser Family Foundation and the Kaiser Industries stock held by Kaiser Foundation Hospitals as well as the regional contribution on a cents per member per month basis, had been agreed to. The medical group rank-and-file physicians were no doubt divided on the subject, and Ray Kay often said that he was for expansion but that he would have trouble "getting his guys to come along."

Nonetheless, a lot of discussion had been conducted, and a lot of people had come to see that there were advantages to expansion. The financial situation was such that the costs appeared very modest to anybody who bothered to analyze them. By this time the program was much bigger than it was in 1964. Financially it was much stronger. It was financed through a consortium of major banks and insurance companies and pension funds and so forth, and not strictly the Bank of America. The kind of financial concerns that I believe had caused Gene Trefethen and Edgar Kaiser to be negative in 1964 no longer appeared significant. All in all, the atmosphere was different. Although no doubt individual physicians and individual managers in various places in the established regions felt that this was a diversion of resources, the reality was that the diversion of resources was trivial and that those people who understood the
realities no longer regarded the resource diversion issue as being serious.

Hughes: Denver particularly represented a departure from what Ernie Saward called the genetic code. Did you ever hear him use that term? It's probably a term that he coined in retrospect.

Fleming: No, Ernie was talking about genetic code then. I don't know whether I first heard it in the 1950s, but certainly in the early 1960s. However, it's not clear to me that Denver represented a departure from the genetic code.

Hughes: One departure would be that Kaiser didn't own the hospitals. The Kaiser Permanente model was not rubber-stamped and transplanted to Denver. There was an understandable adaptation to the local situation. Was that ever an issue of discussion at the committee meetings?

Fleming: First of all, it was not feasible, for various reasons, to do what we did in Hawaii--go in and build a hospital and then open up the program. Denver was a heavily overbedded city as far as hospital beds were concerned. At that time, (I can't recall the legal specifics), there were legal constraints on hospital construction derived from the whole comprehensive health facility planning thrust. Legislation at the federal level had not yet been enacted but there were assorted hurdles to be surmounted to build a hospital. It would not have been realistic to seek approval for a hospital in Denver. Moreover, building and running a hospital is a very expensive activity. It would have been economic nonsense to establish a hospital in Denver before building up a membership base sufficient to support it. In addition, we were going into Denver with a group of established, highly respected Denver physicians who had appropriate hospital staff privileges. Our forerunner and presumptive regional manager for Denver, John Boardman, was skilled and knowledgeable regarding hospital relations. We were in fact able to work out satisfactory hospital relationships at existing hospitals. If our Denver effort had depended upon establishing a hospital at the outset, it would never have been accomplished.

Hughes: Can you explain the appeal of what in Denver certainly was an untried system, namely the Kaiser Permanente system, to a group of established doctors?

Fleming: I guess the easiest way to explain it is that Dr. Raymond Kay was a very persuasive evangelist. The doctors there understood the problems of traditional fee-for-service practice. I think that
Hughes: Do you remember any opposition from the local medical societies in either Cleveland or Denver to the entrance of Kaiser?

Fleming: In Cleveland, of course, we were taking over an established plan. While I was not on the scene, I don't recall any particular problems. The prevailing attitude, I believe, among physicians in the traditional practice community who even had an attitude on the subject was that if Cleveland was going to have a prepaid group practice plan here, better it be Kaiser with an established reputation, know-how, and a good degree of professional respect, than a plan with less sophisticated and respected leadership.

As far as Denver is concerned, there was resistance relating to hospital privileges. On the other hand, the hospitals felt that they didn't have a solid basis for denying privileges, and we, of course, did have the core group of established and respected Denver physicians who had their hospital privileges.

The initial problem there was that we could only use one or possibly two hospitals. We actually ended up using the Children's Hospital as well as our main hospital, but there were four hospitals in the downtown hospital group in Denver. They told John Boardman and Bill Reimers, the medical director, that you've got to get all four; no one of this group of four is going to be the one that opens the door. We know you're not going to use all four hospitals, but you've got to make peace with all four hospitals before you can expect to be welcome at any one of them. It was a peculiar "After you, Alphonse" situation. Nonetheless it represented an obstacle that Reimers and Boardman successfully overcame.

It's quite clear that many of the traditional practitioners -- probably most of them -- did not welcome the program, but overt activities like boycott attempts, et cetera, did not, to my knowledge, occur. If they occurred it was at such a low-key
level that it never became an issue for attention from the Central Office.

[tape interruption]

Hughes: Mr. Fleming, as you are in a very good position to know, that was certainly not the end of expansion. Could you summarize what happened from Denver and Cleveland on?

Fleming: A lot of things happened. I'll try to give you the highlights as I see them. First, digesting the Denver and Cleveland expansions was a sizable undertaking, and the financial requirements, as is often the case, were greater than had been projected, although by no means enough greater to challenge the fundamentals of expansion financing.

Incidentally, as I recall, the decisions on expanding into Cleveland and Denver occurred when I was the chairman of the Kaiser Permanente Committee. Although the chairman is just one member of the committee, there is a little bit of subtle influence. I was certainly one of the strong pro-expansion voices.

During the digestion period--Cleveland and Denver both opened in 1969, and they were moving along in '70 and '71--in the middle of 1971, I got tapped by recruiters for Elliot Richardson to take a position in the Department of Health, Education, and Welfare. I took a leave of absence to accept this position commencing in September of '71. It happened that in August '71, Nixon announced his notorious wage-price controls. If I had known that was going to happen before becoming committed to go to HEW, I would not have gone. My situation then I've described as being in a fur-lined rut. I had a good government relations department, and a good legal department. The initial expansion decisions had been made and were under way, and I felt that I was not doing as much as I could be doing because things in my part of the organization were running very smoothly.

Hence I was willing to take a leave of absence, and except for the wage-price control matter, there wouldn't have been any special problems.

In any event, I was in Washington, D.C. from the end of August of 1971 until the end of June 1973, so there's a little hiatus in my direct personal knowledge, but I'm pretty clear on what happened. First there was the digestion of the Denver and Cleveland expansions. Then the problems of wage and price controls really became all-consuming for many people in the program and particularly the Central Office, which bore the brunt
of those activities. There was less time and energy to devote to things like expansion. In addition, the HMO Act, enacted in 1973, would stimulate a lot of development of prepaid group practice and other HMOs.

The consensus within the Kaiser Permanente Committee was that direct expansion should be discontinued and that the Kaiser Permanente organization should expend its evangelical zeal by providing consultation to other sponsors that were willing to undertake development of prepaid group practice plans. We had a shell organization that provided the basis for what became Kaiser Permanente Advisory Services (KPAS). KPAS was explicitly on an evangelical mission--namely to identify potential strong sponsors for prepaid group practice and to encourage them and assist them in establishing such plans.

Expansion to Texas, 1979

Fleming: The posture remained this way until late in the 1970s--I can get exact dates but I don't have them in mind--when as an offshoot of Kaiser Permanente Advisory Services activities, Prudential Insurance Company approached the program and suggested a joint venture in Dallas, Texas. We would provide the "know-how," they would provide financing, and we would jointly establish a prepaid group practice plan in the Dallas area. This started out in June of 1979, as the Kaiser Prudential Health Plan.

In a sense this represented a transition between the "no direct expansion but assist others" philosophy and the later return to direct expansion. Although Kaiser Prudential Health Plan developed more or less as expected, the partnership was not entirely comfortable. There was never animosity or outright friction, but they were two different strong organizations with different philosophies. In a few years--1982 as I recall--Prudential decided to relinquish its interests so that operation became the Texas Region of the Kaiser Permanente Program.

This was also the period in which the competitive forces contemplated by the HMO Act began to become significant. In addition, there was a heavy shift from nonprofit sponsorship to profit-oriented sponsorship of "health maintenance organizations"--a term that Kaiser Permanente has never been happy with. At any rate, some members of the Kaiser Permanente Committee became concerned that "we were educating the competition." They felt that Kaiser Permanente Advisory Services should discontinue its evangelism and devote its attention to
program-oriented activities with the door being open to continue providing assistance to plans that we were philosophically comfortable with. Potential candidates were not explicitly restricted to nonprofit plans but certainly did not encompass the wheeler-dealers like Maxicare.

We need to double back a little. When I finished my HEW tour in the summer of 1973, there was something of a management vacuum in the Oregon Region which we now call the Northwest Region. Ernie Saward had left in 1970, and the successor to him as medical director, although a wonderful person, was not a strong leader. The regional manager also did not offer much in the way of leadership, so the program there was deteriorating. When my leave of absence to HEW ended, Jim Vohs asked me to assume the position of regional manager in the Northwest Region, which I did, and was there until the end of 1976.

Hughes: Why did Mr. Vohs choose you?

Fleming: There weren't many obvious candidates available. In addition, while I had been on leave of absence, my former position as head of government relations and legal affairs had been very competently filled by Bob Erickson, and there was certainly some question of exactly what kind of a role I should assume. Thus the combination of a key position that Jim felt I could fill--not a vacancy, but a situation and a need--and the problem of finding a suitable position for me combined to cause Jim to ask me to assume that position.

I was delighted to do so even though my wife and I had intended and still intended to return to our home in Berkeley. I mention this because of the period when I was not with the organization, and another period when I was a member of the Kaiser Permanente Committee but was not in the Central Office. I devoted my attention primarily to managing the Oregon Region and not to the general subject of expansion policy.

Hughes: Can we come back at a later date to Oregon because I think you want to say a little bit more about it. But let's continue with expansion.

Fleming: We can come back there at some point.

At any rate, the attitude within the Kaiser Permanente Committee shifted away from assisting other plans, and there was a broad consensus that geographical expansion was a good idea. We were seeing a number of what claimed to be national plans such as Cigna and Maxicare. Within Kaiser Permanente leadership, there was wider recognition of the advantages, from a marketing
viewpoint as well as a government relations viewpoint, of being able to cover more of the nation's geography.

So two things happened more or less concurrently. The Kaiser Permanente Committee commenced to think about expansion policy and another key expansion opportunity arose.

Expansion to Washington, D.C., 1980

Fleming: In 1980, the Georgetown University Community Health Plan in Washington, D.C. was approaching insolvency. In fact, they were insolvent but didn't know it.

I should digress briefly to an unusual circumstance: I was doing some things to support our government relations activities and was on a national Chamber of Commerce committee relating to health care. I often visited Washington in that connection. A staff man for the Chamber of Commerce working with the Chamber's Health Care Committee happened to live next door to Dean John Henry of Georgetown University, who was on the board of directors of the Georgetown University Community Health Plan. This Chamber of Commerce man, whose name I forget at the moment, had heard rumors about the financial difficulties of the Georgetown plan and talked to me about it.

I made a few discreet inquiries, and emerged with the conviction that they were dead but hadn't yet fallen down. When I told this to the Chamber of Commerce associate, he asked me to meet with Dean John Henry, which I did. Dean John Henry was astounded at the information that I provided. The management of that plan really did not fully understand the situation and I believe they had not been particularly candid with the board.

It happened that Alain Enthoven, a consultant to Kaiser Permanente, was or had been on the Board of Trustees of Georgetown University and was a close friend of Dean McNulty, who was the chief executive of the university. Alain Enthoven was highly instrumental in creating the climate that led Georgetown University to request that Kaiser Permanente take over the Georgetown University Community Health Plan, which we did.

This was in line with our evolving expansion policy which, among other things, emphasized expansion to areas with national significance as well as to areas that would provide geographical diversification. We wanted to be represented in the major geographical areas of the country, and accomplished this with our
moves into New England, and into the Research Triangle area in North Carolina, and Atlanta, Georgia. Another of our geographical targets was "the Midwest," which Easterners think includes Cleveland but which Westerners think runs from eastern Colorado to about Chicago.

Rejection of Expansion to Chicago

Fleming: One additional digression: in the spring just preceding our takeover of the Georgetown plan—that is, in 1980—we also were approached by the Northcare plan in Chicago, Illinois. Northcare was one of two reasonably successful prepaid group practice plans in Chicago. Their approach to us was not motivated by financial distress because they were financially successful. Rather, the motivation was that they did not have the capital nor foreseeable means of generating the capital that would be necessary to cover the Chicago area effectively. They felt that a vital opportunity was slipping away as other plans developed in various parts of the Chicago area and they were constrained from doing the kind of geographical expansion that they believed to be appropriate and necessary to assure a solid, long-term place in the Chicago market.

The consideration of this opportunity—at a special meeting or maybe even an informal meeting of the Kaiser Permanente Committee—was heavily influenced by Dr. Sam Packer, who had been and then was the medical director of the Cleveland Plan. Sam was one of the few members—indeed, perhaps the only member of the Kaiser Permanente Committee—who then held a generally negative view toward expansion. I said earlier that nobody did; I'd forgotten about Packer. He may not have been against expansion in principle. However he could find something wrong with every place we considered expanding to.

He was then the senior medical director in terms of length of service, and as such perhaps more influential on the Kaiser Permanente Committee than the weight of the Ohio Region would indicate. In addition, of all the areas in which we operated, Cleveland was certainly more like Chicago than any of the others, so Packer had some basis for claiming a degree of expertise about the problems of industrial areas in the Midwest.

Packer was against taking on the Chicago plan. The pro-expansion forces within the Kaiser Permanente Committee could almost certainly have overcome Packer's resistance. However, we also knew or strongly suspected that the Georgetown plan was in
the process of becoming available. Even though we could have prevailed on the Chicago issue, that would have, to some extent, jeopardized the Georgetown prospect, which we deemed to be more important, essentially for politically related reasons. Accordingly, and quite reluctantly, the pro-expansion faction deferred to Sam Packer's negative attitude, and we forwent the opportunity to move into Chicago.

I say "opportunity." Even though Chicago would have been almost a bottomless pit for money, it was also a situation which was capable of generating revenue sufficient to service the indebtedness that would be required to meet the facility needs. It could, in my estimation, have been a highly successful, vitally important, and in large measure a self-financing expansion. Nonetheless, we chose to forgo that opportunity because we deemed the situation in the nation's capital to be more important.

Hughes: That was a good summary. Do you want to move on to the program policy committee?

Fleming: Let me just say one more thing about expansion. While we were making these expansion decisions, we were also developing an expansion policy document, which captures the views of the Kaiser Permanente Committee on this subject.

I was the primary draftsman of the document, but that doesn't mean it primarily reflects my ideas. I was being an honest draftsman and trying to articulate the views expressed by all members of the committee, of whom I was one.¹

Hughes: What year was that?

Fleming: We worked on it in 1981 and 1982; it was officially approved in 1983. I think it's an appendix in the program history.²

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¹See Statement of Expansion Policy of the Kaiser Permanente Medical Care Program in Appendix, p. 206.

Hughes: Mr. Fleming, the Kaiser Permanente Committee established the Program Policy Committee. Why was it thought necessary to form this subcommittee?

Fleming: Conceptually, the Program Policy Committee was an executive committee of the Kaiser Permanente Committee. What led to establishment of the Program Policy Committee was a feeling among a number of people, and particularly among the medical directors and regional managers of the big California regions, that the Kaiser Permanente Committee was becoming too big, that it was cumbersome, that it took too long to make decisions and that too much time was spent in fruitless palaver. I think there was also a little resentment that the Kaiser Permanente Committee was in a formal sense a committee of equals, and yet the medical director from northern California with three thousand physicians and 2.5 million Health Plan members had a voice equal to the medical director in Kansas City with seventy-five physicians and eighty thousand Health Plan members or something of that sort.

So at some point—that will appear in the Kaiser Permanente Committee minutes—a subcommittee was appointed, chaired by Carl Berner, now deceased, who was then the regional manager of the Southern California Region. The subcommittee was to deal with the problems of the unwieldy nature of the Kaiser Permanente Committee. I guess I was a skeptic because I believed that unwieldiness was one of its big advantages. It was slow to make decisions, but at the decision-making level we're talking about, quick decisions are rarely necessary. Moreover, when a quick decision was necessary, such as the decision to take over the Georgetown Community Health Plan, the Kaiser Permanente Committee was perfectly capable of making a quick decision. But many people were less patient with a fairly inefficient, deliberative forum. Thus the subcommittee had the opportunity to find a less frustrating way of functioning.

One step along the way was an attempt to define "consensus." I referred several times to consensus in connection with Kaiser Permanente Committee activities. Like pornography, you know it when you see it, but it's very difficult to define. For example, even though the committee is, in a formal sense, a forum of equals, all members understand that the medical directors and the regional managers of the big regions are more equal than others. I think that there was an informal weighting of the "votes," of a nature that really worked quite well. For example, I think it was clear to everybody on the committee that we could have a consensus if the only dissenters were the medical director from
Kansas City and the regional manager from Texas, for example. On the other hand, we couldn't have a consensus if the objector was a medical director or regional manager from one of the California regions.

So it was a touch-feely kind of thing. The chairpersons of the Kaiser Permanente Committee were usually quite successful in concluding either "I guess we have a consensus on this" and pausing to see whether anyone would object or, on the other hand, saying, "It does not appear that we are reaching a consensus on this." We had a system that worked, but it wasn't neat. Some people sought a greater degree of neatness. The effort to define consensus was almost laughable, but it led to the decision that there should be a smaller decision-making group.

The result was establishment of the Program Policy Committee, which, as I recall—and I'd have to check the records to be sure—consisted of roughly one-third of the members of the total Kaiser Permanente Committee. It specifically included the regional managers and medical directors of the two California regions as permanent members—just like permanent members of the United Nations Security Council. Jim Vohs and the executive vice president from the Central Office were also permanent members. An equal number of other members were selected, three by the medical directors, and three by the Health Plan.

The Program Policy Committee was to become the actual decision-making body in any cases in which there was not a clear consensus within the Kaiser Permanente Committee as a whole. The Program Policy Committee functioned for two or three years, but the result, which some of us did not find surprising, was that it stultified the activities of the Kaiser Permanente Committee as a whole.

Particularly on controversial issues, the sentiment on the part of many members of the Kaiser Permanente Committee, not including myself, was that there was no reason to speak out and potentially irritate somebody or somehow or other lose political points when the decision would be made by the Program Policy Committee anyway. So there was just a general diminution of meaningful participation by those members of the Kaiser Permanente Committee who were not also members of the Program Policy Committee. Moreover, the Program Policy Committee members themselves did not speak out candidly in Kaiser Permanente Committee meetings because they could just as well hold their fire until they met as the Program Policy Committee, "where it really counted." The result, as became increasingly apparent, was to negate much of the value of the Kaiser Permanente Committee. In due course recognition of this was sufficiently
widespread that the Program Policy Committee decided to self-destruct and formalized this decision in May, 1988.

Kaiser Foundation International

Hughes: Let's go on to Kaiser Foundation International.

Fleming: Okay.

Hughes: Why was it formed in 1964?

Fleming: In the earlier days, the medical program was part of the "Kaiser Family of companies," at least in the perception of Henry J. Kaiser and Edgar Kaiser and the senior Kaiser executives, although the Permanente medical groups did not share that perception and indeed took strong exception to it. But it was natural that, when the Kaiser industrial organizations had need for medical services, they would look to the Kaiser Permanente Medical Care Program. This was generally handled in an informal way with no particular problem.

I should enter a qualification here. In the late 1950s, the government relations component of the medical program, which I then headed, had obtained an amendment to certain legislation that permitted the Kaiser industrial companies to establish an employees' medical service facility. This was a complicated technical issue that I won't develop except to say that for a multi-employer group of companies to have done this would not have been permitted under the law prior to the amendment, and the California Medical Association chose to oppose the amendment for reasons obscure but probably related to their paranoia about anything related to Kaiser.

In any event, we overcame their resistance, got the amendment, and established a medical facility in the Kaiser Center that provided employee physical examinations, employee medical services of a minor nature for on-the-job problems, and especially medical support for the international activities of the Kaiser companies. The latter had extensive international activities and needed both the preparatory immunizations, the medications needed on site in various locations in South America, Africa, and Asia, et cetera, and also guidance on obtaining medical services in these remote areas.

So the Kaiser Employees' Clinic did the routine support for the overseas activities of the Kaiser industrial companies, but
occasionally things of greater magnitude came up, and on an informal basis they borrowed assistance from the medical program, as far as I know, paying in an appropriate way. But nonetheless, when major projects were in the offing, it appeared that something more formal was needed.

The immediate occasion for activating Kaiser Foundation International was the Bandama Dam on the Volta River in Ghana.

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Fleming: Kaiser Engineers was undertaking a major construction project in Africa, and the Kaiser Aluminum and Chemical Company was going to follow with an aluminum reduction plant and major aluminum extraction and fabrication facilities. We had an inactive corporation on the shelf. I believe it was a corporation that had been formed when Mr. Kaiser first decided he wanted to establish the medical program in Hawaii but it had never been utilized for that purpose. We renamed it Kaiser Foundation International, and set it up to establish a medical care facility in Ghana to support the Volta River Project and the related aluminum project.

Other activities included some in South America in connection with the Kaiser Motors operations in Argentina and Brazil, and a number of consulting and small logistical support activities for other Kaiser overseas operations. Kaiser Foundation International spread out a little bit to undertake some projects for the U.S. Agency for International Development, one of the major ones of which was the restoration and continuing operation of a war-devastated hospital at Port Harcourt on the Ivory Coast.

Kaiser Foundation International was entirely separate and distinct from the remainder of the Kaiser Permanente Medical Care Program, except that occasionally it borrowed and paid the compensation of medical program personnel who were particularly needed for some specific overseas activity. Its activities ranged from logistical support for Kaiser overseas activities to consulting services for a number of foreign governments and organizations that were interested in some aspect of medical services, including a number that envisioned establishing group practice prepayment plans. Consulting clients included, for example, the Archdiocese of Taiwan, which was interested in a prepaid group practice plan there; the government of the Bahaman Islands; some countries in the Middle East; on one project, I believe Turkey, though I'm not sure. But it was fairly widespread activity.
The only one of these that I was personally involved in, except to a very minor advisory extent, was an invitation in 1968 from the government of Peru to advise on their hospital system for obreros—that is, for the blue-collar workers. Peru had a health care system that was marvelous to behold, with separate systems for the blue-collar workers, the white-collar workers, the indigent, the military, and the expatriates, and maybe a couple more that I can’t recall at the moment.

Hughes: All operating independently?

Fleming: Yes. All operating independently and often counter-productively.

We were engaged with the idea that the medical aspect of the Peruvian social security system for the obreros might be converted into something analogous to a prepaid group practice plan or at least that its efficiency could be markedly improved. A group of us, including Felix Day, the regional hospital administrator in northern California, Ernie Saward from the Northwest, Walter Reddell, a Kaiser Foundation International employee whose mission was to generate business in Latin America where he had good political connections and cultural knowledge, and myself. I think there were only the four of us.

At any rate, we studied the obreros' hospital system, came back and wrote a report which led to a request for long-term consultation. We were gearing up to provide this and recruiting personnel within the program who would be willing to commit extended periods—we were looking at a three- to five-year project to reconstruct the obreros' hospital system. Then there was a not-infrequent coup and the incoming Peruvian government would have nothing to do with anything that had been supported by the outgoing Peruvian government, so that project came to an early end.

At any rate, Kaiser Foundation International, though a very small and modest organization, achieved some significant accomplishments, including a role in establishing a prepaid group practice plan in Cordoba, Argentina, that, to the best of my knowledge, is still functioning. However, it was beginning to draw, to what some people regarded as an inappropriate degree, on resources in the Kaiser Permanente program and particularly the Central Office.

Hughes: Do you mean human resources?

Fleming: Yes. It had been entirely self-sufficient financially, and I don't really think that the human resource demands were much of a problem, but they were perceived by some people to be a problem.
But the nail in the coffin occurred when Kaiser Foundation International undertook, in partnership with an influential figure in Saudi Arabia, to establish a prepaid group practice plan to serve the expatriates working in an area known, I believe, as Al Kobahr or some such, where there was a major petrochemical complex. Many U.S. companies and companies from other parts of the Western world had sizable work forces on site and relied for any major medical care on transporting their personnel to Europe or the United States. The Kaiser Foundation International management and the Saudi partner believed that this was a prime opportunity both to establish additional KFI activity, to provide an important service, and to introduce a useful idea to Saudi Arabia.

Unfortunately, there were major cultural and legal problems, and the effort was sinking into a morass that threatened to become quite expensive, so the decision was made to terminate that project and to discontinue the activities of Kaiser Foundation International. It was perceived to be a drain on resources and not to be providing services that the recipients could not obtain from commercial consulting organizations, et cetera.

Hughes: Who had those perceptions?

Fleming: I guess it's more complicated than that. I think that in general, the members of the Kaiser Permanente Committee weren't particularly well informed about it, weren't interested in it, and didn't see why they should be concerned with it. Jim Vohs in particular was concerned about the financial exposure that was threatened in the Saudi Arabia situation. Although there were, at least as I recall, funds available that were not generated by the regions sufficient to extricate the program from Saudi Arabia in a graceful manner, there was the potential of other involvements that could have entailed financial commitments that the Kaiser Permanente regions would probably not have been inclined to support.

Hughes: In 1974 Henry Meade Kaiser became CEO of KFI. Was that a titular position?

Fleming: Oh, by no means. It was a full-time job. Edgar Kaiser was attempting to find an appropriate position for Henry Meade within the Kaiser organization. At one point, there was some consideration given to sending Henry Meade to the Northwest Region to become assistant regional manager while I was the regional manager. This would have given him an introduction to a real management responsibility within the Kaiser Permanente
Program, so that he would be a logical candidate for other higher-level management positions.

However, for reasons that were never clearly explained to me, Henry Meade or Edgar or both decided that was not an appropriate position. Instead Henry Meade was given responsibility for Kaiser Foundation International, and concurrently Kaiser Foundation International acquired greater importance and received more attention. Although I'm not familiar with the details, in part because I was in the Northwest Region at that time rather than in the Central Office, my impression is that Henry Meade worked very energetically in an effort to develop enough business to make Kaiser Foundation International an organization worthy of his commitment. However, he was not able to generate that kind of business and in due course he parted and pursued his career in the investment field independently of the Kaiser organization.

Hughes: And died an early death, is that not true?

Fleming: No. You're talking about Henry Kaiser, Jr. That's Henry J.'s second son, who was afflicted with multiple sclerosis. But Henry Meade was Edgar Kaiser's second son, and he's very much alive and is conducting a venture capital business in the Bay Area with an office in San Francisco.

Hughes: All right. Well, is that enough on the KFI?

Fleming: That's enough.

Hughes: Very good.

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Hughes: Mr. Fleming, please tell me when and why the Legal and Governmental Relations Department was established.

Fleming: They both came about in response to fairly immediate and pressing needs. Prior to the Tahoe conference and related activities, the law firm of Thelen, Marrin, Johnson, and Bridges in San Francisco had done all of the legal work for the medical program. A slightly related firm, Stanton and Johnson, had done most of the medical program's government relations work, although some had been done by internal resources within the Kaiser Industries complex.

Gardiner Johnson of Stanton and Johnson was the brother of Gordon Johnson, who was the Johnson in Thelen, Marrin, Johnson, and Bridges.

When I started to do some work for the medical program as assistant to Bill Marks,¹ (who was the secretary of the medical care organizations as well as all of the Kaiser-affiliated companies), Marks directed me explicitly to limit my activities to the duties of the corporate secretary's office and not to do legal work. He had a "treaty" with Thelen, Marrin, Johnson, and Bridges to the effect that the Kaiser Industries legal personnel would not intrude into legal work for the medical program.

However, this changed by force of circumstance in the Tahoe conference period, when, as mentioned earlier, I got loaned to

¹Head of the Henry J. Kaiser Company Legal Department.
the medical program to work on resolution of the impasse between the Kaiser people and the Permanente physicians. Although this was a limited-purpose and limited-term assignment, the fact that I was an attorney and was conveniently available naturally led to questions that involved me more and more in legal work for the medical program in addition to that specifically concerned with the impasse problem. Problems requiring legal consideration seemed to increase fairly rapidly--perhaps because I was conveniently available.

Moreover, I enjoyed good relations with the attorneys in the Thelen, Marrin firm; the switch in emphasis from outside counsel to internal counsel occurred gradually in response to circumstances and never created a fracas between Bill Marks and the management of the Thelen, Marrin, Johnson firm.

The way it worked is that I, together with my secretary, Vivian Kocher, a long-time, outstanding employee, became de facto the legal department. Of course I relied on Thelen, Marrin both in San Francisco and in their Los Angeles office for much of the organization's legal work, because I certainly couldn't do it all. We also had a leading law firm in Portland, Oregon, for what we now call the Northwest Region.

**Representation in Sacramento**

Fleming: In 1957, at the time when the most urgent impasse resolution work had been fairly well completed, we had a critical legislative problem in Sacramento. A legislative proposal sponsored by the California Dental Association--at least overtly--would have rendered prepaid group practice illegal in California. (The proposal was supported and indeed largely managed by the California Medical Association.)

As commonly happens, the people handling legal work for an organization are at the forefront of government relations activities. I concluded that we needed direct representation in Sacramento. Because we had two California regions and needed to speak with a single voice in Sacramento, this activity needed to be centralized. I obtained internal approval and borrowed Gibson Kingren, who was a health plan representative in northern California. I had his services on what was theoretically a half-time basis, which meant full-time in Sacramento when needed.
Fleming: Gibson proved to be a very effective lobbyist. We successfully opposed the measure that would have made the Kaiser Permanente operation illegal.

Hughes: You mean the whole Kaiser medical operation?

Fleming: The proposed legislation would have made Kaiser Foundation Health Plan, the group practice prepayment system, and the relationship with the Permanente Medical Groups illegal.

Hughes: In what way?

Fleming: I don't recall the technicalities. For one thing it would have prohibited a "closed panel"--the requirement that persons enrolled obtain services from designated physicians (i.e., physicians in the Permanente Medical Groups) except for emergency and urgent out-of-area services. There were other provisions incompatible with prepaid group practice.

The legality of prepaid group practice had been challenged initially by the San Diego County Medical Society in the litigation known as the Complete Service Bureau case—Complete Service Bureau vs. San Diego County Medical Society. That case, which was decided in the California Supreme Court in about 1954 or '55, as I recall, rejected medical society contentions that the Complete Service Bureau, which was a prepaid group practice program, was violating the California Medical Practice Act and was also violating the legislation authorizing the Blue Shield and Blue Cross plans. The Kaiser Permanente program, through Thelen, Marrin et al., filed an amicus curiae brief supporting the San Diego Health Association.

The California Supreme Court rejected the contentions that this operation violated the Medical Practice Act and also concluded that if the Blue Shield enabling act were interpreted to be exclusive, there would be serious questions of its constitutionality under the California constitution. Therefore, the California Supreme Court decided that alternative methods of organizing prepaid medical care were permissible.

The California Dental Association's 1957 legislative proposal would have undone the California Supreme Court decision in the Complete Service Bureau case and would have rendered prepaid group practice illegal. Actually, we had a tenuous theory that operation as a nonprofit trust would have been permissible, but this theory only covered part of the problem. The Health Plan had not previously been incorporated because of legalistic and I believe not well-founded notions that the trust form would be a defense against charges of "the corporate
practice of medicine." This proposed legislation clearly posed a major threat.

My concern about handling this legislative challenge arose because Stanton and Johnson, the law firm I mentioned before (which in reality was more a government relations firm than a law firm) had traction primarily with the conservatives in the senate. They were quite effective at blocking legislation. However, Stanton and Johnson's key legislative contacts were essentially the same as key legislative contacts of the California Medical Association and the California Dental Association. I felt that we really needed to derive our legislative strength on the prepaid group practice issue from entirely different sources.

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Fleming: Gibson Kingren quickly "learned the ropes," developing a key legislative contact that he knew (George Miller, Sr. from the northeast Bay Area) and building a coalition of predominantly liberal-thinking people, organized labor, and some people from academia who contacted their legislative representatives and urged support for our position on the pending legislation.

There were actually two other bills of interest but the CDA-sponsored bill was absolutely crucial. The outcome was a decisive win for our side with the dental association (and the medical association working behind the scenes) unable even to get their bill voted out of the first committee.

It just happened that the three bills of interest to us came up for hearing in their initial committees on three successive weeks, and we were successful three times in a row. This was an unprecedented and devastating experience for the California Medical Association, which had been accustomed to calling the shots on health-related legislation in Sacramento.

After the third committee hearing, Hap Hassard--a great name for an attorney (Howard Hassard of the law firm Peart, Barraty and Hassard, which represented the California Medical Association)--phoned me.¹ Hap suggested that we should have lunch, to which I readily agreed. His agenda at the lunch was to attempt to forestall continuing confrontation between Kaiser

Permanente and the CMA in the legislature. He argued that we had many interests in common and should not be fighting. I assured him that I had no desire to fight with the CMA but had been dealing with a situation which I felt required strong and effective representation of our viewpoint.

The net of it was a kind of gentlemen's agreement, if such a sexist term is permissible, under which we agreed that we would discuss our differences informally and attempt to reach mutually acceptable compromises. If we needed to take issues before the legislative committees, we would do so only after mutual discussion, sincere efforts to reconcile our viewpoints, and forthright presentation of our respective views rather than typical legislative gaming tactics. This understanding held as long as I continued major involvement in Kaiser Permanente government relations and, to the best of my knowledge, it holds to the present under the guidance of my successor, Bob Erickson.

Hughes: Did Gibson Kingren have previous ties with Sacramento?

Fleming: No. By original profession Gibson Kingren was a teacher. He had been a Health Plan representative for many years. He had absolutely no prior lobbying experience. But he was a highly intelligent, hard-working person who had an outstanding capacity for getting along with people and being highly persuasive in a low-key way.

Hughes: You were the one that spotted him and thought he would be good for the job?

Fleming: Gibson Kingren was the most promising person that I could locate within the Health Plan in northern California, which was my only practical place to look for someone on short notice. Although it was a matter of expediency, it proved to be an excellent selection. Gibson Kingren later became our representative in Washington, D.C., and had a highly successful career which ended with his mandatory retirement (due to age) from the Kaiser Permanente program. He's continued to work as a highly successful lobbyist for other organizations, notably the Blue Shield program.

Hughes: Would you characterize the forces that he rallied to Kaiser's support?

Fleming: Broadly speaking, the Health Plan's appeal was to the liberal side of the political spectrum. More specifically, the program had very good friends and good connections with organized labor,
which was one of the places where Gibson naturally sought support. We also had support from, broadly speaking, academia. Thus, Gibson was able to garner support from the liberal/labor/academic portion of the political spectrum. Over time, he also made many key political contacts and developed strong support for our positions.

Hughes: Did your improved relationship with the California Medical Association in legislative matters "trickle down" to affect the animosity that was rife in certain county medical societies?

Fleming: I don't think that our understanding at the legislative representation level with the California Medical Association was very important as far as local county medical societies were concerned. That problem was handled quite skillfully by the Permanente Medical Groups which worked successfully through a variety of professional and medical society-related activities to achieve an accommodation with the county medical societies. This proceeded quite rapidly in the major urban counties but was much slower, and probably not yet fully achieved in some rural counties.

Program Relationships with Medical Societies ##

Hughes: Were you ever asked to give legal advice regarding problems between PMG physicians and county medical societies?

Fleming: I was called upon, as far as California is concerned, more in a public relations than in a legal way. I helped to write rebuttals to some ill-founded charges by some physicians and some of the county medical societies, et cetera. I also provided some advice on issues relating to medical ethics. The code of ethics of the American Medical Association at that time was a document that mixed what would normally be called ethical considerations with elements aimed at maintaining the traditional economic situation in the practice of medicine. Indeed, there were antitrust issues implicit in certain provisions of the code of ethics of the American Medical Association. For that and other reasons, it has been extensively revised at least twice since the middle and late 1950s--the period we're talking about.

I also had an interesting medical society encounter in the Oregon Region which I will discuss when we get to that topic.

Probably the most significant single event in improving medical society relationships was the Larson Commission Report
that I think I referred to earlier. This was the report of a commission established by the American Medical Association to investigate the implications of assorted third-party payment systems. Among these were "miscellaneous and unclassified plans" which included prepaid group practice. The Larson Commission, under excellent chairmanship, did a conscientious, objective investigation, including on-site investigation of at least The Permanente Medical Group and, I believe, the other two Permanente Medical Groups as well as other prepayment plans. The Larson Commission concluded that prepaid group practice did not produce lower-quality medical care and was indeed a professionally acceptable mode of practice.

Hughes: Did that report indeed make a real impact?

Fleming: Well, this was an internal document of the American Medical Association, and its impact was primarily within the American Medical Association. I suggest two main influences: it either greatly lessened the hostility of the more thoughtful components of organized medicine or, if you are a little more cynical, it gave medical association leaders a graceful way to withdraw from a confrontation that they increasingly perceived that they were not going to win.

However, as I've indicated, this reconciliation with organized medicine was evident in the more populous urban areas and much less so in the surrounding less-populated counties. In fact, the Northwest Permanente Medical Group encountered considerable overt hostility when the operations of the medical program were expanded into the Kelso-Longview area in Washington and into the Salem area in Oregon. We have also encountered quite significant hostility in some of the newer regions where the program is neither well known nor well established.

The underlying fact is that prepaid group practice is an economic threat to traditional practice and is resented and resisted in those situations in which the physicians involved feel that it may be rewarding to resist. So far, they have not achieved any significant success, but they have achieved some minor successes relating, for example, to keeping Kaiser Permanente from using particular hospitals, which the physicians involved probably regard as worthwhile.
Fleming: I've mentally classified this portion of the oral history as something like "Kaiser Permanente and Public Policy" because I think the Kaiser Permanente involvement in public policy related to health care has been a significant and important story. To double back to more or less the beginning, government relations, then handled by the Kaiser Industries organization, had been vitally important during World War II. For example, Mr. A. B. Ordway, for whom the headquarters building of the Kaiser Permanente program is named, had obtained a directive from Franklin D. Roosevelt exempting Dr. Garfield from military service and actually getting him out of the army. Garfield held a lieutenant's commission or captain's commission as a medical officer and was on the point of active duty. However, because of Garfield's importance to medical care in the shipyards and elsewhere in the Kaiser Industries war effort, Roosevelt willingly approved his release from service.

After the war, Mr. Kaiser had testified a number of times before congressional committees urging government intervention to establish prepaid group practice plans throughout the United States. He had received a lot of attention and a lot of publicity, but, in terms of changing government policy, his effort had no discernible effect. As far as the medical care program was concerned, the government relations function became quiescent and purely defensive from the late forties through the Tahoe conference period. However, the California events I just mentioned emphasized the importance of having some government relations capability specific to the medical care program rather than being a side issue for the government relations personnel representing Kaiser Industries and affiliated companies.

Hughes: Was there an event that made it obvious that some formal representation of the medical plan was necessary?

Fleming: The threat to the legality of prepaid group practice that I just discussed was the event. However, the degree of legislative activity affecting the health care field commenced to accelerate very rapidly. This is a rather specialized field, with legislative proposals involving a group of interests that the Kaiser industrial companies rarely dealt with. It was just sensible to have some capability that specifically focused on the kind of issues that concerned the Kaiser Permanente program.
The Federal Employees Health Benefits Program, 1959

Fleming: The next major development, and it was a major development, occurred in 1959 when the Eisenhower administration decided that the time had come for the federal government to provide health care coverage as a fringe benefit for federal employees. By that time, and propelled by some World War II-related developments, health care as a fringe benefit was becoming very widespread in the private sector. One concept underlying federal employment, though often ignored, is that the compensation, benefits, working conditions, et cetera, for federal employees should be comparable to those prevailing in the private sector.

To provide perspective on some of the things that don't sound like health care issues but that are very crucial, let's look at how this fringe benefit economy had developed. During the latter part of World War II, controlling inflation was a major problem and one that the government was handling with only modest success. One understanding reached between organized labor and the Roosevelt administration was that the pressure for wage increases could be better contained if some fringe benefits incident to employment were permitted outside of the basic wage control formulas. As a result, the tax laws were administratively interpreted to provide that certain fringe benefits, including health and the pension benefits, would be tax-deductible expenses to employers but would not be taxable income to employees. This initiated the tax preference for health care benefits that has been a major, long-term factor in the escalation of health care coverage and health care costs in the United States.

Along with this, health coverage benefits became an appropriate issue for collective bargaining. Many histories report this as having occurred in about 1948 because of a Supreme Court decision which indirectly affirmed the appropriateness of bargaining over fringe benefits. However, cases don't get to the Supreme Court as initial issues. The collective bargaining over fringe benefits had commenced during World War II if not before, and had been recognized by the National Labor Relations Board through administrative actions long before the matter became an issue before the Supreme Court. The Supreme Court case actually involved other fringe benefits, not health care, but the principles were the same.

At any rate, in 1959 the Eisenhower administration proposed a nationwide health benefits program for federal employees modeled after the General Electric Corporation Major Medical Program. This was heartily endorsed, if not largely initiated,
by the health insurance industry. Blue Cross and Blue Shield naturally came in advocating a nationwide, basic health care coverage program to be managed by Blue Cross and Blue Shield.

Note that I said, "managed," not "underwritten." The federal work force was of such magnitude that no conventional insurance carrier or Blue Cross, Blue Shield plan could realistically accept federal employee coverage on a true risk basis. In fact, true risk is rare in the health insurance field because of experience rating and a variety of addenda thereto which limit the risk of the carriers. The insurance industry is not, as commonly supposed, in the risk-bearing business; it is in the risk-avoiding business.

Either of these nationwide programs would have left no room for prepaid group practice or other variations, one of which was federal employee association plans. Associations of federal employees indeed had, as one of their major recruiting tools and one of their major attractions, the fact that they permitted federal employees to obtain health care coverage in the group rather than the individual market. For many such associations, their major attractions, their health benefit programs, would have been eliminated by a uniform nationwide program such as that proposed by the Eisenhower administration and the alternative proposed by Blue Cross and Blue Shield.

The group practice prepayment plans were a minor factor in this picture. One, the Group Health Association (GHA) of Washington, D.C., (GHAA is a trade association, not a medical care plan) did have significant federal employee enrollment, but most of the others did not. GHA should have been vitally interested in the F.E.H.B.P., but, as has often been the case, their management was consumed by internal problems, and, according to Gibson Kingren, they were not active in connection with this legislation. The exception was Kaiser Permanente, which probably had something on the order of thirty thousand federal employees enrolled under a complex "collector" system in which federal employees at various federal installations undertook the responsibility of collecting dues from federal employees who wished health plan coverage and remitting the dues to the health plan through an arrangement of couriers, deposit boxes, et cetera. In fact, if anyone were to exhume federal records from the late forties and early 1950s at Mare Island or Hunter's Point or Alameda Naval Air Station, they would find federal employee job descriptions that included "collecting Kaiser Health Plan dues."

The uniform, nationwide proposals presented a major threat to prepaid group practice because, even though the federal
enrollment was generally not significant, the precedent-setting effect of the federal role and the potential exclusion of the largest employer group in the country from prepaid group practice was something that we felt we could not ignore.

Important matters sometimes hang by very slender threads. The situation might have been almost hopeless with the Eisenhower administration, the insurance industry, and the Blues united in support of uniform, nationwide plans and willing to accommodate the federal employee associations under some kind of a "grandfather" provision.

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Fleming: It happened that the chairman of the Senate subcommittee handling this legislation was Senator Richard Neuberger of Oregon who, prior to election to the Senate, had been a journalist on the Portland Oregonian newspaper, which was one of the early Kaiser Permanente dual choice groups. He had been a health plan member and had seen the functioning of a dual or multiple choice health care system. Arthur Weissman and Avram Yedidia, along with Ernie Saward, called on Richard Neuberger and convinced him of the great public importance of having choice of plans and competing alternatives in the federal employees program rather than a monolithic, uniform, nationwide system.

Senator Neuberger was a very intelligent man with an excellent sense of public policy; he readily understood the importance of what Avram, Art Weissman, and Ernie Saward were advocating. So he stood firm in insisting that the federal employees program be a basic-benefit, choice-of-plan system, embodying an element of competition, rather than a nationwide, uniform, Blue Cross, Blue Shield or insurance industry type of plan.

The Dual Choice Concept

Hughes: Could you digress a minute and comment on the origins of the dual choice concept?

Fleming: I suspect that Avram Yedidia has covered that in his interview because he is widely regarded as the originator of dual choice, but I'll summarize it briefly.¹

¹See the oral history in the Kaiser series for Mr. Yedidia.
Traditionally, insurance carriers seek to cover an entire group with a uniform set of benefits and generally a uniform premium rate. This had been the nature of group life insurance, which long preceded group health insurance. The entire environment of the insurance industry favored total group coverage and opposed any choice of plan system within a group. This attitude would have precluded development of prepaid group practice or other alternatives in an employment-based fringe benefit health care system. Rarely, if ever, would a prepaid group practice plan be able to serve all the members of a group because of geographical limitations, and rarely would all members of a group be willing to have their choice of physician and hospital so restricted.

To meet this problem, prepaid group practice plans developed the dual choice system. Although I've heard that it existed in some places before Avram Yedidia explicitly articulated the principles of dual and multiple choice, he is nonetheless generally and appropriately regarded as the originator of that system because he is the one who gave it structure, an intellectual framework, and practical administrative mechanics.

The insurance industry, the Blues, and the administration protested long and loud that a choice of plan system would not work because it would fragment the group, introduce elements of adverse risk selection against certain plans, and ultimately be more expensive for the federal government. However, they were trying to sell this story to a man who had seen the choice-of-plan system work just fine in his own personal experience. They could not convince Neuberger that choice-of-plan was unworkable, and before too long it appeared that this crazy system from California would not only be taken seriously but had a significant chance of prevailing. Accordingly, the major players concluded that half a loaf was better than none, and the choice-of-plan approach became respectable. Indeed, before the legislative scenario was played out, it enjoyed support from all quarters.

As an aside, I personally drafted the choice-of-plan features of this legislation, and despite innumerable proposed amendments they survived the legislative process virtually intact.

Hughes: Remarkable.

Fleming: I should also mention the House of Representatives side and the importance of the role played by Gibson Kingren. With the introduction of the Federal Employees Health Benefits legislation, we sent Gibson to Washington to manage the
legislative advocacy effort there. In fact, during this period I received a multi-page telex from Gibson practically every morning and responded to it by ten or eleven o'clock our time so that my suggestions got to the East Coast for consideration the same day. It was a hectic period, but Gibson was a natural legislative advocate and had become quite skilled during his limited experience in California. He took the lead in coalition building to support the choice-of-plan concept, found allies in a number of places, blunted criticisms, and generally played the advocacy role most effectively.

Hughes: Allies included the Group Health Association of America?

Fleming: Oh, yes. I haven't mentioned the Group Health Association of America (GHAA). In my estimation, GHAA was not a particularly effective organization at that time, although they were ideologically on the same side and certainly provided some support. As a matter of fact, I'll have to talk to Gibson and get his perception of this,¹ but Kaiser Permanente, far and away the largest participant on the choice-of-plan side, played the lead role.

An aside: the Health Insurance Plan of Greater New York, (HIP) with some 900,000 enrollees, was the largest prepaid group practice plan at that time, but their enrollment did not include federal employees, and, as I recall, they played a fairly minor role in the Federal Employees Health Benefits Program. They were a useful ally, particularly with the New York congressional delegation and they sent a witness to testify at one hearing.

Gibson's other vital work concerned the chairman of the subcommittee handling the legislation on the House side. I can't remember the name of the congressman involved, but he was from the deep South--Mississippi or Alabama, I think--and was, from all I have heard, a thoroughly distasteful individual that the lobbyists for the administration, the insurers, and the Blues really didn't have much rapport with and didn't like to deal with. Gibson's diverse background includes some significant activities in agriculture, and he got along just fine with this old Southern farmer. The result was that we had a strong position both in the Senate and in the House. Ultimately, the legislation went through pretty much in the form that we had recommended and supported.

¹See fuller discussion, p. 123ff.
Hughes: That was a remarkable achievement, because didn't it mark a completely new alliance of groups that were determining governmental health policy?

Fleming: Well, I guess I wouldn't put it quite that way. It was certainly a watershed event on the U.S. health care scene because the choice of plan and competing alternatives, which had been opposed and virtually precluded from significance by the insurance industry and the Blues, suddenly became important and respectable, not only on the kooky West Coast but much more broadly throughout the nation. This concept of competing alternatives is fundamental to the entire development of the current competitive health care system. This includes the HMO Act and the risk-contracting provisions of Medicare, which I'll discuss later on. It was, in a sense, a turning point in U.S. health policy.

As for the significance of the coalition, that's more problematic. Kaiser Permanente has maintained good relations with organized labor and has been able to obtain labor support on a number of health care legislative issues. Working together with the Blues and the insurance industry on the federal employees program legislation and particularly later during its implementation has generated contacts and associations that have been significant, and engendered a degree of willingness to cooperate that might not otherwise have existed. But there was, from my viewpoint, no coalition that persisted.

I should note that during this period (in the fall of 1959) I recruited Bob Erickson who became my successor in charge of Legal Affairs and Government Relations. Bob Erickson took charge of our efforts during the regulation development and implementation stage of the Federal Employees Health Benefits Program (FEHBP). He is clearly the leading expert within Kaiser Permanente and one of the leading experts in the United States on this important program.

Hughes: What about the role of the AMA (American Medical Association) in this affair?

Fleming: The AMA, to my knowledge, did not, in and of itself, play a significant role. This was subsequent to the report of the Larson Commission, which I believe I've mentioned in an earlier interview. The official posture of the AMA at that time, as I recall, was to recognize the validity of competing alternatives. They certainly did not weigh in heavily against the choice-of-plan system.
Hughes: Was one of the charges leveled at Kaiser, which of course was supporting the dual choice provision, that Kaiser was doing so simply to tap into this immense market of federal employees?

Fleming: I don't think, in the United States, it is a persuasive argument that some organization wants access to the market. If they have something to offer that the market is prepared to accept, that is widely regarded as being in the nature of our competitive, market-oriented system. Of course Kaiser Permanente was self-interested. So were the Blues, so was the insurance industry, and so indeed was the Eisenhower administration. All of the players had objectives that they wished to accomplish, and the final result was widely accepted as a satisfactory result.

I should mention that the doomsayers talking about the problems of adverse selection and risk fragmentation ultimately were, in large measure, correct. At the stage of development of dual choice plans in 1959 it was not at all evident that the selection problems were serious problems. However, since that time, as competition has intensified and as some of the competitors have been unable to be effective in delivering comprehensive benefits at reasonable cost, the risk selection problem has emerged as a valid and significant problem.

The trade-off, of course, is that competition as a cost constraint has, in my opinion, been worth infinitely more to the United States economy and society than would have been the alleged benefits of avoiding risk selection within insured groups. I say this with full awareness that health care costs are widely regarded as out of control and not effectively constrained by the competition strategy. I certainly read the numbers and I also see how diligently many competing health care organizations work to constrain costs. I see no simple, clear, right or wrong answer. But I do believe that the interests of the consumer are ultimately best served by having the opportunity to choose among competing alternatives.

I called this "Kaiser Permanente and Public Policy." It has been my view and I believe a view widely accepted or held within the Kaiser Permanente leadership that we can be successful in government relations only by paying careful attention to the public policy issues surrounding the things that concern us. We strive to advocate things that we conscientiously believe do represent sound public policy, and our advocacy of competing alternatives has been one continuing, unifying thread in much of our government relations activity.
Medicare Origins

Hughes: Is the next step Medicare?

Fleming: The next step is Medicare.

Going back to the original enactment of Social Security legislation in the middle 1930s, I think about 1936, the liberal portion of the political spectrum has advocated health insurance as a fundamental social policy objective. It was eliminated from the original Social Security legislation in order to avoid opposition from the American Medical Association. The political leadership then felt that Social Security alone was radical enough; additional opposition they did not need.

However, the same forces that advocated Social Security continued to advocate some form of national health insurance. As health insurance through employment-based fringe benefits became more widespread for the active work force, their focus shifted to health care coverage for the elderly. This became a major agenda item for organized labor, which, in addition to general social motivation, was concerned that health care costs for elderly parents were a major burden to working people, including the membership of the AFL-CIO. Hence labor and liberals had maintained a continuing, persistent effort to develop some kind of national system of health care, particularly for the elderly. This ultimately evolved into the Medicare program.

Medical help for the elderly was a significant issue in the 1960 political campaign and was one of President John F. Kennedy's commitments. With his election it appeared likely that motion would occur on this front despite the continued intransigent opposition of the American Medical Association and many of the more conservative forces in government and the economy.

In my capacity as head of government relations for Kaiser Permanente, I actually flew to Washington, D.C. on the very day of Kennedy's inauguration, which was a snowy January day in 1961. I met with delegates sent by Wilbur Cohen, namely Allanson Wilcox, general counsel for the Department of Health, Education, and Welfare, and Nelson Cruikshank, director of Social Security of the AFL-CIO. Organized labor's key role became clear as I learned that Nelson Cruikshank was essentially acting as deputy for Wilbur Cohen, then undersecretary of HEW and the lead man for the administration on the initiative to provide health care for the elderly.
Fleming: We had developed a series of amendments to the pre-Medicare legislation, which would be reintroduced following Kennedy's inauguration. These amendments, if accepted in full, would have provided a competing alternative to the fee-for-service system in the form of direct Medicare reimbursement on a per-capita basis to group practice prepayment plans and any other plans that could qualify under standards relating to capacity to assume responsibility for the actual delivery of health care services.

Hughes: Was dual choice always a part of the Medicare discussions before the law was actually enacted?

Fleming: Absolutely not; we tried, with highly limited, but not zero, success to make it a part.

Hughes: Some of the literature makes it sound as though the Federal Employees Health Benefit Act made dual choice an automatic inclusion in the Medicare discussions, even at a very early stage. Yet Kaiser had to fight to get that included; it was not an automatic part of Medicare.

Fleming: Automatic, hell! It never became meaningful, even though we started our effort in 1961. Choice-of-plan never became meaningful until 1984, and Kaiser Permanente was the lead actor in the effort throughout the 1960-1984 period. The position of the social insurance intellectual group, for lack of a better term, (Wilbur Cohen was certainly a major leader in that group; the AFL-CIO was a major leader; they had other intellectual and political support) on what became Medicare was that Medicare as a social welfare or social insurance program, could not permit any "opting out," or other division of the insurance base. In short, no alternatives.

This was the position that I faced in my numerous discussions with Nelson Cruikshank, Allanson Wilcox, and other people in the Department of Health, Education, and Welfare over the ensuing months and years. They were very friendly, very sympathetic. They were advocates of prepaid group practice and wanted to see a role for prepaid group practice in the Medicare program but they absolutely refused to accept anything that looked to them like an opt-out or a side system competing with the basic system.

Hughes: The basic system being fee-for-service?

Fleming: They wouldn't have said that. The basic system, in their view, was the federal government as the only Medicare insurer. Because
the U.S. system was fee-for-service, even though they didn't advocate fee-for-service, to be a uniform arrangement, it had to be fee-for-service. They were troubled by this. They recognized that they were, of necessity, adopting the fee-for-service system but they were unwilling to depart from their fundamental position that the government was to be the only underwriter. No other organization would be permitted to participate in a risk-taking role in the Medicare program—a very costly but understandable mind-set.

Wilbur Cohen, I believe, had a marvelously naive belief—I don't know how to put this exactly—in the responsibility and public benefit orientation of the hospital industry. Bear in mind that, as introduced to Congress, Medicare was a hospital benefit, not a medical benefit, except for in-hospital medical care. Wilbur Cohen and his followers did not clearly perceive the extent to which Medicare was going to be supporting and bolstering the fee-for-service system. Perhaps if it had not been for Part B of Medicare they might even have been right.

However, we were extremely skeptical because we were keenly aware of the interplay between hospital benefits and medical benefits, and between the hospital field and the medical profession. We were dubious about the ability of the hospitals to maintain a public interest orientation in dealing with the government as a major payer for hospital services.

Be that as it may, the Wilcox-Cruikshank axis accepted some of the amendments that I proposed but rejected others. I use this analogy: you take somebody the plans for a Boeing 747 and they say, "We'll take the left wing and the right engine and some but not all of the fuel tanks and part of the tail." You have something that won't fly, and that was exactly what happened.

Hughes: And you said that before the fact?

Fleming: Oh, sure. Of course I said it. But, there was this absolute ideological commitment to the concept of no underwriter except the federal government, no risk-taker except the federal government, and hence no ability to function on anything other than a cost reimbursement basis under Medicare Part A. They had the preposterously naive view, which I heard expressed innumerable times during the Medicare legislative battles and the subsequent administrative implementation, that anything in the nature of a profit or margin has to be in addition to cost; therefore it would be cost increasing and unacceptable. They were unable to perceive that an efficient organization could produce certain services at less than the cost to other organizations and thereby exert a restraining influence on costs.
It was something that was beyond the comprehension of the people I dealt with in the HEW establishment.

Hughes: Why were they so blind on that point?

Fleming: I wish I knew. [laughter] It is sad but true that a rudimentary understanding of how the world (or more modestly the U.S. economy) works is not a requirement for elevation to a policy-making level in the federal government. Why hell--the presidency of the United States does not require the credential that a third-grade schoolteacher needs.

There are probably tapes in the bowels of the federal government somewhere of meetings of the task forces appointed in connection with Medicare implementation in which various Kaiser Permanente representatives were articulating the viewpoint that I have just expressed. Their voices were falling on deaf ears.

The official viewpoint was that if there were any margin for anyone, it could only increase costs; therefore no margin would be permitted--except they ultimately did one of the dumbest things--I was going to say the dumbest thing, but that's a crowded competition and there were certainly dumber ones--in U.S. political history.

This was the kind of "thinking" that led to the politically imposed add-on for the proprietary hospitals. They asked Wilbur Mills, who was highly influential, "Don't we have a right to make a profit?" Ultimately Wilbur Mills agreed that they did have a right to make a profit. So we had the preposterous distortion of nonprofit hospitals being reimbursed for costs only, and the proprietaries reimbursed "cost plus" with no comprehension that both "cost" and "cost plus" are inherently cost-escalating systems. There was no apparent awareness that the U.S. economic system provides an opportunity, but not a right to make a profit, and no understanding of the difference between a price system and a cost system. I guess (or hope) it is now clear that the basic driver for efficiency in our economic system is the opportunity, in a competitive arena, to achieve, maintain, and even increase the margin between price and cost, with price effectively constrained by competition.

Finally this was dimly perceived and implemented with the diagnostic-related groups reimbursement method that came along in the 1980s--the first ray of sanity in the Medicare reimbursement system. The notion that competitive price reimbursement places pressure on and thereby constrains costs was terra incognita to the people originally responsible for Medicare legislation and its implementation.
Kaiser Permanente's Medicare Goals

Hughes: Was Kaiser Permanente's main concern in all this to insure that there was dual choice?

Fleming: Ultimately, we wanted to see dual choice in Medicare, and we now have it to some degree, but that was not the primary issue. What we really sought was a basis for reimbursement under Medicare that was compatible with a non-fee-for-service health care system. Our underlying concern was that a fee-for-service system for Medicare (not then a large part of our population but one that we knew would grow, and a part of the population that used a disproportionate amount of medical services), would undermine the cost-constraining culture of the Kaiser Permanente program. Cost reimbursement rewards increasing costs, and fee-for-service reimbursement rewards unnecessary proliferation of services. How can an organization at one time function in a cost-restrained manner with, say, three-quarters of its health care dollars, and deal with incentives to increase costs and proliferate services with the other quarter?

We were concerned about the fundamentals of a prepaid group practice system and reconciling those with the Medicare program. The amendments that I took to Washington, even though they did not provide the competing alternatives arrangement that was our objective, did provide a "handhold"--a way in which the Medicare system could compensate the Kaiser Permanente program on a quasi-capitation basis rather than by payment for individual services.

As history unfolded, this might have come about in some other manner but during the legislative enactment phase it was not clear that there would be any alternative to traditional cost reimbursement for hospitals and fee-for-service payment for physician services, except through the amendments that we were advocating. As they were not accepted as a unified package, it was not altogether clear that we would succeed in this objective. However, in the implementation stage enough people finally came to appreciate the importance of an alternative to fee-for-service that they did interpret the legislation in a manner permitting Kaiser Permanente to function under a quasi-capitation system. This was ultimately based on cost reimbursement but avoided billings for individual services.

Hughes: It's an enormous subject, of course. Is there anything more you want to say in a brief period of time on Medicare?

Fleming: In the first half of the 1980s it finally became possible for Medicare beneficiaries to enroll in prepaid group practice plans
in a manner analogous to that of the rest of the population, with the plans assuming financial responsibility for the services and being compensated on a price rather than a cost reimbursement methodology.

Hughes: Did Kaiser Permanente have a role in that change?

Fleming: Kaiser Permanente had the primary role. There were other interested people and organizations, and cooperation and support from other sources. However I think until well along in the process Kaiser Permanente representatives were the only ones who really understood it.

Medicare Amendments, 1972

Fleming: The next stage came in 1972, with the Medicare amendments of 1972, in which there were specific provisions enacted for reimbursement of health maintenance organization-type plans. This was proceeding through Congress concurrently with the HMO legislation. I believe that both Congress and the administration at that time would have been willing to accept the fundamentals that we were advocating.

However, there was one staff person on the Senate Finance Committee, Jay Constantine, whom I refer to as "the senator from outer space" because he appeared to have the power of a senator but no one could identify the state from which he derived that power. Jay Constantine had a very cynical view of the world--not without reason--and believed that any departure from cost reimbursement would provide a basis for preposterous rip-offs, even though the proposed amendments clearly required that reimbursement to a plan operating under the provisions be less than the cost for serving a comparable population in the fee-for-service sector.

The combination of taking an underwriting risk and being subject to retroactive changes through cost reimbursement methodology was not practical from the viewpoint of Kaiser Permanente and most other plans. Hence the Medicare amendments of 1972, although providing a systematic structure for reimbursement to HMO-type plans, had little or no effect in the real world because they continued to utilize cost reimbursement methodology. It was not until the Medicare amendments of 1982, when the Medicare authorities were beginning to recognize the value of a price system as contrasted with a cost system, that the legislation was finally amended in a manner that permitted
Hughes: Realization, within the government, of the difference between a price and cost system was simply gained through those years of experience?

Fleming: Yes, or maybe. There were any number of turnovers of personnel within the Department of HEW, and within the Medicare administration. Circumstances compelled recognition that the cost reimbursement system was not effective in constraining costs, so the relevant bureaucracy was finally dragged kicking and screaming into some degree of enlightenment. [laughter]


Hughes: Shall we move on to the HEW secretary's report?

Fleming: My role regarding Medicare legislation and Kaiser Permanente's role in the legislation and implementation had caused me to become fairly well known among people in Washington who were involved in the Medicare program. Accordingly, when HEW Secretary John Gardner became concerned about escalating costs in the Medicare program, he decided to appoint an advisory committee called the Secretary's Committee on Hospital Effectiveness. I was invited to serve on that committee as what they probably referred to as "the token prepaid group practice representative." As is always the case, this committee was balanced to reflect a variety of constituencies, geographical areas, et cetera, and was, not surprisingly, dominated by people from the hospital field with a sprinkling of people from insurance industry, business, and organized labor.

Hughes: What was the purpose of the committee?

Fleming: I guess we should look at the document.

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1"Secretary's Advisory Committee on Hospital Effectiveness Report," U.S. Department of Health, Education, and Welfare, 1968, has been deposited in The Bancroft Library with Mr. Fleming's papers.
Fleming: Quoting from the report: "Hospital effectiveness including improving internal efficiency of hospitals, better methods of reimbursement of hospitals, and in general, a more effective role for hospitals in the health care field, and consideration of what the optimum mix of in-patient and out-patient services might be."

Hughes: Do you know what specifically had prompted the secretary to form the committee?

Fleming: I believe it was the simple fact that, almost immediately following implementation of Medicare in July of 1966, hospital cost escalation commenced to run significantly ahead of general cost escalation in the economy, and ahead of the cost projections on which the Medicare legislation was based.

The charge to the committee really doesn't add much to what I said. The driving concern was cost to the Medicare program, and the notion was that the effectiveness with which hospitals functioned was an important aspect of keeping the costs under control.

Conclusions

Hughes: Is the next step, then, to talk about what the committee concluded?

Fleming: Yes. This was obviously a big plateful. The committee, with a staff primarily from HEW, but from some other government agencies too, held extensive meetings, had extensive discussions, and had many conflicting philosophies, but wasn't getting very far. At some point as the due date for a report was approaching, after seven or more two-day meetings over a period of seven months, the chairman of the committee, (a very able man by the name of John A. Barr, dean of the business school at Northwestern University), decided that there needed to be an executive committee or drafting committee or some such in order to move things toward a conclusion. I guess he was the chairman, but it included Walter J. McNerney of Blue Cross, and I don't recall who all else, but it was predominantly the hospital professionals--three to five people--who came up with a draft report that was conventional wisdom in the hospital industry.

Hughes: What was conventional wisdom?
Fleming: That would be too long a discussion. I guess I can refer people to the report because it does indeed reflect the conventional wisdom.

Hughes: Could you put it in a nutshell?

Fleming: Let me glance over the recommendations. It was essentially trying to do the same old things better. There was a great deal of emphasis on areawide health services planning and franchising of hospitals. This was during the era of the "empty bed blues"--the fallacious notion that excess capacity was a major part of the health care cost problem. So one of their major focuses was on planning and giving more "teeth" to the health facility planning system.

One of the areas in which the Kaiser Permanente position has appeared to many to be at variance with sound public policy has been our opposition to governmentally sanctioned health facility planning. It is such a superficially appealing idea but the realities are that any imaginable, politically acceptable, health facilities planning system will become planning of, by, and for the status quo and will stifle innovation.

One little anecdote will evidence this as strongly as anything: there was a voluntary committee or some such established in the early 1960s in the San Francisco Bay Area. This was at the beginning of the big boom for health facility planning, in which people represented hospitals and health insurers, supposedly consumers and so on would work to assure more "rational" health care facilities development. The group included a token prepaid group practice representative in the form of a public affairs person from the Kaiser Permanente system.

At the first meeting, one of the medical society representatives arrived late and did not know that a Kaiser Permanente representative was present. As the toe-dancing progressed, he became increasingly frustrated, and after a while he could contain himself no longer because of the abstract and ineffective suggestions being made around the table. So he said, in effect, "Let's cut out this garbage and get down to business. We all know that what we're here for is to keep Kaiser from building any more hospitals."

We have been highly skeptical about governmentally sanctioned health facility planning. In fact, our legislative efforts have been reasonably effective in keeping the planning system from being totally an instrument for preservation of the
status quo. That's another aspect of Kaiser Permanente and public policy.

To get back to the Secretary's report, planning was one of the major thrusts of the report, and there were many details on how planning would be made more effective and "given teeth." Then there was some pabulum on internal management of hospitals, including budgeting and state agencies to accumulate data on operations of health care institutions and develop reporting systems. Tied to planning, there was a recommendation that all federal financing for health facilities and services would only be available where appropriate planning and financial disclosure systems were in effect. There were some recommendations relating to insurance, including reasonable and controlled limits on all carrier "retentions," which is where profits come from--but they are not the same as profits. There were recommendations for minimum benefits under health insurance plans and a federally insured borrowing system for capital for health care institutions, all, of course, tied to planning.

The only recommendation of much validity and significance was a recommendation that hospitals having third-party reimbursement systems (insurance, Blue Cross and so forth) would be under a rate negotiation arrangement with annual negotiations between the third parties and the health care institutions. That is to say, the Blues and insurers in an area would negotiate rates with the hospitals in the area. That has some promise, and in weak implementation experiments has worked to a modest degree.

In any event, when I read the draft report prepared by what we called the "steering committee," I found that I disagreed with more than half of the individual sentences in the report and I felt compelled to dissent. It was unheard of for the token representative from the fringe of the health care economy to be so presumptuous, and there was considerable effort applied to persuade me to give up my dissent and join in the report.

Hughes: Pressure by whom?

Fleming: Some of the leaders of the HEW staff who wanted a unanimous report, some members of the committee who were, I think, afraid of what I would say in a dissent, because I had covered all the essential points in the course of the meetings. As I recall, the chairman, Barr, did not really take that attitude. He didn't talk to me about the nature of my dissent. Although he was, of course, by position and inclination with the majority, he nonetheless was a businessperson and a business school professor and he recognized a great deal of validity in much of what I was saying, so he assured me that my dissent would be accepted. The
committee wanted to make it as minimal as possible and asked me to limit it to one page of the report.

Fleming's Dissent

Hughes: What was your main dissent?

Fleming: It was an almost total disagreement with the report. As I say, I disagreed with more than 50 percent of the individual sentences. The ones I didn't disagree with were mostly innocuous; there wasn't anything in them to disagree with. It wasn't that I agreed with them; it was just that they didn't matter.

Hughes: There was one statement that particularly caught my eye, where you thought the thrust should be health care for people rather than health care for patients.

Fleming: Yes. I think that this dissent should be set forth in the oral history. It's relatively short. The people who look at the history can see what it says. But I did say, "I suggest that the industry's purpose is wrongly conceived; the industry should develop the capability of delivering comprehensive health care for people rather than merely providing episodic treatment for patients."

The report of the Secretary's Committee on Hospital Effectiveness joined innumerable other reports on library shelves and received little attention, which was all that it deserved, in my opinion. However, my dissent did attract the attention of Doctor Paul Ellwood, who was the executive director of what had been the Sister Kenney Foundation in Minnesota. It had fallen into disarray and he had been successful in restoring the Foundation to respectability and effectiveness. However, in the process, his interest shifted from physical medicine and rehabilitation, which was his specialty, to health policy. He became quite active in the health policy debate that was going on at about the time that the Nixon administration took office in 1969.

\[See complete dissent in report in The Bancroft Library, as noted on p. 116.\]
The HMO Act

Paul Ellwood's Plan

Fleming: As I mentioned before in connection with the Federal Employees Health Benefits program, sometimes significant things hang by fine threads. It happened that Paul Ellwood's father had been the family physician for the Veneman family. John Veneman became undersecretary of HEW in the Nixon administration. In midwinter 1970 I received a phone call from Paul Ellwood, who referred to my dissent in the Secretary's committee report and told me that he had "sold something very important to the administration" and needed some help. I'd never heard of Ellwood so I made some phone calls to people that I knew around HEW, including Tom Joe, who was the chief administrative assistant to Veneman, and asked him, "Who is this Ellwood guy?" His answer was in effect that Ellwood is an influential person and specifically that he is "the only physician that Veneman will believe."

So I called Paul back and agreed that we would meet with him to discuss the subject of his concern. We met on the 26th floor of the Kaiser Building on the first Saturday in March of 1970, with several people from my staff, including Bob Erickson and Jerry Phelan, some other key Kaiser Permanente personnel, and Avram Yedidia, to learn what Ellwood had "sold to the administration" and to see whether we felt that it was anything we should help with. That was the beginning of the federal HMO Act. After two or three hours discussion we dictated a conceptual outline that was the starting point of the HMO legislation, and gave it to Ellwood to use as he wished.

Hughes: What was Ellwood's plan?

Fleming: Ellwood's plan was to stimulate competing alternatives in the health care field as a means of improving the efficiency of health care services.

Hughes: Now, why had he gotten on that tack?

Fleming: I would say, in a nutshell, that after his successful resurrection of the Sister Kenney Foundation and his shift of interest to health policy, he was looking for new fields to conquer. He knew that the Nixon administration was seeking some kind of an initiative in the health care field. He felt that it would be desirable to have organized systems along the line that I discussed in my dissent as an explicit public policy; that is, competition among organized systems should be a major federal
policy to apply competitive restraints and market-type constraints to health care costs.

Origin of the Term Health Maintenance Organization

Hughes: Was what later became termed a health maintenance organization an explicit component of this competing system that he envisioned?

Fleming: Yes, but let me answer it this way. We developed the conceptual outline for what subsequently became the HMO Act. After we finished in mid-afternoon, we repaired to the Tia Maria, which was a Mexican restaurant then located on Grand Avenue not too far from the Kaiser Center, and got a pitcher of margaritas to relax with. Ellwood said, "Now that we've got this thing on paper, what do we call it?" We thought a little bit and said, "It's a prepaid group practice system, of course," and a few other things about competing alternatives. He said, "Aw, none of these are good terms. No sex appeal. Shopworn. We've got to have something better to call it." So we didn't solve the problem, but a few months later I found out that I'd been spending my entire career in a health maintenance organization--[laughter] and never knew it.

Hughes: Was that Paul Ellwood's coinage?

Fleming: It's widely attributed to Paul. However, I don't think so. I think the name came about this way. I think the conceptual outline that we had started--no doubt modified by Paul after he got back to his own headquarters and talked to other people--was given to Undersecretary John Veneman and put into the bureaucratic system at HEW. It naturally would have gone to the Health Services and Mental Health Administration where Beverly Myers, who was subsequently the chief health officer of the state of California, was the Assistant Administrator for Planning and Evaluation--as the jargon goes. So she was naturally the one who would have received something like this.

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Fleming: A group of bureaucrats on the staff of the Health Services and Mental Health Administration then got together in a brainstorming session at the request of Beverly Myers. They probably came up with half a dozen names because they try always to present options. Then someone or other, probably Beverly, decided that "Health Maintenance Organization" was the best choice. Although
Hughes: Would you check with Dr. Ellwood?

Fleming: Yes, I will try. I think I've already asked him once, and I think that all he could tell me was that he didn't give it the name and that it came out of HEW. I just embroidered on the scenario because I know how things work there.

Hughes: Sounds very plausible.

Fleming: At any rate, that's the essence of how the HMO Act originated. I've often said that it was all downhill from the first meeting we had at the Kaiser Center, because by the time our conceptual outline got into legislative language and got through the congressional committee process, it had become unwieldy and in many respects unworkable. The unworkabilities were finally resolved, in large measure through amendments. Originally enacted in '73 the HMO Act was amended in '76 and again in '78. After the '78 amendments it became reasonably workable. The Kaiser Permanente Program was the primary prototype for the HMO Act and the Exhibit A cited by advocates for HMOs during the legislative process. It wasn't until the 1978 amendments that Kaiser Permanente felt the act was sufficiently workable for it to become a federally qualified HMO.

There were another round of HMO Act amendments in 1988 which again increased the flexibility of the act and made it more feasible for more organizations.

Group Health Association of America

History

Hughes: Do you care to comment on the GHAA's role in getting the HMO Act passed?

Fleming: Let me comment a little more broadly on GHAA. GHAA was the outgrowth of two predecessor organizations. One was the American Labor Health Association created by organized labor, which sponsored a number of diverse health care plans. The other was the Cooperative Health Federation of America sponsored by the consumer cooperatives. Many of the earlier prepaid group practice plans were consumer cooperatives--the Group Health
Association of Washington, D.C., the Group Health Association of Puget Sound, the Group Health Association of St. Paul, and some other smaller ones. These two groups, both very affirmative toward prepaid group practice, merged, I think, in 1959--

Hughes: That's correct.

Fleming: --to establish the Group Health Association of America.

Hughes: Was it just chance that this was the year that the Federal Employees Health Benefits Act was passed?

Fleming: As far as I know, that was coincidental. The separate predecessor organizations were interested in a Federal Employees Health Benefits Program and perhaps part of their motivation was to try to become more effective politically by merging. However, GHAA was really not well established. It was established on paper but did not have much substance during the legislative work on the Federal Employees Health Benefits program. Again, I'll have to check with Gibson Kingren. I am sure they were an ally, but I don't think that they were a particularly significant one.¹

The Kaiser Permanente program as such was not a member of GHAA, but The Permanente Clinic, the medical group in the Northwest Region under leadership of Dr. Ernie Saward, was an institutional member. A number of us, including Art Weissman, Avram Yedidia, and myself were individual members. I don't remember specifically, but several persons in Kaiser Permanente were individual members. I was interested in GHAA partly because the nature of the legislative representation game in Washington gives a slightly preferred position to trade associations. Congressional committees generally prefer to hear from a single trade association than from a disparate bunch of witnesses from the same industry.

Also I recognized the value of allies and GHAA was a natural ally.

Hughes: Why didn't the other Kaiser groups join?

Fleming: Despite its being perceived as a somewhat radical organization in the health care field, much of the Kaiser Permanente leadership, particularly in the medical groups, is quite conservative politically and was then particularly anxious to maintain good relations with the American Medical Association. The American

¹Gibson has since confirmed that they played, at most, a very minor role.
Labor Health Association was overtly anti-AMA and, to a considerable extent, the Cooperative Health Federation of America was also anti-AMA. As a matter of fact, some of their member plans had to engage in heavyweight litigation with the American Medical Association over restrictive practices. One major antitrust case involves the Group Health Association in Washington, D.C. versus the American Medical Association.

Thus one basic reason for not joining GHAA was that the leadership of the Permanente Medical Groups—with the exception of Ernie Saward who had a much more advanced sense of the socio-political world than the other Permanente Medical Group leaders—was simply not comfortable with an organization that was pretty much on the liberal end of the political spectrum at that time and was also antagonistic toward the American Medical Association.

In addition, the GHAA bylaws contained a provision espousing consumer control of medical care. That's the anti-Christ from the viewpoint of many physicians who greatly prize professional autonomy and feel strongly that physicians should not be subject to any organized control from sources external to the medical profession. Hence the "consumer control" provision was unacceptable to key people in the leadership of the Permanente Medical Groups.

I found this situation to be awkward and GHAA found it to be exceedingly awkward. Somewhere during this period we had passed HIP (Health Insurance Plan of Greater New York) in total enrollment. We were the largest and soon to become by far the largest prepaid group practice system in the United States. It was awkward for GHAA not to have the largest plan as an association member and it was inconvenient for us not to be able to utilize GHAA directly in government relations.

We cooperated and had generally similar interests on most issues, but when it came to testifying on legislation, for example, GHAA would have a prior position as a trade association and we would come along later among the miscellaneous witnesses. It didn't matter all that much; our testimony was always well developed, well thought out, and well presented so I don't think we suffered in any significant way, but it was still an awkward situation. However, although I brought this up various times in the Kaiser Permanente Committee, the attitude of the Permanente Medical Group leadership was that they really didn't want Kaiser Permanente to be part of GHAA.

The Hawaii Permanente Medical Group had been heavily influenced by Ernie Saward and may have been an institutional
member of GHAA before 1970. At any rate, due to a variety of circumstances that I won't go into, it came about that the Kaiser Permanente Hawaii Region was to be the host to GHAA for their 1970 annual convention. This appeared to be the propitious time to join the association, and I think the Permanente Medical Group leadership increasingly recognized the importance of government relations and the validity of my position on GHAA membership.

However, the "consumer control" provisions still stuck in the throats of some very important Permanente Medical Group leaders. So I negotiated an amendment to the GHAA bylaws to substitute the concept of health care managed in the interests of consumers for the prior control by consumers provision. Despite vigorous opposition from Hilda Birnbaum (one of the key members of the board of the Group Health Cooperative of Puget Sound and a dedicated consumerist who greatly resented any dilution of the consumer control concept) the GHAA membership adopted the bylaw change at their Annual Institute in Hawaii in 1970. Thus Kaiser Permanente components became institutional members of GHAA. Of course, when we became members we represented substantially more prepaid enrollment than all of the other plans combined.

[laughter]

Hughes: So you had a little clout.

Fleming: So we had some influence in GHAA, which we attempted to exercise with a degree of restraint.

Hughes: Did GHAA indeed change course after Kaiser membership? Aside from the change in the bylaws?

Fleming: Not in any dramatic way. We'd been somewhat active previously with various Kaiser Permanente people participating as individuals. Also we had the institutional membership of The Permanente Clinic in the Northwest and probably the Hawaii Permanente Medical Group. Thus there was no overnight change. However the GHAA budget went up dramatically, the staff increased, and as I see it GHAA became a much more effective organization. I don't mean to belittle what they were doing before, but with our institutional membership, financial contribution, much closer relationships and greater participation on committees et cetera, we did significantly enhance GHAA resources.

Now, we continue, of course, to maintain our own government relations office in Washington, D.C., but we work very closely with GHAA.
Hughes: Does that pretty well cover GHAA? I realize there's a lot more that could be said.

Fleming: Oh, yes, there could be an oral history of GHAA and the various convolutions it's gone through. Following the amendments that made the HMO Act effective, the number of prepaid group practice plans greatly increased. Then with the different kinds of plans and the lines between prepaid group practice and IPAs (Independent Practice Associations) becoming blurred, GHAA expanded to include plans other than traditional prepaid group practice plans. The total enrollment represented by GHAA member plans increased dramatically so that Kaiser Permanente, although still the largest plan in terms of enrollment—we based GHAA dues on enrollment—ceased to be totally dominant in the form that it once had been, and many other strong voices are now present in GHAA.

In order to accommodate many additional organizations without making the board too unwieldy, the number of Kaiser Permanente positions on the board has decreased and the relative number of committee chairmanships and so forth has shifted. Thus GHAA is now an organization with a broader constituency and many more active participants than it was.

Hughes: Does Kaiser Permanente accept that as a fact of life?

Fleming: We've never opposed it. It's just the nature of the world has changed and GHAA has appropriately changed with it. To some extent it does increase the importance of our own independent Washington office because we are focused on prepaid group practice, whereas GHAA must represent all of the other constituencies that it now includes.

Member, Board of Directors, GHAA, 1974-1981

Hughes: Do you care to comment on your tenure on the Board of Directors of GHAA from 1974 to 1981? Is that an elected position?

Fleming: No, not really. The board positions are allocated among member plans in rough proportion to the enrolled membership and hence to the dues paid by the plans. Each member plan designates its representatives on the GHAA board. I dropped off in order to make a slot for Al Silverstone, our regional manager in Washington, D.C.
Frankly, I'd flown back and forth across the country enough times and didn't feel any great need to attend more GHAA meetings. It was something that Al was interested in, so I felt that it made sense for me to drop off the board and for Al to go on. I don't know whether or not he's still on the GHAA board, but we still have substantial representation. However as a proportion of the total, our representation is significantly less than it was at the time we originally joined and for a few years thereafter.

Hughes: I'm sure there were many issues, but one of the ones that I read about was the problems connected with the shift from nonprofit or cooperative HMOs to proprietary and profit-making HMOs. Do you want to comment?

Fleming: Back in the good old days, the participating plans were for the most part either consumer cooperatives, which is one form of nonprofit organization, or they were otherwise organized as nonprofit plans. Among other things, until the federal HMO Act became effective nationally, for-profit, prepaid medical care plans were either illegal or suspect in most states. That was not true in California. The first significant prepaid group practice plan that still exists in some form was the Ross-Loos Medical Group in Los Angeles, which was a medical group-owned plan, so I guess one would call it a profit-oriented plan.

For various reasons including one aspect of economic theory, I see a difference between an investor-owned plan and a plan owned by the professionals who are providing services in the plan. I see the investor-owned plan as a profit-oriented plan, whereas the professionally owned plan of physicians practicing in the plan is an alternative method of providing and getting paid for professional services; in economic terms this represents "wages" not "profits." Thus while I don't exactly classify the original Ross-Loos as a "for-profit" plan, it definitely was not a nonprofit plan. It now has become a part of Cigna, which of course is a profit-oriented insurance company.

I have mixed feelings on this issue. I don't think that profit orientation is intrinsically bad or nonprofit orientation is intrinsically good. I think there are fine, responsible, profit-oriented organizations, and I think there are inept, ineffective, incompetent nonprofit organizations, and nonprofit organizations that front for greedy organizations. So I don't draw the kind of distinction between profit and nonprofit organizations that some people do.

However, I think there are advantages to nonprofit organizations in the health care field. I think there's a
widespread public perception that profit orientation is not desirable in the direct delivery of health care services. I think that many professionals are more comfortable being associated with a nonprofit organization. Also it's a little easier for a nonprofit organization to take a longer-term view. This is most particularly true when you talk about publicly held, profit-oriented organizations. If management must focus in large measure on quarterly earnings per share, that's hard to reconcile with long-term organization building. This is something that, in the general field of business, many thoughtful observers regard as a deficiency in the United States industry as compared with Japan, for example.

Apparently, at least to date, Japanese business focuses less on short-term earnings and more on building long-term capability. However, I think it's a mixed bag and do not automatically endorse nonprofits or denounce profit-oriented institutions.

Hughes: In 1989 you received the GHAA's Distinguished Service Award. Was that for any specific service?

Fleming: No, I don't think so. I guess the most important specific service I performed for GHAA was negotiating the entry of Kaiser Permanente. [laughter] I was active on a number of committees and I think I was a constructive board member. Also, having been around from the middle 1950s, I had become one of the old-timers, which I think is part of what such awards tend to recognize.

Deputy Assistant Secretary for Policy Development, Office of the Assistant Secretary of Health Policy Development, HEW, September 1971-June 1973

Appointment

Hughes: I can't remember your exact title at Health, Education and Welfare.

Fleming: As the jargon went, I was Deputy Assistant Secretary for Health Policy Development.

Hughes: What did that really mean? What did they hope you were going to do?

Fleming: In the HEW bureaucracy, it meant that every issue that the executive secretariat (sort of the nerve center of the
department) identified as involving health and some type of policy issue came to the Deputy Assistant Secretary for Health Policy Development. That was a lot of things. But let me back up and tell how I came to go there and then a little bit about how I dealt with this massive array.

I think that many attorneys, at least of my generation, have a little bit of an inkling toward public service. In 1968 and 1969 I'd been chairman of the Kaiser Permanente Committee and had been instrumental in moving along our decisions to expand into Ohio and Colorado, a course of action that I had strongly advocated. By that time I'd built up what I think was an excellent legal and government relations department.

So in 1970, the time that I received that call from Ellwood, as I mentioned earlier, I perceived my situation as what I've referred to as "being in a fur-lined rut." It was a comfortable rut; I had a good staff, I had a good position, and everything was fine as far as my career was concerned. But I had some involvement with HEW through Medicare and through the Secretary's committee and had the possibly naive notion that I could add a dimension that was lacking there. However, I wasn't at all looking for a different job.

When I got a phone call in the spring of '71 from Elliot Richardson's recruiters, it was totally out of the air. I had become known through my Medicare work and through the Secretary's committee work, et cetera. So in their recruiting efforts, somebody had identified me as a prospective candidate. I subsequently learned that the other leading candidate was Arthur Hess, Deputy Director of the Social Security Administration under Bob Ball, and probably the person most suited to the job because he would have started with in-depth knowledge of how the federal bureaucracy functions.

Hughes: Why wasn't he appointed?

Fleming: Because he declined.

Hughes: Oh. [laughter] That's a good reason.

Fleming: He felt that his position as Deputy Director of the Social Security Administration was a more appropriate position for him, and I couldn't disagree with that. Art Hess was an absolutely outstanding person and excellent in his position. I think he felt that the turmoil of the Secretary's office was something he didn't need. Besides, what happens there usually doesn't have any very prolonged effect--something that I was less clear on then than I am now.
In any event, I received the request to take that position.

Hughes: Which I understand consisted of a quite drastic cut in salary.

Fleming: Yes, it was roughly a 50 percent salary cut in addition to the costs and complications of moving, et cetera. I took a leave of absence; I certainly expected to, and did, return to the Kaiser Permanente program. I wouldn't have taken the position as a career change.

I went east to meet Secretary Richardson. Everything I knew about him at that time was favorable. I didn't think very much of President Nixon, but I thought I would be even farther removed from the White House than I turned out to be.

I was a Democrat, and the Nixon administration was not noted for appointing Democrats to policy positions. My interview with Richardson was eminently satisfactory. One highlight I think is worth recounting. I wanted to be sure that I wasn't sailing under false colors. I had my opportunity during the interview when Richardson noted, "I see that you're a Democrat." I responded to him, saying in effect, "Yes, sir, I'm a Democrat, and what's more, I'm a California Democrat. In common with most California Democrats, I am deeply skeptical about Richard Nixon, but I do respect the office of the presidency." Richardson gave me an odd sidewise glance, and then continued with the interview which occurred in his official limousine, driving from HEW to his home in MacLean, Virginia, because he'd been tied up with department business until well after closing hours. I have often wondered whether he recalled this incident at the time of the "Saturday Night Massacre."

At any rate, the net of it was that he asked me to take the job and I said that I would do so. There was a long, subsequent song and dance with getting informal clearance from some key members of Congress. This was not a position that required congressional approval, but, under established practices it was a position that the department informally cleared with chairpersons of the key committees, with the minority leader (the Republicans being the minority party in Congress) and with key minority people on these committees. I was for a long period in limbo while that process occurred. I believe, without knowing for sure, that one or more of the Republican committee members was either negative or wanted more information before approving a Democrat.

Hughes: Because you were a Democrat?
Fleming: Yes, that's all. Or conceivably because of Kaiser Permanente. It could have been somebody who was an AMA stalwart or opposed to prepaid group practice—but that's speculation. All I know is that it took unusually long to obtain these clearances. I was about to tell them to bag it because I either needed to know that I was going or wasn't going. I couldn't have much more time disrupted with uncertainty, but anyway, I finally got the clearance and went back there in September of 1971.

Hughes: Do you think your appointment was related to the pending HMO legislation?

Fleming: Not particularly. While I did work on that, it occupied maybe 5 percent of my attention. I did more work on Medicare than I did on the HMO legislation. I was involved in policy recommendations on all sorts of things, so the HMO Act was incidental. I am sure that it was something that people back there regarded as a plus. On the other hand, my responsibilities were in no way specific to HMOs. That was just another item on the platter. I think that what they wanted was someone with private sector experience in the health care field who would bring a different perspective to some of the issues that the department was dealing with.

Hughes: Do you think that Kaiser Permanente hoped in any way to gain by your presence in an official high-up position in Washington?

Fleming: Absolutely not. Dr. Keene, who was the president of Kaiser Permanente Health Plan and Hospitals, really resented my going. He acquiesced but I think he somehow or other took it personally that I didn't like working for him or something. Anyway, there was an extensive conflict of interest review—the usual formality kind of thing that I had to go through. Bob Erickson, who took over my responsibilities, might even have thought that my position in the government was a minor embarrassment or complication. He certainly wouldn't have regarded it as an advantage. He certainly never approached me on any Kaiser Permanente legislative interest while I was in Washington.

The Kaiser Permanente program had very mixed views about the HMO Act. They were highly skeptical, quite appropriately so, as to whether it would come through Congress in a workable form. Indeed as the process proceeded they became convinced that it would not emerge in a workable form.

The Medicare amendments in 1972 that I did work on in HEW were not acceptable to Kaiser Permanente. Because of Jay Constantine, a key staff person on the Senate Finance Committee, I couldn't get them in a form acceptable to Kaiser Permanente. That wasn't what I was trying to do. I was trying to get them
into a form that made sense, and even this was not possible because of Jay Constantine. I called him "the senator from outer space," because he had as much influence as a senator but no identifiable constituency. Most of the issues I worked on had little or no direct significance to Kaiser Permanente.

Health Policy Issues

Fleming: One issue that I dealt with was the Nixon administration notion that the Food and Drug Administration should be financed by "user fees" to be paid by the pharmaceutical companies that were being regulated by the FDA. I thought that was about as dumb as anything I'd heard of, and I opposed it on the ground that it was simply not appropriate that a regulatory agency should be financed by the regulated industry. That's just one example.

The health agencies issues within the domain of the Assistant Secretary for Health were the Health Services and Mental Health Administration, the National Institutes of Health, the Food and Drug Administration, and the Centers for Disease Control.

One of the things I did was lean heavily and somewhat successfully toward increasing the allocation to the National Institute of Environmental Health Sciences because I felt that the environmental health area was seriously underfunded and had profound implications for national health over the long term. It was a stepchild in NIH because of the very heavy orientation toward more immediate and specific things, such as the ill-founded and ill-conceived Nixon Administration "War on Cancer."

The Health Resources Agency was concerned with health manpower and medical education. The Health Services and Mental Health Administration included several programs for health care for the impoverished, Maternal and Child Health, the Indian Health Service, the U.S. Public Health Service, including the merchant marine hospitals, and a baffling array of activities and programs. The big-ticket items, Medicare and Medicaid, were not within the jurisdiction of the Assistant Secretary for Health at all, but they did involve health policy issues, so that stuff came to me as well as to other policy people. It was the entire enchilada.

I had, of course, resources I could call upon in all of the agencies. In addition, because I had strong support from Richardson, I was able to recruit an excellent staff in a very
short period of time. I realized that I needed somebody who knew his way through the bureaucracy. I got a man named Dan Zwick who was and is an outstanding individual and a superb manipulator of the bureaucracy. With his help in the bureaucratic maze and an excellent professional staff, I was able to deal, reasonably well, with the many and diverse policy issues--everything from lead paint poisoning to appropriate collective bargaining units in hospitals.

The Medicare amendments of 1972 established the PSRO, (Professional Service Review Organization). I had the responsibility for planning the implementation of the PSRO system. Although it was part of Medicare, it was delegated to the Assistant Secretary for Health. So the HMO Act was, as I say, a relatively small part of what I needed to handle.

**National Health Insurance**

Hughes: Does that cover it in at least superficial fashion?

Fleming: I think so, except there's one other thing I ought to mention because it has had some continuing significance and may ultimately have more significance. When Nixon was reelected in 1972, the word came down from the White House that the administration wanted a complete new look at "national health insurance." The administration was being criticized for not doing anything significant about health care for the uninsured and underinsured. In fact Nixon and his crew were not eager to do anything about it. However there was enough political and public pressure to call for rethinking national health insurance.

Two deputy assistant secretaries had relevant responsibilities. There's an Assistant Secretary for Planning and Evaluation, which is "governmentese" for the internal think tank concerned with "What are we doing? Are we doing it right? What should we be doing in the future?" etcetera. And there was a Deputy Assistant Secretary for Health Planning and Evaluation, working for that Assistant Secretary. I was Deputy Assistant Secretary for Health Policy Development, which is another set of words for the same function. Stuart Altman, now I guess dean of the Heller School at Brandeis University, was the Deputy Assistant Secretary for Health Planning and Evaluation. We had essentially the same job, which was moderately awkward. However, we worked well together and divided things up. There was plenty for everybody to do, so it was not a turf battle, which it could
have been. Secretary Richardson favored some intellectual
competition in policy development.

Stuart Altman previously had been doing some work on
national health insurance. We were called into the Secretary's
conference room with appropriate other personnel present,
although we were the two who were really going to do the work.
Richardson asked us to take a fresh look at "national health
insurance" and develop options for HEW to consider in formulating
a recommendation to the president.

Stuart Altman's department developed three different options
that I won't bother trying to describe; they really didn't plow
any new ground. I, with my staff, developed one, which I called
"Structured Competition Within the Private Sector." It did
represent a new and different approach. It was essentially a
choice-of-plan system to be administered in conjunction with the
federal income tax in which employers would contribute toward
health care coverage as they were in the existing fringe benefit
system, but with a mandate covering nearly all employers. People
not in covered employment would receive tax credits equivalent in
value to the value of the tax preference for people in regular
employment. People covered under this scheme would have their
choice among several alternative health care arrangements,
involving distinctly different types of plans. It would be in
many ways analogous to the Federal Employee's Health Benefits
Program, but mandatory, nearly universal, and would, I believe,
have assured vigorous, consumer-oriented competition.

Elliot Richardson was extremely interested in this, and if
he had continued to be the Secretary, he might very well have
picked it as the department's recommendation to the president.
We started this exercise in August when it looked as though Nixon
would be reelected. Very shortly after he was reelected, he
assigned Richardson to the Department of Defense, and Cap
[Caspar] Weinberger became Secretary of HEW. Weinberger was head
of OMB [Office of Management and Budget] at the time, and he
couldn't leave OMB until the budget was prepared, so from the
middle of November until about the first of February, Richardson
was really at the Defense Department, Weinberger was at OMB, and
HEW was running on momentum.

Anyway, Richardson had understood my proposal and liked it.
Weinberger didn't understand it. I thought Weinberger was a
brilliant man. He had the reputation in OMB of being a brilliant
man, but I think maybe he's just quick with numbers.

Let me back up just a minute. I did a lot of policy papers
at HEW. Often they went home with Elliot Richardson in the two
Hughes: Fleming: briefcases that he carried when he left the office. I thought he carried them for ballast, because nobody could go through that stuff. [laughter] However when they came back, it was clear that they'd been carefully studied by somebody of great intelligence--things underlined appropriately, thoughtful marginal notes, questions that made sense, and Richardson also corrected typographical errors. [laughs]

Weinberger marked things up in a similar fashion, but it was clear that he wasn't on the same wavelength. His marginal questions didn't make a lot of sense, and he didn't underline the important things.

When I put the proposal before Richardson and said, "There's going to be political opposition from these various quarters," Richardson's attitude was, "If it's the right thing to do, let's proceed and deal with the politics later." Weinberger looked at the same political analysis, noted the probably sources of opposition, (including the Nixon-friendly Teamsters Union), and that was all he wanted to know.

Hughes: Really?

Fleming: Yes. [tape interruption]

The sequel is that when I left HEW and went to the Northwest Region in the middle of 1973, I took copies of some of my key HEW papers, including my national health insurance policy papers, with me. Soon thereafter I met Alain Enthoven, who had been an assistant secretary in the Defense Department when [Robert] McNamara was the secretary and had worked on major defense policy issues. He was interested in the health care field and had become a consultant to the Kaiser Permanente Program. He was circulating to meet the regional managers, medical directors, and other key personnel in the program.

We got to talking about our government experiences, and I gave him a set of my national health insurance papers. He became interested in these and they became the starting point for the extensive work that he has done on national health insurance. This is the origin of "managed competition," a significant aspect of Clinton's proposed national health care reform. It may prove to be influential, although the final outcome of the health care reform effort is highly uncertain. The Enthoven proposal, an elaboration and refinement of the "structured competition"

\[^{1}\text{One important aspect of policy analysis is how the policy will play politically.}\]
concepts is embodied in many articles and a book entitled *Health Plan*. It is the most rational and realistic approach to this topic that I'm aware of. Unfortunately, it will face heavy political opposition from many sources. However it is on the table as our society may finally be commencing to do something on national health insurance instead of just talking about it.

Hughes: Well, thank you.

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1Alain C. Enthoven, *Health Plan: The Only Practical Solution to the Soaring Cost of Medical Care*, (Reading, Mass: Addison-Wesley Publishing Co., 1980.)
As management put the elements of the post-Tahoe reorganization into place in late 1956 and early 1957, another important development commenced. Mr. Henry J. Kaiser had moved to Hawaii and busied himself developing his hotel and convention center on what is now regarded as Waikiki Beach. Then it was mostly tidelands lying roughly to the west of Fort de Russey, the U.S. military establishment that had marked the western end of Waikiki Beach. The Kaiser property extended to the Ala Moana Yacht Harbor. After the hotel complex (known as the Kaiser Hawaiian Village) was well underway, Kaiser turned his attention to the Hawaii Kai residential and commercial real estate development in a large, previously undeveloped area near Diamond Head.

However, the Medical Program was never far from his mind. Having reluctantly accepted the post-Tahoe "partnership" arrangement with the Permanente Medical Groups in California and the Portland, Oregon area, he was determined to "do it right" and establish his version of the Medical Care Program in Hawaii. It would be insulated from what he conceived to be the erroneous directions pursued on the mainland, primarily because of the influence of the Permanente Medical Groups.

Objectively there was relatively little need, at that time, for a Kaiser Foundation Health Plan type program in Hawaii. The Hawaii Blue Shield Plan--Hawaii Medical Services Association--unlike physician-dominated Blue Shield plans on the mainland, was

1This entire section, "Hawaii Startup," was written by Mr. Fleming as an addition to the interview.
dominated by a somewhat paternalistic business establishment. They were quite concerned with cost control and with serving as much as possible of the Hawaii population.

Despite absence of significant public need, Mr. Kaiser with a "whim of iron" was determined to establish "his" medical program in Hawaii and was not inclined to listen to those who held a different view. The Permanente Medical Groups in California and the Northwest strongly opposed the Hawaii venture, but, from Mr. Kaiser's perspective, it was none of their business.

I don't personally know what Dr. Sidney Garfield's views were, but I do know that Dr. Garfield, now Henry J.'s brother-in-law, did work closely with Mr. Kaiser on the design of the Honolulu Medical Center and engaged the Portland architectural firm of Wolf and Zimmer to do the architectural work and manage the engineering work.

Dr. Garfield certainly knew that a health plan requires an organization including physicians and non-physician managers, and that physical facilities, although necessary, are in many respects a secondary issue. It is not clear, however, that he was effective in communicating this vital point to Henry J. Kaiser. Although Mr. Kaiser developed an industrial empire of major proportions and made development of the Kaiser Permanente Medical Care Program possible, it seems, from my limited knowledge of the man, that his primary obsession was building--building in a very physical sense.

He wanted to build a highrise medical center near the Kaiser Hawaiian Village complex where he maintained his office. He seemed to believe that if he constructed a good, modern facility, other things would take care of themselves.

In addition, his approach toward establishing the medical program in Hawaii seemed to involve what I have frequently called "the virus theory." He seemed to feel that the Kaiser Permanente Program on the mainland had become infected with some noxious virus that kept it from performing in accordance with his desires and expectations; if he permitted Program personnel from the mainland to become involved in developing the Program in Hawaii, they would somehow transmit the virus and sicken the Hawaii program with the deficiencies that he perceived on the mainland.
Legal Groundwork

Fleming: However, he either recognized or was persuaded that some legal groundwork was essential so I made several trips to Hawaii, mostly in the latter half of 1957. At that time, Hawaii was still a territory with a legal structure somewhat, but not greatly, different from that in a typical state. The Kaiser Permanente Medical Care Program was an unconventional organization that did not fit the legislative framework in Hawaii--or much of anywhere else for that matter.

Working with Richard Sharpless, an attorney in the law firm that Mr. Kaiser used in Hawaii, I was able to persuade the territorial government of several key points:

- The Medical Program was not an insurance company and did not fall within the Hawaii insurance laws. (It was clearly not a Blue Cross or Blue Shield Plan and could not fit within existing enabling legislation).

- Under Anglo-American common law, one does not need enabling legislation; if it is not prohibited, it is permitted--a concept vital to organizational innovation.

- Kaiser Foundation Hospitals, despite its unconventional revenue generating system, qualified for hospital tax exemptions under Hawaii law.

- The Health Plan, a non-profit organization, but not yet recognized as tax exempt under federal law, would not be required to pay the Hawaii gross receipts tax on Health Plan dues. (The Hawaii gross receipts tax, then at a 3.5 percent rate, applied to essentially all gross receipts; there was no credit or offset system to avoid duplicate payment, as there is with a value added tax.)

The net result was that we were able to qualify the Hospitals and Health Plan in Hawaii effectively as tax exempt organizations. Only the Medical Group would pay the gross receipts tax--a result that put the Program on a tax parity with Hawaii Medical Services Association, the primary competitor.

There were a number of other less vital legal issues on which we also achieved highly satisfactory results. In retrospect, and with the experience of a number of other bureaucratic situations, I think the results were quite remarkable. The key results were vital to establishing the program in Hawaii. However, at that time the Kaiser culture
embodied a very strong "can do" attitude and none of the Kaiser associated personnel involved saw anything unusual in achieving a successful result in a reasonably short period of time. Several factors were important here:

- Although I provided the legal advocacy, Richard Sharpless, with a background in Hawaii government and an excellent reputation with key government personnel, provided entrée and lent credibility to some unconventional legal arguments.

- Resentment over domination of the political economy of Hawaii by the "Big Five," or "Big Six" companies—depending on how you classify the Dillingham Construction Company—although muted, was widespread.

- Mr. Henry J. Kaiser, the first one to mount a major challenge to the hegemony of the feudal barons, was something of a folk hero. Perhaps some of the key Hawaii civil servants were influenced to some extent by the belief that it might be good public policy to open up what had traditionally been a quite closed society.

- In any event, although it would have been standard bureaucratic practice to "just say no," the key officials all finally said, "yes" to the important elements of our proposals for overcoming the legal barriers to operation of the Medical Program in Hawaii. They might well have "just said no" to some key points, an answer that Henry J. would not have readily accepted. We could easily have gotten into a political row involving great turmoil, expense, delay, and uncertain outcome.

"Fast Track" Construction

Fleming: With the legal obstacles out of the way before the end of 1957, construction of the Medical Center started at the beginning of February 1958—about one month behind schedule. Henry J. Kaiser was a marvelously impatient man and construction started before the plans were finished. Indeed, Wolf and Zimmer in Portland were working as fast as they could to keep the architectural and engineering work ahead of the construction. As I understand the situation, the architects and engineers were regularly doing design work only one or two floors above the level at which the construction contractor was pouring concrete—a construction methodology that does not necessarily produce optimum results in the placement of mechanical components of a complex building.
Meanwhile, Mr. Henry J. Kaiser was out at the construction site nearly every day in his pink aloha shirt, straw bossing the job and driving the contractor crazy. However, that complex, high rise medical facility, commenced at the beginning of February, was serving patients November 15, 1958, just two weeks behind Mr. Kaiser's schedule. Two to three years would have been "par for the course" to construct such a facility.

Establishing the Medical Group

Fleming: With construction well underway in the spring of 1958, someone--probably Gene Trefethen--stimulated by Dr. Clifford Keene or possibly Sidney Garfield, was able to turn Mr. Kaiser's attention to the vital issue of finding some doctors to provide the medical services. Mr. Kaiser and his family had been receiving medical care from three Caucasian physicians who, as I understood the situation, shared office space but were not partners. They were Dick Dodge, an orthopedist, Dick Durant, a family practitioner, and Wally Herter, specializing in Ob-Gyn. Their only apparent qualification for forming the nucleus of a medical group for a prepaid group practice system was their acquaintance with Henry J. Kaiser. I am not certain when we in Oakland first learned that Mr. Kaiser viewed these physicians as the nucleus of the medical group. I learned of it on one of my trips to Hawaii devoted to "tidying up" some legal loose ends.

I knew that Caucasians were a distinct minority in the Hawaii population, that the two largest population groups were Japanese and Chinese, and that a significant portion of the population came from the Philippines and assorted Pacific Islands as well as various parts of Asia.

On returning from a visit to Hawaii, I reported to Gene Trefethen--as I always did on such occasions because he wanted to keep track of "what Henry is doing about the Medical Program." I explained my concerns about what I thought were serious potential difficulties with the nucleus of the medical group being all Caucasian, the population predominantly Oriental, and the apparent strong preference of many Orientals for physicians of their own ethnic group. Trefethen immediately recognized that the absence of Oriental physicians from the Medical Group nucleus could compound the difficulties of physician recruitment and adversely affect the potential for membership enrollment. He expressed his concerns very strongly to Mr. Kaiser who took the matter seriously enough to ask Dodge, Durant, and Herter to expand their core group. They brought in Dr. Sam Yee, an
internist specializing in cardiology and the current or recent past chief of staff at Queens Hospital, the preeminent hospital in Hawaii, and Dr. Homer Izumi, a general practitioner with a high volume "production line" practice.

Each of these five physicians "had it made" in the medical profession in Hawaii. Yee and, to a somewhat lesser extent, Dodge were truly eminent. Both had held high offices in the Territorial medical society. All had quite successful practices and enjoyed good relations within the professional community in Hawaii. There was no rational basis for them to associate with the Kaiser Foundation Health Plan, thereby incurring professional ostracism. However, Mr. Kaiser believed fervently in the Medical Program and could be a highly persuasive salesman. In addition I suspect (although I do not have direct personal knowledge on the subject) that he sent visions of dollar signs dancing in their eyes.

Moreover, from the Health Plan viewpoint there was very little reason to believe that these physicians represented a promising nucleus for a first rate medical group. Only Yee and Dodge had reasonably impressive professional credentials and there was no particular reason to believe that either of them had significant leadership capacity. In short, Mr. Kaiser selected Dodge, Durant, and Herter to form the nucleus of the medical group for the proposed Hawaii Program simply because he knew them. Dodge, Durant, and Herter selected Izumi and Yee because Mr. Kaiser was persuaded of the need for Japanese and Chinese physicians in the nucleus of the proposed medical group. The five physicians elected to affiliate with the Program because of Mr. Kaiser's persuasiveness, probably enhanced by intimations of quite significant financial rewards.

Neither professional management on the Health Plan's side nor the leaders of the Permanente Medical Groups had any opportunity to participate in this process. The five physicians may have had some legal advice, although I did not, at that time, have any contact with an attorney representing them. Also they did not, to my knowledge, obtain any qualified guidance on the business aspects of the undertaking before them. (I don't know where they could have obtained qualified independent advice on the business aspects of the enterprise. People knowledgeable about prepaid group practice were few and far between; most of them were either in the Kaiser Permanente Program or in a few scattered places quite remote from Hawaii.)

Before the physicians became committed, Dr. Clifford Keene and I spent extensive time with them, explaining how the Program functioned, relationships among the Medical Group, Health Plan
and Hospitals, the nature of marketing, and something about the demands of a high volume, membership-based health care system. In the course of these educational sessions, we tried to make clear fundamentals of the Program, including the responsibilities of the Medical Group, the financial responsibility of the region, and the problems of marketing and of serving the prospective Health Plan membership. Although we did our best to "tell it like it is," our voices did not ring very loudly compared to Henry J. Kaiser's.

As I recall, we spent about three weeks early in the summer of 1958, meeting with the five doctors nearly every evening after the conclusion of their office hours, for sessions two to three hours in length. We tried to explain the Program in some depth, often attempting to tell them more than some of them seemed to want to know. We answered all their questions in a candid and forthright way. Mr. Kaiser sat in, at least part of the time, on most of the sessions. He was an impatient man and tried to "hurry things along," although for the most part, he just listened.

I do remember one occasion quite vividly. At the time, the International Longshoremen and Warehousemen's Union (ILWU) was on strike in Hawaii. They represented the pineapple and sugar cane workers as well as the longshore and warehouse workers who loaded and unloaded the ships. The ILWU was a powerful force in Hawaii; they dominated the unloading, storage and transportation of practically all imported goods, and Hawaii lived on imports. They also dominated warehousing and loading exports--mostly pineapple and raw sugar products.

At that time, when the ILWU was on strike, Hawaii was closed down. The tourist portion of the economy (relatively much smaller than now) was not too seriously affected because of air transport, but most other aspects of the economy came to a virtual halt. Emotions naturally ran quite high. At an evening session with Mr. Kaiser present, Dr. Durant, as I recall, asked, "Well now, if we join up with your Health Plan, will we have to take care of the ILWU?" I responded substantially to the effect that:

- In spite of the tensions existing at the moment, ILWU members were people too who needed medical care.
- On the mainland, the ILWU was one of our oldest and most strongly supportive groups.
- Because of the large potential membership that they represented, and because of the generally excellent
relations prevailing between the ILWU and the Health Plan on the mainland, I thought that the Program in Hawaii would be glad to have them as members.

Mr. Kaiser, then a very heavy man, heaved himself up in his chair to a semi-standing position and declared, "I disagree with Mr. Fleming on that."

Despite the considerable time and effort Dr. Keene and I spent in our attempt to educate them about the Program, much of it did not "take." They filtered what we said through their own notions and preconceptions. As I recall, except for the longshore incident, Mr. Kaiser never directly disagreed with Cliff or me. In the course of the sessions, however, he cast a rosy glow over the realities we were presenting. I suspect, but do not know, that he had private meetings with some or all of them in which he altered the message in subtle ways. A few examples of non-comprehension or confused communication follow.

We tried to communicate the necessity that the nucleus of the Medical Group provide leadership, inspiration, direction, and a sense of purpose to the physicians joining the group, and that a number of physicians occupying a common facility does not constitute a Medical Group. If they understood, intellectually, that they needed to develop a team and perform the demanding task of managing professionals to develop a cohesive, unified cooperating group, they never--fortunately for the Health Plan as it turned out--appeared to understand or carry out this responsibility in actual operational management.

Although we emphasized that they would be in a competitive market, that HMSA was an effective organization, and that building an adequate membership base would be a demanding task, Mr. Kaiser was personally convinced and apparently convinced the physicians that, when the doors were open, they would be swamped with membership applications. Thus, they saw no need to be concerned with building the membership.

Although we emphasized the importance of efficiency in delivering clinical services, only Homer Izumi, who was running a high volume practice, had any real notion of what we were talking about.

In short, the five founding partners had, under the most affirmative plausible evaluation, only strictly limited qualifications to organize, lead, and manage a medical group in a prepaid group practice setting, let alone the capacity to perform their responsibilities in the joint management of the total Program.
Realistically, they cannot be blamed for this. They did not understand what they were getting into. Despite the effort that Dr. Keene and I devoted to the subject, their backgrounds, preconceptions, and Mr. Kaiser's pervasive influence prevented any real understanding. Mr. Kaiser, an outstanding man in many ways, did not understand dealing with doctors and other high level professionals—except for engineers and lawyers (with whom he did work effectively).

The Permanente Medical Groups on the mainland, working in cooperation with Health Plan management and Mr. Kaiser could have assembled an excellent professional nucleus for the Hawaii venture. But this reasonable approach was totally unacceptable to Mr. Kaiser.

Probably influenced by Mr. Kaiser's view of the deficiencies of the Kaiser Permanente Program on the mainland, the Hawaii physicians chose not to seek any advice from Permanente leaders. They picked the name Pacific Medical Associates, rejecting Permanente—and they proved not very permanent.

**Equipment and Staffing**

Fleming: Hospital construction was proceeding rapidly and Mr. Kaiser soon realized the need for obtaining equipment. Reluctantly he approached Dr. Keene for help from the Medical Program on the mainland. He requested, as I recall, "a complete equipment list." He apparently expected to receive "new hospital startup document number 137" or something of that nature "off the shelf." Well, it does not really work that way. But the Kaiser Foundation Hospital mainland personnel stepped into the breach and, without adequate time to study the most appropriate constellation of equipment, they managed the process of equipping the hospital.

Marketing had consistently been the least of Mr. Kaiser's concerns, because he confidently expected a rush of enrollment applications. However, as opening time approached, and throngs of enrollment applicants did not appear, he again, reluctantly, accepted some help from the mainland. Belatedly, Health Plan and Hospital managers on the mainland filled other gaps.

Robert Jack, a good man with a background in accounting and finance, accepted the position of regional controller. By default he soon became the hospital administrator—a peculiar application of his talents. Dr. Keene commenced the process of
selecting a non-physician to fill the position that we call "regional manager"—the CEO of Health Plan and Hospital operations within the region. After two inappropriate selections had not worked out, Robert Jack became regional manager in 1960 and performed quite well under the circumstances.

Because the Bess Kaiser Hospital was under construction in Portland, Oregon, and what we now call the Northwest Region was on the verge of a major expansion, they certainly had no management talent to spare. For the most part, apparently qualified personnel in the California regions were not interested in going to Hawaii for a variety of reasons, not the least of which was their correct perception of the difficulty of working with Mr. Kaiser. In due course we selected Don Nesbitt, an experienced hospital administrator in the Northern California Region.

Although I do not think he was an outstanding candidate, he was adequate. He understood the Program and most important, he was willing to undertake the assignment. Indeed, I personally hosted a farewell party for him at my home so that his closest friends and associates could give him a good send off. However, within just two or three days before that affair, we learned that Don Nesbitt was not acceptable to Mr. Kaiser.

I suspect, based on rumors that I picked up at the time, but do not know personally, that Henry's wife Alyce, had intervened. Apparently she either had personal reservations about Don or obtained some negative feedback from people she knew well in the Northern California Region. In any event, we approached the opening of the Medical Center with no regional manager or equivalent, a sparse skeleton of people who knew anything about the Program, and the need for Mr. Kaiser's approval (and probably indirectly, Alyce Kaiser's approval), of any significant appointments.

Mr. Kaiser then selected "Handy" Hancock, his jack of all trades, who was reasonably intelligent, intensely loyal to Mr. Kaiser, and quite adaptable, based upon a career of being "available Jones" to do Mr. Kaiser's bidding.

**Open for Business**

Fleming: Despite many inauspicious aspects of the startup, the facility opened to serve members and patients in mid November 1958. In spite of numerous fiascoes which were to be expected in a new
facility and a new and unconventional Program with a new, inexperienced staff, things functioned fairly well, at least superficially. Although membership growth fell far behind Mr. Kaiser's expectations, it was reasonably satisfactory by more realistic standards, probably because of Mr. Kaiser's "folk hero" status and the desire of many people for an alternative to the Hawaii establishment.

With a few notable exceptions, physician recruiting was mediocre. As those who understood the situation expected, the five founding partners in Pacific Medical Associates were ostracized by the Hawaii medical community.

We had projected significant startup losses, and these did indeed materialize. However, we had also expected something approaching a breakeven as the membership approached the 25,000 level. But this did not materialize and losses were becoming a significant problem, particularly as arrangements with the Permanente Medical Groups on the mainland effectively precluded devoting significant financial resources from the mainland regions to subsidize Hawaii operations. The Permanente Medical Group leaders who had opposed the Hawaii venture from the start took the unsurprising attitude that this was Mr. Kaiser's problem and he could solve it without tapping Medical Program resources on the mainland.

As is the case throughout the Kaiser Permanente Program, the Hawaii Medical Group (Pacific Medical Associates) had a basic contract, renewable annually, with most provisions expected to continue in effect. Financial provisions were subject to annual renegotiation. The first full contract year, 1959, was essentially a cost reimbursement period. As I recall, even though we nominally have fixed price contracts (X dollars and x cents per member per month), 1960 was much the same. The necessities of the situation demanded that the Health Plan meet the financial requirements of the Medical Group in order to keep the Program operating. Nonetheless in order to achieve some financial discipline, Program management in Oakland was pressing hard to move toward the type of fixed per capita, risk sharing arrangement that was and is fundamental to the Kaiser Permanente system. As I recall we approached this for 1961 and thought we had pretty much arrived in the contract for the calendar year 1962.

Although the Hawaii Region had enjoyed an important boost with the effectiveness of the Federal Employees' Health Benefits Program in mid 1960, membership continued to fall behind expectations. Moreover, the five founding partners in Pacific Medical Associates were becoming increasingly disenchanted by the
very real problems of generating membership and at least participating in the management of a complex organization in a highly competitive environment.

HMSA, which at the beginning of the 1960s had great financial strength and huge reserves, was determined to "drive Mr. Kaiser's Health Plan out of Hawaii." They held their rates at unrealistically low levels despite considerable escalation of medical care costs. Indeed HMSA was sufficiently dominant in the Hawaii economy that they were apparently able to force the hospitals and physicians to absorb significant cost increases which were being passed on to the third party payers in the rest of the United States.

**Decline and Fall of Pacific Medical Associates**

Fleming: The Program was not functioning well. The quality of service, commonly a sore point in the Kaiser Permanente Program as well as in other large prepaid group practices, was not good. Mr. Kaiser, one of the most prominent individuals in Hawaii, was not insulated from the complaints. One particular problem was that the five founding partners of Pacific Medical Associates devoted more attention to maintaining and if possible enhancing their individual "private practices" than to serving Health Plan members. (Although common usage distinguishes "private practice" from "prepaid group practice," both are entirely private. A medical group in a prepaid setting is not a unit of government or otherwise in the public sector.)

There was blatant discrimination against Health Plan members. For example, when appointment waits for Health Plan members were long, the "private" or non-plan patients of the five partners had immediate access. They got red carpet treatment, they got their parking tickets validated, and otherwise received first class service, while the rest of the Health Plan membership received tourist class treatment.

By now, continuing financial and service difficulties had shattered Mr. Kaiser's dream of showing the mainland Medical Groups and Program managers how a prepaid group practice health care program should be run. He was severely disappointed and disillusioned.

In the late spring and early summer of 1962, the situation was becoming critical. Service was poor and declining. The PMA partners were unwilling to cease discriminating against the
Health Plan membership in favor of their "private" patients. They evidently felt that they could not make enough money under the Health Plan contract and had to rely on their non-plan practices. Morale was abysmal within the rest of the medical group. Complaints from members and groups were a major problem. From a financial viewpoint, performance was dismal and no improvement was in prospect.

The PMA partners seemed to have essentially no recognition of their responsibilities for Program success. With respect to all of the foregoing problems and numerous others that I did not even know about, their attitude appeared to be "that's Mr. Kaiser's problem."

In light of their very limited qualifications to perform their responsibilities, none of this should have been surprising. In many ways the most distressing part was that they did not seem to recognize their management and leadership roles and responsibilities. They appeared essentially unwilling to learn or even to make a good faith effort to effect improvements.

Managing a group of physicians and a complex prepaid health care program is not easy, and the five founding physicians seemed neither willing nor able to deal with difficult problems. My impression is that they felt misled and indeed betrayed by Mr. Kaiser. They felt that the Program could not function correctly without vastly more resources, and that the unsatisfactory and deteriorating situation would force Mr. Kaiser to provide these resources. They also apparently thought that, without great difficulty, a man of Mr. Kaiser's wealth and power could provide the resources that they felt to be appropriate.

Of course, there are times and places within the Kaiser Permanente system--a fair number of them in fact--in which greater resources in terms of personnel, facilities, and equipment, which all can be translated into money and time, are essential. However, by and large, resources available to Kaiser Permanente physicians and managers are generally at least equal to those available in traditional hospitals and medical practices. One sure sign of an inadequate manager is demanding more resources without having thoroughly optimized performance within the limits of available resources. Of course, a first-rate manager would use foresight to anticipate, request, and justify additional resource needs in a timely fashion to provide the service base for reasonably anticipated growth. A good manager would also devise transitional strategies to handle inevitable imbalances with minimum impact on quality of service.
However, the PMA partners were inadequate as leaders and managers. In the Central Office, we reluctantly concluded that future prospects for the Hawaii Region were exceedingly poor without a complete change in Medical Group leadership. We also recognized that effecting such change would be extremely difficult and potentially very expensive—though almost certainly not as expensive as continuing to operate in the manner of the spring and summer of 1962. We thought it likely that the five partners would provide adequate justification for drastic action, but we could only guess when this would happen, and what form it would take.

Meanwhile, life and business went on. Accordingly, as I recall in mid to late July 1962, after clearing things with Dr. Keene, I went with my family on a vacation to the high Sierra back country out of reach of mail and phones. When I returned on a Sunday afternoon in early August, I found a note tacked to our front door telling me to get on the first possible plane to Hawaii. Dr. Keene and Dr. Saward, medical director of The Permanente Clinic in the Northwest, had already gone over to take stock of the situation. Probably Art Weissman and Avram Yedidia were there as well, although I do not clearly remember.

During the late spring and early summer of 1962, I had gone through a number of scenarios in my mind anticipating just such a crisis that would demand quick action. Fortunately, the PMA partners made the first move in my favorite scenario. They demanded that their contractual payments be substantially increased "or else!" The "or else" clearly indicated their intention to withhold services, under the belief that Health Plan's contractual obligations to the membership and the huge cost of purchasing medical and hospital services in a community hostile to the Kaiser Permanente Program, would force the Health Plan to yield to their demands.

Terminating Relations with PMA: Birth of Hawaii Permanente Medical Group

Fleming: Faced with this ultimatum and consequent opportunity, we elected to take the "or else" path. We treated their ultimatum as a repudiation of their contract. By about noon of the first day I was there, we prepared and delivered eviction notices ordering them to vacate the premises by five p.m. Concurrently, we invited all of the employed physicians—thirty-three of them—to
a meeting to convene immediately after office hours ended for that day.

As I recall all of the physicians attended except for a couple who were engaged in critical patient care duties. Dr. Keene, Dr. Saward and I explained the situation and invited them to take over the responsibilities of Pacific Medical Associates.¹

It was almost immediately clear that practically all of the physicians were eager to do so. If anyone was more angry than Mr. Kaiser at the five original PMA partners, it was the members of the employed medical staff, who clearly knew that the partners had mismanaged the group, failed even to attempt to satisfy the Health Plan membership, and exploited the employed physicians.

I then--while the meeting was in progress--dictated to a secretary a document that I modestly declare to be a masterpiece of legal brevity. Although I don't have a copy, and may not correctly remember the precise words, the essence was as follows:

We, the undersigned, hereby associate ourselves together as an unincorporated association to practice medicine as Hawaii Permanente Medical Group, and we assume the rights and responsibilities of Pacific Medical Associates under that Medical Service Agreement with Kaiser Foundation Health Plan, Inc. dated January 1, 1962.

This single sentence accomplished formation of the group as an unincorporated association and a takeover of the PMA contract. Of course the group subsequently developed more formal articles of association, but the essentials of the transaction were accomplished when all of the employed physicians of Pacific Medical Associates (including two who already had commitments to take other positions) signed the document.

Loss of the medical care capability represented by the five partners was a significant but not a serious problem. Dr. Saward brought Dr. Norman Frink, a surgeon in the Oregon Region (whom Ernie described as "worth any three surgeons"), to help.

Although the California Medical Groups had strongly opposed the Hawaii venture, they also recognized their stake in seeing it succeed, as it did carry the Program name and reputation. For the most part, I don't recall the specifics, but I believe both

¹Dr. Saward had done some careful and discrete exploratory work and had a clear sense that most of the employed physicians would stick with the Program.
the Northern and Southern California Regions sent two or three physicians to help out in Hawaii. Dr. Sam Yee, the chief and possibly the only cardiologist, left one significant gap which was filled by Dr. Rosemary Lenel, a cardiologist with The Permanente Medical Group who happened to be our next-door neighbor and a good friend. My wife and I provided "house sitting" while she was working in Hawaii.

The disruptions caused by the breakup with PMA were quickly repaired. Under the guidance of Dr. Saward, service to the Hawaii Region membership was soon better than it had ever been. Dr. Saward had been in Hawaii for a week or so prior to the breakup and had identified Dr. Philip Chu, a general practitioner with natural leadership and management qualities, as the logical chief executive of Hawaii Permanente Medical Group. His leadership was accepted by the professional association, and with considerable guidance provided by Dr. Saward, he became quite a successful medical director. Although many years elapsed before the Hawaii Region thoroughly overcame the legacy of an inauspicious start, the Region achieved steady improvement.

The Battle of the Press Releases

Fleming: The five partners naturally felt badly abused and immediately sought legal redress. Their attorney, who presumably relied on their version of the facts and who probably did not know a lot about Henry J. Kaiser, decided to "try the case in the newspapers." Mr. Kaiser was a master of many things including the art of public relations. We recognized that a blast in the local press was a distinct possibility and prepared to respond. The blast came on Sunday morning under a front page banner headline. For the next few days, I spent six to eight hours each day sitting across the desk from Henry J. Kaiser as we jointly drafted and re-drafted press releases to which the PMA attorney promptly responded. Although Mr. Kaiser recognized that I wrote well and graciously accepted me as a joint author, my basic role was to see that he could not be successfully sued for libel.

There were two main newspapers in Honolulu: the Star Bulletin, and the Advertiser. One came out in the morning and the other in the evening. We had evicted the doctors on a Friday evening and they evidently worked with their attorney on Saturday so it was not until Sunday that the morning paper carried the PMA version of the story. For four or five days, the media battle went on with both newspapers printing the opposing press releases
verbatim and supplementing them with everything relevant that they could dig up.

There had not been this much media excitement in Hawaii since the attack on Pearl Harbor. The PMA media blitz dwelled on how badly Mr. Kaiser had misled and mistreated the partners—with all the accompanying nastiness they could think of. Mr. Kaiser played the violins about good health care for the working population and PMA’s failures to do their part. One major repeated theme was that Mr. Kaiser's Health Plan woefully underpaid PMA. We responded with a solid rebuttal to the effect that they were very well compensated but did not give specifics. They came back with a declaration substantially to the effect that this was absolutely untrue, and fell just short of calling Mr. Kaiser a liar.

I concluded that it was time for some stronger medicine. Based on some research I had arranged early in the game, I knew where to find it. The PMA partnership tax returns were in the files at the Medical Center. They included a schedule showing, by name, the amount distributed to each partner by the partnership in the preceding year. We made photostat copies of the distributive share schedules from the tax returns, and attached them to our next press release.

The distributive shares schedule appeared in the middle of the front page on the next newspaper to come out, and the same thing appeared in the other paper's next edition. Some of our people, not including Mr. Kaiser, questioned the ethics of using this information. I have always regarded intentional falsehood in significant matters as outrageous and feel that falsehoods in serious matters deserve effective rebuttal.

The schedules showed that each of the five partners received somewhat over $50,000 from the partnership for the calendar year 1961. That is not a high income by the standards of 1994, but in the early 1960s it was a handsome income, probably comparable to annual earnings in the $250,000 range today. Certainly to most of the general public in Hawaii, a $50,000 annual individual income was big. The tax schedules destroyed their claim of miserly payment and pretty well undercut their credibility on everything else.

Shortly after these tax schedules hit the streets, their attorney phoned me to say that he did not think we should be trying the case in the newspapers. I responded that trying the case in the newspapers was his idea, not mine, and that I would happily agree with him that neither party would issue any more press releases or otherwise feed information to the media.
Preparation for Litigation

Fleming: However, I knew that this was just round one, and that the Pacific Medical Associates vs. Kaiser Foundation Health Plan lawsuit was potentially dangerous. If an effective lawyer could get the issue before a jury, one could imagine a multi-million dollar award—a risk we had recognized when we first started thinking about how we might get the five founding partners out of the Program in Hawaii. Indeed, I had recognized some wisdom in negotiating to buy out their contract, but it was not entirely clear where the money would have come from. Besides, by that stage of development, Mr. Kaiser was so angry at the PMA partners that he would not consider any payment.

Now with the deed done and the lawsuit filed, I was concerned about organizing the best possible legal defense. I had recently recruited an outstanding young attorney, James K. Parker, for the Health Plan legal department. I had known him and learned to respect his ability in 1954, when in law school he was working as a law clerk in the Henry J. Kaiser Company legal department. He had provided exceptional help to me in conjunction with a fascinating piece of mining litigation between Kaiser Steel Corporation and United States Steel Corporation.

However, Bill Marks, head of the Kaiser legal department, was also recruiting and also remembered Jim Parker as an outstanding attorney. Bill thought that the industrial company's legal department offered Jim Parker a better opportunity than the Health Plan and Jim elected to take that job. However, the Health Plan had legal trouble in Hawaii and Bill Marks agreed that Parker could be assigned to the Health Plan as long as necessary to handle the impending row with Pacific Medical Associates.

Parker was particularly suited to this assignment because he had been working on litigation in the offices of Brobeck, Phleger, and Harrison, then clearly one of the outstanding law firms in the nation, especially in litigation. They had just won the American President Lines case with a recovery valued at well over $100 million and a fee for the case of over $30 million. In the 1950s and early 1960s, this was big league litigation—probably the largest litigation award rendered up to that time in the U.S.
When I returned to Oakland, I arranged for Parker to go to Hawaii to review and organize all the relevant documents, interview and get written statements from the prospective witnesses, and generally do everything that he could to assure that we had the strongest possible defense and counter-attack.

I also told him that he need not be circumspect about what he was doing, because I wanted the PMA partners and their lawyer to know that we were preparing for a heavy-weight legal battle. In retrospect, it appears that as the PMA attorney learned more about his case, he became discouraged. After Jim Parker returned to Oakland, and started working in the Henry J. Kaiser legal department, things became quiescent for a period. A year or so later, we got some feelers about settlement. With some difficulty we convinced the PMA attorney that we were talking nuisance value—not real money. We settled for $80,000, which probably about covered PMA attorneys fees and costs.

Postscript

Fleming: I was never happy about the whole affair because it severely damaged the careers and personal lives of the five physicians and the basic fault lay in leading them into a situation that they were unable to handle. On the other hand, Mr. Kaiser had acted in good faith, even though with unwarranted optimism, and their response to the ensuing difficulties was to avoid and deny their responsibilities and blame Mr. Kaiser and the Health Plan instead of pursuing a cooperative effort to resolve the problems.

That concludes the story of my main personal involvement with the Hawaii Region, except for a couple of incidentals. Earlier I noted that there did not appear to be an important public need for Kaiser Permanente in Hawaii, in the late 1950s when we started up there. However, without Kaiser Permanente, HMSA would probably have continued a virtual monopoly—rarely a healthy situation and rarely one which leads to optimum public benefit.

Although the acrimony between HMSA and the Kaiser Foundation Health Plan, which existed in the late 1950s and much or most of the 1960s, has largely dissipated, the two plans remain vigorous, non-colluding competitors. As a result, Hawaii has become a real world demonstration of "managed competition"—a demonstration which receives much less attention from policy makers than it deserves. Due to this competition, health care costs in Hawaii
are significantly lower than in the rest of the U.S., even though living costs generally are significantly higher.

Also, due to a wide-ranging employer mandate providing health care coverage to practically all employees in Hawaii, the percentage of the uninsured population there is much lower than the other states. Despite frenzied objections from the small business community that mandatory employer-provided health care coverage would be a disaster (probably, as I recall the propaganda, causing the Hawaiian Islands to sink beneath the Pacific without a trace), imposing the mandate scarcely caused a ripple and has in fact been quite beneficial to the entire state.¹

Despite its troubled early history, the Hawaii Region has succeeded and indeed thrived. Because it has always existed in a highly competitive environment, it has been forced to be efficient and effective. I have no significant comparative information on quality of care. However, available data indicate that the Hawaii Region has a somewhat lower cost structure and generally a somewhat higher level of membership satisfaction than any other Kaiser Permanente Region.

Thus, despite the troubled beginning and questionable public "need," the Hawaii venture has proved quite valuable to the general public in Hawaii.

¹As it affected all small employers equally, it did not change competitive relations among them. Also as Hawaii is an isolated economy, insulated from the outside world by thousands of miles of Pacific Ocean, inter-state competition was not a significant factor and the impact of international competition was limited largely to the pineapple and sugar cane industries. Thus, the Hawaii example cannot necessarily be extrapolated to the rest of the U.S. However, a national mandate, by largely eliminating health care from competitive relationships among the states, would probably work about as well as the Hawaii mandate—which was very well indeed. Implications for international competitiveness are bafflingly complex; however, by and large marginal small service businesses, which could be the most seriously affected, are not significantly involved in international competition.
VI THE OREGON REGION

[Interview 5: June 19, 1991]##

Comments on Ernest Saward's Oral History

Financial Aspects of the Medical Program

Hughes: I believe you want to comment on Dr. Saward's oral history.¹

Fleming: Yes. I guess I should start out by saying that I have enormous respect for Dr. Saward. He was certainly one of the best medical directors that the Kaiser Permanente program ever had, and an outstanding figure in the socioeconomics of medical care in the United States. Notwithstanding, I believe he was in error on a few points, and I would like to give my version in the interest of historical accuracy. In addition, I think there are some points that might appropriately be somewhat elaborated.

Dr. Saward discounts the importance of tax-exempt status for the nonprofit organizations associated with the medical program. From his perspective at the time this is understandable, because for most of his tenure in the Oregon region, exemption from tax on the organization's own income was not important; there wasn't a great deal of net income until the latter part of his tenure. In addition, the organization had operating-loss-carry-forwards to shelter income in the early years.

He also discounts the significance of donations available to the total program because of tax-exempt status. In the big picture, looking back, the donation component of the organization's capital financing is small, almost trivial, but it

¹See Dr. Saward's oral history in the Kaiser Permanente series.
was of crucial importance at certain key periods. Donated funds were vital to the construction of the Bess Kaiser Hospital in Portland, Oregon—which moved the Kaiser Permanente Oregon (now Northwest) Region from a struggling "backwater" 22,000-member program to its present significant national stature.

To understand this, it's necessary to understand the relationship and the tax situation of Henry J. Kaiser, the members of his family, and some other key Kaiser executives, all of whom held substantial amounts of stock in the Henry J. Kaiser Company or in Kaiser-affiliated companies, all acquired at a very low per-share cost. Under the tax law at that time, donations to be deductible from personal income tax were limited to 15 percent of income for most organizations, but certain organizations, including hospitals, were eligible for an additional 5 percent. The 15 percent from the Kaiser group went to the Henry J. Kaiser Family Foundation, and the additional 5 percent went to Kaiser Foundation Hospitals.

The effect of this in personal tax planning is that Henry J. Kaiser Company and Kaiser Industries stock, essentially nonliquid assets at that time, could be converted into a substantial amount of cash through sheltering income from other sources as a result of the donation process. This was extremely important to the Kaisers and the Kaiser executives because they could make donations to a related organization and, from the viewpoint of Mr. Kaiser Senior, continue to maintain a substantial degree of, although not complete, control.

The situation in the period of '56, '57, '58, and for some time thereafter, was that Mr. Kaiser was not really interested in financing the medical program from the resources generated through his donations, because of his disenchantment with the medical groups and his dissatisfaction with the outcome of the Tahoe conference and related matters. However, he was very anxious to establish the medical program in Hawaii.

There was a strong well-founded feeling among some of his respected associates, including his son Edgar and Gene Trefethen, that it would not be equitable to finance establishment of the program in Hawaii without having solved the desperate need in the Portland area, to have a hospital and major medical office facilities on the Portland side of the Columbia River. Moreover, Dr. Saward had not been one of the prime antagonists in the Tahoe conference situation. Because of his involvement with the Bonneville Dam project as well as Grand Coulee Dam, Edgar Kaiser had a keen personal interest in Portland and a close personal relationship with Ernie Saward.
The result, when Mr. Kaiser wanted to utilize donations to the Family Foundation and Kaiser Foundation Hospitals to finance establishing a program in Hawaii, was to create a situation in which Edgar and others, including, I believe, Trefethen and Keene, were able to persuade him that equity required financing the hospital in Portland at the same time. Thus, the crucial element in the conspicuous success of the Oregon Region depended absolutely on the tax-exempt status of the Family Foundation and Kaiser Foundation Hospitals.

Program Expansion

Fleming: With respect to Cleveland, Dr. Saward also has some erroneous history in his oral account. He places great importance on a meeting between some of the Kaiser leaders and leaders of organized labor during the convention of the American Public Health Association in San Francisco in November of 1967, and incidentally remarks that the Kaiser leaders at that meeting regarded the labor leaders as "nothing."

Actually, the Kaiser organization, from very early in its history, had cultivated good relations with organized labor, enjoyed much closer relations with organized labor than most industrial organizations did, and had a relationship of mutual respect with a significant number of labor leaders. Thus, there was no belittling or antagonistic approach on the part of the Kaiser executives toward organized labor. In fact, the industrial relations department of the Kaiser complex, which was a very important function in the Kaiser organization, was highly respected, highly influential, and devoted to maintaining good relations with labor.

However, although that meeting may have somewhat softened some Kaiser leadership attitudes against medical program expansion, the real decision-making process on taking over the Cleveland Community Health Foundation proceeded on an entirely different track, and the significance of the meeting we've been discussing was minimal.

That meeting occurred in November of '67. The decision to move into Cleveland (and concurrently into Denver) occurred in the Kaiser Permanente Committee during 1968 and was carried out with the takeover of the Cleveland plan, effective January 1, 1969, and opening of the Denver plan to enrollment July 1, 1969. (The timing in Denver was heavily influenced by a legal problem
which was resolved by Colorado legislation enacted in the spring of '69 and effective July 1, 1969.)

In the summer and fall of 1968, the Cleveland Community Health Foundation was in imminent danger of financial collapse, and the financial capacity of the labor groups that had been supporting the program was nearing the point of exhaustion. The Kaiser Permanente Committee dispatched a team to study the Cleveland situation; concurrently, the Kaiser Permanente Committee was also exploring the situation in Denver.

Although it would have been in many ways more logical to undertake these expansions sequentially rather than concurrently, this was rendered difficult by the competition between the Southern California and Northern California Permanente Medical groups. Any expansion at that time really required concurrence of the two California medical groups, because it involved diversion of resources from existing regions. Moreover, the Central Office had essentially no operational capability and could not have carried out the responsibility of managing operational programs in either Cleveland or Denver. The trade-off for Southern California concurrence in Northern California sponsorship of the Cleveland takeover was Northern California concurrence in the Southern California Region assuming sponsorship of the start-up in Denver.

I believe I'm pretty clear on this piece of history because, if I recall correctly, I was the chairman of the Kaiser Permanente Committee at the time, was personally in favor of program expansion, and was attempting to arrive at a methodology that would lead to Kaiser Permanente Committee approval of both the Cleveland and Denver efforts.

At one point, Dr. Saward mentioned that the Denver expansion was the "only deliberate expansion." Even though to some extent the move to Cleveland was the product of circumstance, it was equally deliberate in terms of the decision-making process. Moreover, the expansion to Hawaii, although the product of Mr. Henry J. Kaiser's "whim of iron," was nonetheless a deliberate undertaking.

Hughes: What did he mean by "deliberate"?

Fleming: I'm not sure what Ernie meant by that, and unfortunately, he's no longer available to ask.¹ The Hawaii expansion was not the product of careful analysis but was the product of Mr. Kaiser's

¹Dr. Saward died in 1989.
insistence on doing it. However, it did receive a lot of consideration, a lot of evaluation for feasibility, and was, as I understand the term, a deliberate decision.

Hughes: The deliberation was relative to the Kaiser Permanente Committee?

Fleming: At the time of the expansion to Hawaii, there was no Kaiser Permanente Committee. It was really Mr. Kaiser with staff support from the Central Office. Although key Central Office personnel were dubious about the wisdom of the decision, nonetheless, they provided essential support. For example, I personally devoted a huge amount of time to laying the legal groundwork in Hawaii. It was far from clear that prepaid group practice was a legally permissible or legally feasible activity in Hawaii. That only became established through some intense and extensive negotiations with various departments of the Hawaiian territorial government.

Hughes: What aspect was perhaps not legal?

Fleming: That depends on your starting place. There was certainly nothing in Hawaii law that authorized anything in the nature of a prepaid group practice plan, and there were things in Hawaii law that at least suggested to the contrary.

For example, Hawaii, through the territorial legislature, had a medical practice act and a full range of insurance laws. The medical program could certainly not have qualified as an insurance company. Whereas there was no clear-cut prohibition in the Medical Practice Act, there were provisions that could have been, and in the climate of the time well might have been, interpreted in a restrictive manner. I, along with our Hawaii counsel, particularly a lawyer by the name of Richard Sharpless in the firm that Mr. Kaiser used over there, worked long and hard to gain acceptance of the basic common-law notion that "if it isn't prohibited, it is permissible." The further important concept was that a nontraditional type of organization isn't necessarily an illegal organization. Note that the starting attitude of most bureaucrats, including those we met in Hawaii, is, "Show me the statutory language that authorizes you to do this."

Equally important were some interpretations of the tax laws, and particularly the Hawaii General Excise Tax, which was a very pervasive tax on gross income. The usual application of this tax would have rendered the entire program economically unfeasible. After extended negotiations, we were able to obtain several favorable interpretations, at least some of which were strongly resisted by key personnel in the Hawaii revenue department.
Thus we faced important and challenging legal problems, and the necessity to plow some new legal ground in order to clear the way for program operations in Hawaii.

While we're talking about Hawaii--and this is a kind of an aside--Dr. Saward mentioned that the Northern California Region did not provide support during the crisis in August of 1960 when we parted company with Pacific Medical Associates. Actually, the main support came from the Oregon Region, with Dr. Saward personally spending a huge amount of time managing the transition and getting the new medical group well started. Some physicians from Oregon, including Dr. Norman Frink, who, as Ernie said, "was the equal of any three surgeons," went to work there and filled much of the gap left by the departure of the five principals in Pacific Medical Associates.

There were also, I think, other physicians from Oregon, and from southern California, but there was at least one from the Northern California Region, a cardiologist by the name of Dr. Rosemary Lenel, who spent an extended period in Hawaii with the support and approval of The Permanente Medical Group. My knowledge of this is not merely incidental; Rosemary Lenel happened to be our next-door neighbor, and we provided some house-sitting services to facilitate her stay in Hawaii.

The attitude of the Permanente Medical Groups in California was that, although they thought Mr. Kaiser's venture in Hawaii was ill-considered, inappropriate, and should not have been undertaken without approval of the Permanente Medical Groups, nonetheless, as the program was in fact operating in Hawaii, it was important that it should succeed. Even though they resented Mr. Kaiser's action in unilaterally establishing the program in Hawaii, they also understood that they could not permit it to fail. I'm sure that the Northern California Region would have provided more support if necessary, but in fact the support provided by the Oregon and Southern California regions, together with Dr. Rosemary Lenel, was sufficient.

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1Pacific Medical Associates was the initial physicians' organization in the Hawaii Region, supplanted in August 1960 by the Hawaii Permanente Medical Group.
Dealing with the Multnomah County Medical Society

Fleming: The main item on the agenda today has to do with my involvement with what is now the Northwest (formerly Oregon) Region. We should probably move on to Ernie's departure from Oregon. However, I have one more aside that I think is historically interesting.

Ernie alluded in his interview to problems with organized medicine, which he handled with considerable skill. However, he did not tell one significant story having to do with gaining acceptance by the Multnomah County Medical Society for Permanente physicians. Starting soon after World War II, they had routinely denied medical society membership to Permanente physicians, even though a number of the older Permanente physicians who had been there during the war were medical society members.

In the period beginning in '57 and '58, with the construction of the Bess Kaiser Hospital in Portland, membership growth accelerated in the Oregon Region, and the problem of recruiting physicians became acute. For many physicians, medical society membership is, or at least at that time was, a highly important consideration and thus significant in recruiting. It affected hospital staff privileges (not vital to the Permanente Groups because we had our own hospitals) and also certification in medical specialties, vital in recruiting "board qualified" specialists who had met all requirements for board certification except "experience in practice" and final oral exam. Also, many physicians not sophisticated in medical economics assumed that lack of medical society acceptance indicated some deficiency in the Kaiser Permanente program. Ernie concluded that we had reached the point where something needed to be done about the Multnomah County Medical Society boycott of Permanente physicians. He discussed this with me at length. Although I can't recall exactly when, it was probably sometime in 1958. We devised a scenario that represents one of my most successful legal experiences, because it played out to perfection as we had planned.

We did not wish to institute litigation against the Multnomah County Medical Society because litigation is time-consuming, expensive, and certainly not a way to win friends. On the other hand, the denial of medical society membership was a real and important issue. We decided that we would simulate preparation of an antitrust lawsuit, which we did in the following manner.
I assigned the new man on my legal staff at that time, Martin Drobac, who happened also to be a son-in-law of Edgar Kaiser, to the task of developing a comprehensive legal memorandum on the issues involved. I told him that it was primarily a prop in a play, to be viewed edgewise, so he need not try to be concise, but for realism, it had to be substantive and comprehensive. He came up with an excellent, thorough, and thick memo on the subject.

We had been in consultation with the Davies, Biggs firm, which represented us in the Oregon Region.

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Fleming: Their lead antitrust attorney knew an antitrust specialist in Portland who also happened to be on close terms with the lawyer who represented the Multnomah County Medical Society. Accordingly, we engaged this antitrust specialist as a consultant, even though the Davies, Biggs firm was thoroughly capable of handling the litigation if that had been our objective. We met with this lawyer and presented Martin Drobac's memorandum, which was persuasive evidence of our seriousness. We explained that, whereas we didn't really want to engage in litigation with the medical society, the problem of exclusion from medical society membership was serious enough that it could no longer be ignored.

After this conference, the lawyer told us that he would like to give the matter some consideration and would get back to us. In about ten days, he reported that he had happened to have a conversation with the lawyer representing the Multnomah County Medical Society. He suggested that if the Permanente physicians would resubmit their applications, they would probably be accepted; without exception they were. That was the end of the medical society exclusion problem in Multnomah County, which was the most important one. We continued to have some medical society relations problems in surrounding counties in Oregon and Washington, although they were not sufficiently serious to require legal intervention.

That was one of the times when the practice of law was a lot of fun. However, I think the improvement in relations between the Permanente physicians and the medical societies was primarily due to the continuing success of the program, the fact that efforts to find fault on grounds of quality of care were not successful, and through personal relationships developed between Permanente physicians and their colleagues in traditional
practice. Indeed, in the urban counties the Permanente Medical Groups soon had physicians occupying significant medical society offices, committee posts, et cetera. As the program grew, the number of Permanente physicians became sufficiently great that their membership became a significant factor in county and ultimately state medical society budgets.

Hughes: Shall we skip to the time when Dr. Saward left for Rochester, which was 1970?

Fleming: Yes. The program continued to function well. From the inception of the Bess Kaiser Hospital project, we enjoyed rapid growth, good financial results.

Organizational Structure of the Oregon Region

Fleming: I guess I should mention one thing about organizational structure. Previous to the construction of the Bess Kaiser Hospital, the program in Oregon was conducted through two organizations: The Permanente Clinic, the physicians' partnership headed by Ernie Saward and responsible for medical services; and the Northern Permanente Foundation, later renamed Kaiser Foundation Northern Hospitals, which owned the facilities and the equipment, employed the nonphysician personnel, and generally provided all aspects of program activities except for professional medical services. This included both hospital and health plan operations.

During this period, we had been working with the Exempt Organizations Division of the Internal Revenue Service to obtain tax-exempt status for the Kaiser Foundation Health Plan, which in California and Hawaii was entirely separate from the hospital organization. Ernie Saward, who, de facto, was chief executive of both The Permanente Clinic and the Northern Permanente Foundation, preferred the dual organization structure and wished to avoid the complications of the three-way hospital/health plan/medical group structure that we used in the rest of the program.

Hughes: Putting it crassly, was that because he wanted to maintain control?

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1For more on this topic, see the oral history in the Kaiser series with Wallace H. Cook, M.D.
Fleming: No. He was not concerned about maintaining control. I don't think he had any doubt that he was going to maintain control, regardless of the organizational structure. He just thought it was simpler to have one corporation instead of two, which is true, and that financing was simplified by not needing to finance health plan facilities separately from hospital facilities, which was also true. At that time this was a significant problem in California and Hawaii, because we had not yet obtained tax exemption for the Health Plan. Thus Health Plan facilities had to be financed with after-tax dollars, a disadvantage, which we could minimize with various arrangements but could not eliminate.

Hughes: The Central Office allowed this situation to continue simply because the Northwest Region was so patently successful?

Fleming: No. That kind of has it backwards. Until it became successful--and its success was being achieved concurrently with what I'm talking about--there was no big tax exemption issue. Even though Northern Permanente Foundation was established as a tax-exempt organization under IRC Section 501(c)(3), it was not generating net income, so income tax wasn't a problem, and even if it had been, it had operating loss carry-forwards from earlier days that would have sheltered a very large amount of income. I forget the details of when those would have expired, but the income tax was not a problem at the time. There was also no foreseeable source of major donations until the decision to support the financing of Bess Kaiser Hospital, and the Northern Permanente Foundation was in fact tax exempt and eligible for donations from foundations. By this time it had been renamed Kaiser Foundation Northern Hospitals.

No, the issues were simplicity, the fact that they had been doing it that way and it worked just fine--and more convenient financing of health plan facilities. However, the program commenced to grow well before the Bess Kaiser Hospital was completed. When it became clear to the community that there would be a Kaiser hospital in Portland, the membership grew rapidly. Thus what had been quiescent because of low revenue and no tax issues commenced to become a significant problem.

By this time--I think we're now in late '59 or '60--we had fairly well satisfied the Internal Revenue Service that the Kaiser Foundation Health Plan was entitled to 501(c)(4) tax-exempt status, and Kaiser Foundation Hospitals was legitimately exempt under 501(c)(3). We had also established good rapport with the Exempt Organizations Division, so I met with them on a trip to Washington and discussed the situation in the Pacific Northwest and the fact that there we had both the health plan functions and the hospital functions in a single organization.
They said, "Well, we understand how you're doing things in California and Hawaii, and we think that's the right way to do it. We're not telling you to change your organizational structure in Portland, but we're not very comfortable with that. But that's an issue for the field audit staff, not for us."

I reviewed this discussion with George Link of Thelen, Marrin, Johnson, and Bridges, our principal tax advisor during this period. We concluded that, when you get your tax advice from the Exempt Organizations branch at the Internal Revenue Service, it's probably a pretty good idea to follow the advice. Hence we changed the organizational structure in Oregon to conform to that in effect in California, set up a new corporation--Kaiser Foundation Health Plan of Oregon--qualified it as a tax-exempt organization, and transferred the hospital component of operations to Kaiser Foundation Hospitals to conform the Oregon Region structure to that in the other regions.

We did this reluctantly because we respected Ernie Saward's view and his desire to keep a single corporate structure, but we felt that, everything considered, it was simply not a sound course of action in view of the attitude of key people in the Revenue Service at that time.

Saward's Departure from the Oregon Region

Fleming: The next item has to do with Ernie Saward's departure from Oregon. I've read his version of it, and with all due respect to Ernie, I am going to offer a slightly different version.

The growth of the plan during the sixties had been extremely rapid. The new recruits to the medical group overwhelmed the old core of physician managers that Ernie had developed. Ernie's style of management, which he viewed as benevolently patriarchal, was viewed by many as unduly authoritarian, if not outright tyrannical. I believe that Ernie's motivation in leaving the Oregon Region was complicated and mixed. I believe that he recognized--and he was a person of great insight--that his management style was not viable in the long term with the changed composition of the group, and chose to depart a winner instead of being deposed.

I also think that he had become a little bit bored with his position in Portland. Although the Oregon Region was highly successful and respected, it was still very small compared to the California regions. In the Kaiser Permanente management circles,
Ernie, despite his keen intellect and statesmanship, did not carry the weight that the medical directors of the California regions carried. In addition, I think that he saw other areas related to medical care that he found challenging. The combination led him to conclude that it was time for him to leave.

Hughes: Do you believe that he might have drawn a lesson from what had befallen Sidney Garfield, who some people felt had been left behind by the growth and change in the organization?

Fleming: I think it was different. Sidney was left behind for circumstances unique to Sidney and to the time. Sidney’s management style was ma-and-pa grocery store management, even though he was outstanding as a leader. He was caught up in a conflict-of-interest problem because of his dual involvement with the medical group and hospitals and health plan. He was also Mr. Kaiser’s representative in the medical program during the time that intense antagonism toward Mr. Kaiser developed among the doctors. Thus I don’t really think it’s an apt analogy. Ernie Saward, even though his management style was probably not going to adapt readily to a new, young, independent, and somewhat ungovernable medical group, he still was a good administrator, a good manager, and an outstanding leader.

I think that Ernie’s tenure was approaching its end because of the nature of the medical group and the lack of viability of the highly authoritarian management style that had been his modus operandi. Maybe Ernie could have adapted; he certainly had a lot of adaptability. But he may well not have wished to function within the medical group as a consensus builder rather than a decision maker. In any event, this is long-range psychoanalysis, and I don’t know that anyone fully understood all factors involved in Ernie’s departure.

I do think that Ernie recognized that things had to change in the leadership of The Permanente Clinic, and I don’t think that he was entirely comfortable with his perceptions of the probable directions of change. In addition he had a broad range of interests, not all of which would be satisfied within the continued development of the Kaiser Permanente Oregon Region.

He had been grooming Dr. Paul Lairson to succeed him as medical director, and that, in my estimation, would have been an excellent choice. However, it might have been premature to advocate Paul for the position of medical director because of his relatively short tenure with the group. On the other hand, it was evident that he had been picked by Ernie to become a key part of the management and presumably a successor.
What Ernie actually did, and I don't know why--Paul Lairson may have some insight into this--was pick a surgeon, Dr. Lewis Hughes, to succeed him as medical director. I came to know Dr. Hughes very well during my period as regional manager in the Oregon Region and I think I understand him well. Dr. Hughes was a very fine person, highly honorable, great integrity; I believe an excellent physician; certainly a strong believer in the Kaiser Permanente Program. He was also competent as an administrator, but he was not a manager, and in no sense of the word was he a leader.

There is some evidence that Ernie intended to continue managing The Permanente Clinic from afar, and I suspect that he regarded Lew Hughes as a person that he could manipulate and continue to be effectively a key decisionmaker with respect to happenings in the Oregon Region. Indeed, I believe Ernie continued to be a member of the medical group executive committee for some period of time.

Hughes: He left, as I remember, with the idea that he might return, is that not true?

Fleming: Oh, yes. He left with the definite idea of returning. However, at least overtly--and he discussed this with me on more than one occasion--he did not envision himself returning to a position of leadership in the medical group. He envisioned himself returning after his sojourn at Rochester to a combined clinical practice and research role. He had a very keen interest in the research program that he had brought Mitch Greenlick in to lead. So he certainly did not want to cut his ties with the Oregon Region. However, he did want to get out of the position of being medical director, and he wanted to do other things. At the same time, Ernie, in a somewhat unobtrusive and low-key way, was a bit of a control freak, and I think he felt that he could maintain significant control despite the distance between Rochester and Portland.

Hughes: Do you suppose that one reason that Lairson did not take his place was because Dr. Saward doubted that he could have the same degree of control?

Fleming: I don't know whether or not he could have successfully advocated Lairson at that time, because Lairson was a relatively junior person in the group. On the other hand, I think there was a very good chance that he could have, but I believe that he felt that he would be able to exert more long-distance influence over Hughes than he would have been able to exert over Lairson.
Deterioration of the Oregon Region

Fleming: In any event, he left the Oregon Region, as I recall, in June of 1970, with a weak regional manager, a weak medical director, and an increasingly young, vigorous, and for lack of a better analogy, in part a wild, teen-age component in the medical group. The result, not surprisingly, was a deterioration in the Oregon Region, although it did not happen immediately. I recall some discussions in the Central Office in which we theorized that the program was running on momentum and that the crew had not yet learned that the captain had left the ship. But they did discover that the captain had left the ship, and things did commence deteriorating.

Hughes: How was the deterioration manifested?

Fleming: First of all, let me note that the deterioration became evident after I left the Central Office. I left to go on a leave of absence to the Department of Health, Education, and Welfare in the summer of '71, and as of the time I left, the disarray in the Oregon Region had not yet produced significant, overt consequences. So most of this happened during the period that I was back in the Department of Health, Education, and Welfare.

This was a difficult period; Kaiser Permanente management had the Nixon wage-price controls to deal with--mostly handled by the Central Office. There was a woman regional controller in Oregon, Berniece Oswald, who was a capable regional controller. The program, to a significant extent, did run on inertia, but the medical group was becoming much less productive. The main constraint on income increases within the medical group was the wage-price control system which did in fact limit the degree to which they could increase their incomes. Their working hours were shortened and their nonclinic time was increased. Financial performance soon reflected these changes.

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Hughes: What about membership?

Fleming: The Region had about 145,000 members in 1970, and about 200,000 in 1975, so that for this five-year period, there was quite satisfactory membership growth; however it was quite uneven. I believe that membership continued to grow until the oil shock, which came in 1973. Oregon was at the far end of the oil

\footnote{See the interview in the Kaiser series with Berniece Oswald.}
pipelines. There was an economic downturn. Employment dropped in the forest products industry, which was then the core industry for Oregon, or at least that part of Oregon. That had a ripple effect. I don't have the business cycle charts and numbers in front of me, but I know that, concurrently with the economic downturn, membership growth slowed and halted and even turned negative. The quality of service deteriorated. Ernie Saward had run a tight ship and had been able to maintain a pretty good quality of service, even with a significantly lower ratio of physicians to members than prevailed in the other regions, but that degree of productivity diminished, and with it the quality of service.

**Fleming's Appointment as Regional Manager**

Fleming: The net of it was that with my leave of absence coming to an end in June of '73, Jim Vohs, who was then the chief operating officer for the medical program, asked me to take the position of regional manager in the Oregon Region when I completed my tour of duty in the Department of Health, Education, and Welfare. I completed my federal service at the end of June, took a month's vacation for a leisurely trip across the continent through Canada, and arrived in the Oregon Region at the first of August, 1973. Sam Hufford, the prior regional manager who has been discussed at some length in Ernie Saward's oral history, had been persuaded to take early retirement, and I took over as regional manager at a very challenging and difficult time.

Hughes: Why did you take the position?

Fleming: That was the position that Jim Vohs asked me to take. There was no very obvious position for me in the Central Office. I had expected to return to the Central Office, but by this time Bob Erickson was well established as the head of the legal and government relations department, and there was just no clearly appropriate role. Jim felt that the most urgent need was the position of regional manager in the Oregon Region, even though both Jenny and I regarded our home as in Berkeley and firmly intended to return here. We had an understanding with Jim that we would return to Berkeley when circumstances were right. It appeared that the proper thing for me to do was to take the position of regional manager and see what I could do to help cope with the difficult situation that existed in the Oregon Region.

This had a number of components. As I say, the oil shock hit Oregon much harder than it hit most parts of the country.
The economy in Oregon was seriously damaged by the overall economic downturn which hit the forest products industry particularly hard. In addition, the Sunnyside Medical Center, the second hospital-based facility in the Oregon Region, was under construction. It was much needed because the Bess Kaiser Hospital was seriously overcrowded. But nonetheless, opening a new hospital involves a heavy added financial and service burden. This hit the region at an extremely difficult time. For the Oregon Region to generate the revenue necessary to support operation of Sunnyside would have been demanding under the best of circumstances. The problems in the medical group and Dr. Hughes's difficulty in managing the medical group made it even more difficult.

Hughes: What did you see as your priorities?

Fleming: Attempting to repair the disarray to the extent that I could—and what a regional manager can do on the medical group side is extremely limited; providing leadership for the hospitals and health plan, for Sam Hufford had really not been a respected leader; coping with crises as they arose. It was in many ways a crisis management situation.

A pressing need was to control costs and increase revenues to the point that we would be able to support the impending opening of the Sunnyside Medical Center financially. In short, I guess my management objectives were for the most part fairly short-term oriented. I had a great deal of confidence in the long-term prospects for the region, but there were some difficult channels to navigate before it would be restored to financial balance, absorb the impact of the Sunnyside Medical Center, and function the way a Kaiser Permanente Region should function.

Hughes: Do you have any idea what qualities Mr. Vohs saw in you that he thought would be appropriate?

Fleming: I think he believed that I had a good understanding of the program, of the nature of relations with the medical group, of the economics of the program, and that I had the qualities of character that were needed to restore integrity to the nonphysician program management. I had not had operational management experience, and Jim knew that. It was a very tough situation to serve an apprenticeship in operational management. My prior management experience had been quite different.

I had responsible positions in the Central Office but not day-to-day management of an operating medical program. My direct personnel management had been management of my own staff and management of my staff in the Department of Health, Education,
and Welfare, where I believe I performed my management responsibilities excellently. But that was a different kind of thing from managing an organization of 2,000-plus people, most of them not the highly dedicated professionals that I had previously been managing, so it was a different world.

Hughes: Did you have any problem with credibility because you hadn't had much management experience?

Fleming: I think I had some credibility problems. I think my biggest credibility problem was probably a different one. I'm not good at dissembling, and I did not regard my Oregon assignment as a long-term assignment. I regarded it as one for three or four or X number of years, but as an interim assignment to provide the glue to keep things functioning and improve the functioning as much as I could, but with the expectation that I would be returning to the Central Office and to our home in Berkeley. So I made no secret of the fact that I did intend to return to Berkeley; I was going to manage the region as long as I was there, and it was certainly going to be for a few years, but it was not permanent. So in a sense, I made myself a lame duck at the outset; this was a problem but I don't think it was a big problem.

My management style, I guess, was what you would call participative. I tried to involve and coach and lead the key people in the program, and I believe I enjoyed their respect, although my position would have been stronger if I had been viewed as a "permanent" regional manager. That was probably more of a problem with the medical group than it was with the people reporting directly to me and the second-echelon people on the hospital and health plan side. I understood the program in a way that Sam Hufford never had, and the people reporting to me knew that I understood it, so I don't think I suffered a lack of credibility with them. They also knew that the region had some very severe problems and that we had to do the best we could to deal with them.

Personnel in the Region

Hughes: What do you mean when you say you understood the program, and Sam Hufford didn't?

Fleming: I don't know quite how to put this. Sam Hufford came into the Kaiser organization as a driver. I think he may have been an ambulance driver in connection with the Bonneville Dam project.
He was a man of reasonable intelligence, but certainly not outstanding. He was never a manager until Ernie Saward left, because Ernie was the manager, and Sam was Ernie's errand boy. Sam had a lot of social skills and could, when he was not unduly intoxicated, be a very charming person. But he was not a man who dealt well with figures, which are the language of business in many ways. He dealt with them only in a fairly superficial way. He was just a person who derived his respect entirely from the position that he held, and not from the capabilities or qualities that he brought to the position.

Hughes: That's saying it.

Fleming: But he had been the regional manager. He'd gone through the motions as Ernie Saward's errand boy, and he continued to go through the motions after Ernie left.

Hughes: And it worked as long as there was a strong medical director who essentially was also regional manager?

Fleming: Yes. After Ernie left, I would say it worked on inertia; Sam knew the rituals and could pretend to be the tough negotiator, et cetera, but there was not a lot of substance under Sam's veneer. There were some good people, and some fair people in the Oregon Region. I probably should have made some changes in the people reporting to me. I did not do that. I tried to resort to coaching rather than replacement. I think the people reporting to me were, by and large, not outstanding although some of them were able and dedicated.

Mitch Greenlick, of course, in his way was outstanding. However he was in research, not operational management, but he was one of the key people in the region.

There was Jim DeLong, who was highly energetic, highly motivated, highly committed to the program, and had acquired a lot of management skills by experience, although he'd never had formal management training. He was the regional facilities administrator, as we might use the term now. He was the manager of nonphysician operations, and I really think that it was DeLong primarily who kept the program functioning reasonably well during Sam Hufford's tenure.

The regional controller, Robert Scott, had impressed me favorably at the outset, but as time went on, it appeared that there was less to Bob than met the eye. As a matter of fact, my successor as regional manager, Carl Berner from Colorado, insisted that I fire Bob Scott before he took over, because he
regarded Bob as not acceptable as a regional controller, and by that time I had reached a similar conclusion.

Hughes: Did you fire him?

Fleming: I did. It was a directive. I didn't initiate it.

The other key people--there was Jim Crockwell, who was the health plan manager. Jim Crockwell, I believe, was a good salesman. He was not an analytical thinker. The region needed somebody who was knowledgeable about and skilled in marketing and not just a good salesman, so Jim Crockwell was satisfactory, barely.

Again, I should have strengthened the health plan component of the organization, but I was very much concerned, among other things, with not increasing the administrative overhead, even though in retrospect I am sure that building up the marketing strength would have well paid for itself.

A man named Jack Thompson, head of industrial relations, was also a weak person, and I did replace him with a man from the Southern California Region, Al Bolden, who now heads up the entire personnel and industrial relations activities for the Kaiser Foundation Hospitals and Health Plan.

There was a young lady, younger than she is now, on Jack Thompson's staff, by the name of Sally Newton, who was excellent. She has held several key personnel and industrial relations positions and is now in charge of that function in the Southern California Region.

Hughes: Was there ever any interest on the part of the Central Office or Northern California in general, in bringing the Northwest Region into the fold, so to speak, exerting a bit more control over the region which had always been the most independent region of the original three groups?

Fleming: The Oregon Region had been more independent because of Ernie Saward, and after Ernie Saward's departure, it was certainly not more independent. I guess distance itself confers a certain degree of independence.

But the degree of autonomy of the regions is quite high. The degree of Central Office supervision increased when Jim Vohs became manager of operations in the early 1970s. I don't remember exactly when that was, though I was among the people who advocated Jim's appointment to that position, even though the "logical candidate" was probably Karl Steil, who was then the
regional manager of the Northern California Region. Arthur Weissman and I were the ones who prevailed upon Dr. Keene to select Jim Vohs rather than Karl Steil. I think underlying both Art's view and mine was a conviction that Jim Vohs was a person of very high integrity, and we could not feel the same about Karl Steil.

Hughes: Even then?

Fleming: Yes. Absolutely.

Hughes: It proved to be true, didn't it?

Fleming: Yes. While not fruitful to go into at length, we had adequate evidence, not just a personal hunch that Art and I shared.

Buying Real Estate

Hughes: Mr. DeLong, in his interview in The Bancroft Library, said that you had the good sense--and those are his words--to buy land.

Fleming: I foresaw--I don't think it took all that much foresight--the growth of the West, the population growth in the Portland area, and had basic confidence in the soundness of the medical program, even though we were experiencing tough times while I was there. I anticipated growth, the need for more facilities, and the importance of providing geographic coverage in an area in which the population was moving out in various directions. I strongly advocated strategic property acquisitions at what seemed to me to be quite reasonable prices. I'd been familiar with some of the property acquisitions in California and knew about land values in

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1Karl Steil later resigned "under a cloud." Although I am not personally aware of definitive findings, it appears that he utilized program personnel and materials for improvement or maintenance of his personally-owned boat and residence. His forced resignation was attributed to permitting development of an environment, in at least one portion of the program, that fostered misuse of program resources. One high-level internal construction manager apparently made extensive use of construction department personnel, facilities, and materials to make major improvements to property which that manager owned in the Pebble Beach area.

Hawaii, and I felt that even though we were hard pressed for capital, those were important for long-term success.

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Fleming: --I was mistaken on one. We bought some land in Wilsonville which is, some ten to twelve miles south of the southern edge of the built-up Portland area. I judged this to be an area that would grow rapidly. It grew, but less rapidly than I had expected, and the program subsequently sold off the Wilsonville land. They sold it at a very substantial gain, so it was sound as an investment but at least up to now did not prove to be a good facility location.

Hughes: Where else did you buy land?

Fleming: I'm not sure that I can remember all of the places. We acquired land in Vancouver, Washington, for facility expansion. We acquired land in what at that time was the east fringe of Portland. We also acquired all the land that we could in the vicinity of the Bess Kaiser Hospital, and not far from the Bess Kaiser Hospital in what was recently the regional headquarters area. At that time, we had a major outpatient facility which we called the Interstate Clinic. Across Interstate Avenue, the main north-south thoroughfare through that part of Portland, we acquired land as it became available in what has become a major group of facilities including the center for Health Research.

The Region in the Mid-1970s

Hughes: Mr. DeLong also said in the interview that the Northwest Region had a low period, and he gave the years as 1975 to 1976. Was this more than just an extension of the oil problems that you mentioned before?

Fleming: No. In a sense, it was the aftermath of that. A bunch of things were happening. This was the period during which we were digesting the Sunnyside Hospital.

Hughes: You mean financially?

Fleming: Yes, financially. That was a big step up in expenses, and we were also suffering the deterioration of the medical group. It was in '76 that it became my chore to persuade Dr. Hughes that he should resign from the position of medical director and accept Dr. Marvin Goldberg from the Southern California Region--he'd
been the physician-in-chief at San Diego--to take over as medical director of The Permanente Clinic.

 Goldberg is a complicated man. He brought a lot of knowhow which Lew Hughes did not have. He was able to manage the medical group, which had been rather unmanageable under Dr. Hughes, and he brought a lot of knowhow to improving the functioning of the operations of the medical offices which are crucially dependent upon how the doctors conduct their practices. So Marv Goldberg was a person who had the knowledge, experience, and knowhow to be an effective medical director, which Lew Hughes did not have. It's very hard, if not impossible, for a regional manager to obtain good functioning from a Kaiser Permanente region if the medical group is not functioning well, and the medical group under Lew Hughes was not functioning well.

 Hughes: What did the doctors think about the departure of Dr. Hughes?

 Fleming: I think most of them liked Hughes; he was well accepted and respected when he returned to clinical practice and continued until he retired. I also believe that most of them knew that he was not effective as a medical director and that the medical group did need a strong medical director. The "wild teenagers" had had their fling, and I think there was a lot of recognition that, for the continued successful functioning of the program, they did really need to have a good, strong medical director. The internal candidates were few and far between and not anxious to take the position.

 Hughes: Now, who chose Goldberg?

 Fleming: Goldberg was chosen in a very informal fashion. The other key medical directors were agreed that someone with appropriate credentials should take that position, and Goldberg was willing to do it. As I understand the situation, it was a kind of a consensus choice between the key medical directors and Jim Vohs.

 I did not personally know Goldberg. What I knew was that we needed somebody with more management and leadership skills than Lew. Lew had many excellent qualities, and maybe at the right time and circumstance, he could have made the grade as a medical director, but he came in at a time when the physicians in the medical group were really unwilling to be managed. So he had, I think, essentially an impossible task. There was a great deal of resentment of Ernie Saward's highly authoritarian management style, and to some extent they took their resentment of Ernie Saward out on Lew Hughes.

 Hughes: Did the "wild teenagers" want anything specific?
Fleming: They felt overworked, they felt underpaid, they wanted more free time, they wanted more control of their individual practices, they wanted a lot more freedom. I guess I'm a believer in a pretty high degree of freedom for highly trained professionals. I think they really have to be self-motivated. I don't think you can get productivity and effectiveness out of scientists or lawyers or doctors by old-fashioned business management methodologies.

But they need to purchase their freedom with commitment, dedication, and energy. The "wild teenagers" really wanted to have the nice parts and not provide the offsetting commitment to serving the membership. This is a very broad generalization. The "wild teenagers" were a small minority among the many solid, effective physicians in the Permanente clinic, but they had a disproportionate influence on the effectiveness of the medical group.

The program worked, and it worked because a great number of the physicians were in fact dedicated to doing their jobs, but there were some troublemakers, some young Turks, who made a career out of promoting divisiveness in relationships between the medical group and the health plan and who otherwise directed their energies in nonproductive ways. The program worked. It worked reasonably well. It didn't work extremely well. It did not achieve financial objectives.

I think it was probably unrealistic in the economy occurring at that time to assimilate the Sunnyside Hospital without having some negative financial results. But this was a temporary period. With Marv Goldberg's arrival and the establishment of effective management within the medical group, time to make adjustments and assimilate Sunnyside, things began to improve. With Carl Berner, who had a very good relationship with Goldberg and was a skilled and experienced regional manager, the program became solidly reestablished. The transition that I was heavily involved in and a key part of was successful. It was not as successful as early or as vigorously as I wish it had been, but it was successful, and the program went on to successor leadership with the fundamentals intact, with a lot of progress made, and has continued to be a solid and successful program.

It's had hard times subsequently and is now, I believe, functioning reasonably well, but only reasonably well. It has now a medical director, Fred Nomura, who was my candidate for medical director at the time of Lew Hughes's resignation, but he

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1Medical Director at the time of this interview.
was not willing to take the position. I think Fred Nomura is an excellent medical director. The program is not achieving the levels of performance that it had at various times in the past, but it's functioning well.

Hughes: Mr. DeLong mentioned that another problem in this same era was the loss of six thousand Teamster members. Was that a significant event?

Fleming: Oh, sure. Six thousand members represent a lot of revenue.

Hughes: That's saying something about the competition, isn't it?

Fleming: The issue is complicated, but it is not primarily about competition. There are two parallel Teamsters organizations in Oregon. This may be generally true; I don't know. There are the long-haul or over-the-road drivers, represented by what is called the Western Conference of Teamsters. That is a well-paid, high-benefit-level, economically strong union. Then there are the Oregon Teamsters, which were the local drivers—the short-haul, intercity but not interstate; for the most part, smaller vehicles, much less productive, lower paid, and with much more limited fringe benefits.

The Kaiser Permanente program has tried very hard to adhere to a rating program with integrity: no negotiated rates, no special deals, a fairly determined rate, and that's what all comers have to pay. That has been general policy. At the time I arrived in Oregon, an exception had been made for the Oregon Teamsters. The union could not afford the rates for the health plan benefits that they had traditionally received. Some minor cutbacks in benefits had been negotiated, and their contract had been renewed with significant shading of the valid community rate.

That was a situation that I wanted to get out of, and at the same time, I didn't want to lose the Teamsters. I forget which year it was, but we had a rate increase and they said they couldn't pay it. I would not permit further eroding of the community rate that they were supposed to be paying. They were already receiving a rate that I could not justify, and while I didn't want to demand that they get on the proper rate immediately, I didn't want to let the situation get any further out of whack.

The net of it was that they concluded that they couldn't pay the rate and dropped the program. Whether if I had intervened more vigorously, I could have prevented that, I don't know. It was something that Jim Crockwell had been handling and it was in
his area of responsibility. I probably should have involved myself more fully than I did; that would have been deeply resented by Crockwell, who felt that this was his domain. Although we talked about it at great length, we were not able to come up with any strategy acceptable to us that would have met the Teamsters' demand, so they dropped the program.

The OEO and Dental Programs

Hughes: I'd like to talk now about the social outreach programs in the Oregon Region which I think are unique to that region. Dr. Saward talked about the OEO [Office of Economic Opportunity] program. Do you have anything to add to his commentary?

Fleming: I don't think I really do. By the time I got there, the Nixon administration's cutback in funding for that kind of activity was taking effect, and the OEO, the Office of Economic Opportunity, had been disbanded. The former OEO program had become an adjunct of the state Medicaid program. We did have something called Project Health in Multnomah County—a very fine project in which the county supplemented funds available from other sources to provide a choice-of-plan system for people who were above the categorically eligible Medicaid cutoff but still in the poverty population. That program functioned well. I had occasion a couple of times to testify before the Oregon legislature with respect to various aspects of that program, including criticisms that it was costing too much. I think we were able to make a fairly convincing case that it was the best buy available. I should note that the Oregon Region, although somewhat more active in relation to size than other regions in social outreach, is not unique. All well-established regions have their own analogous efforts.

There was one aspect that I do want to mention because it led to one of the developments in the Oregon Region that I'm personally most proud of. Part of the OEO program had been a dental program for OEO beneficiaries. In connection with that, we had established a dental clinic, the physical facility being owned by the federal government but operated by the Kaiser Permanente program through the OEO project. With that being phased out, one question involved the future of the dental program.

In my view, in a rational world, dentistry would simply be another medical specialty like orthopedics rather than a totally different profession. I felt that, with the experience gained in
the OEO dental program and some of the staff who had managed or conducted that program, we could establish a prepaid dental program for the general health plan membership. The Federal Employees Health Benefits Program wanted a preventive dental benefit, so we explored the possibility of continuing to provide a dental program but to expand it to the general health plan membership.

We attempted to negotiate a basis for acquiring the OEO dental facility with the HEW people, but they were ultimately not willing to agree. There was a dentist at the medical school that wanted to control that facility, and he was able to win the political fight, so we lost the opportunity to include that facility in the base for the dental program that we were envisioning. We explored other options, including a temporary facility in a trailer.

After some difficulty and some false starts, we identified an Oregon dentist who was willing to assume responsibility for establishing a dental group and take over as dental director. We did proceed to establish a prepaid dental program very economically, using basement space in existing clinics and similar improvisations, including the trailer. We established dental facilities at a sufficient number of our medical office facilities to provide reasonable geographic coverage and open the dental program to the health plan membership at a time concurrent with the phase-out of the dental program that we had operated for the federal beneficiaries. It was fraught with trials and tribulations, as anything of that sort is bound to be, but the Northwest Region now has a quite successful prepaid group practice dental program that I took the lead in launching.

The Center for Health Research

Hughes: What about the Center for Health Research and the role of Mitch Greenlick?

Fleming: I had long been a supporter of the research activity in Oregon. I think maybe at one time I was even on the advisory council for that group; leastwise, I went to a few of the advisory council meetings. That was before I went back to Washington.

Hughes: Was it a Saward creation?

Fleming: Yes. It was a Saward concept; Saward recruited Mitch Greenlick to manage it; and Saward supported it. After Saward left, it
Hughes: What do you mean by that?

Fleming: I guess you don't know Mitch.

Hughes: No.

Fleming: Well, Mitch is big. He's tall and he's wide. He has never been known, to my knowledge, to wear a coat and necktie. He's not the image of the executive in Kaiser Foundation Hospitals or Health Plan. There's a story, and I don't have this altogether clear, but this version will do because it makes the point. Supposedly, at some Kaiser Permanente function at which Edgar Kaiser was present, Mitch showed up in his usual attire, which would, for such an occasion, be neat but not conventional. Edgar Kaiser asked, "Mitch, don't you ever wear a necktie?" and Mitch replied, "They don't go well with turtlenecks." [laughter]

Mitch is a very strong personality. He's a very, very bright person, much brighter than the other people in the management group up there. He knew it, and they knew it, and they knew that he knew it, and they didn't like it. [laughter] They resented the lifestyle, the work style and so forth, in the research organization, which was quite different than in the medical offices. They regarded this very energetic, hard-working, productive research group as goof-offs and not real workers: "What the hell are they doing for the program?" The attitude was that "since Ernie Saward wanted it, we've got to tolerate it," but they, for the most part, didn't regard the research activity as something that really deserved the resources it was getting.

Hughes: What were they doing?

Fleming: They were doing health services research. I think they're one of the outstanding health services research centers in the country. They were doing a lot of different things that are going to be increasingly important as time goes on. They were maintaining a complicated statistical sample of all provider encounters. Our society has minimal valid data about outpatient encounters. Something goes into the medical records, but that's very
difficult to retrieve, and programwide, we have really minimal statistics.

On their sample, they have extensive data on diagnosis, on treatment prescribed, medications prescribed, the follow-up. They've got a gold mine of systematically accumulated medical care data that permits analysis of the comparative effectiveness of different kinds of treatment. Much of medicine is quasi-scientific folklore. The medical profession, generally speaking, does not know the relative merits of alternative therapies.

In other areas, one that I'm somewhat familiar with, there was the so-called Mr. Fit Program--Multiple Risk-Factor Intervention Trials on heart disease. The Oregon Region research center was one of the nationwide centers conducting that program, evaluating in a scientific, statistically valid way, the impact of smoking, obesity, cholesterol. Those were the main ones, but there were multiple risk factors and various interventions. How do you lower people's cholesterol? What different kinds of interventions work and which don't, et cetera? That's just one example.

They're one of the centers in the social HMO experiment, on what can be achieved for care of the elderly through a variety of home health, homemaker services, and basically, how do you minimize institutional care for the frail elderly?--a highly important problem. Their work in that area is certainly at the forefront of what's happening in the United States. I can't call to mind a lot of these things--

Hughes: Well, that gives an idea.

Fleming: Compliance with physicians' directions on taking prescribed medications--do patients or don't they take their drugs; what is important in obtaining compliance; what factors lead to noncompliance, et cetera? Very basic research in how to make health care work.

Hughes: Does the money come at least partially from outside grants?

Fleming: Yes. It's complicated, and I don't think we want to take much time on this. As a tax-exempt organization, Kaiser Foundation Hospitals has an obligation to provide community services, which can be in the areas of charity, scientific research, and education. We have chosen to put a certain amount of this emphasis into research and education, so a portion of the community service funds of Kaiser Foundation Hospitals is committed to the support of the research center. They're doing the same thing in northern California with a different emphasis
and they're doing some of the same in southern California. These internally generated funds are a continuing "hard-money" source of support for the research center.

In addition to that, the National Institutes of Health, the National Science Foundation, the National Center for Health Services Research, other government organizations, Office of Naval Research--I forget them all--do make grants. You submit a grant application, propose a study, have it go through the peer review process, and ultimately, you may be awarded a grant to conduct some particular kind of study.

Also, on these major projects like the Mr. Fit program, the National Institutes of Health may decide that they want to conduct some big study, and they will invite competitive submissions to participate from qualified organizations around the country. Then they will select several of these organizations to conduct the study, presumably on the basis of competency, to do what the national institute involved wants done. The Center for Health Services Research in Oregon has been successful in obtaining a number of such grants.

Private foundations support various research activities. So it's been a combination, but it's important that the research center have the core support from the Kaiser Permanente program, because all of the rest is soft money; you get the grant or you don't. You can't maintain continuity that way unless you're Harvard or UCSF or something like that. Core support from the program assures the continuity of the research center and permits it to function in a meaningful way irrespective of what grant support they have at a particular time.

The Service Employees International Union Strike, 1974

Hughes: Is there something you care to say before we discuss your departure in 1976?

Fleming: Well, that was three and a half years, the middle of '73 to the end of '76--a very busy period. I could talk about it at any length. I guess I should mention a particular problem while I was there. We had the first strike that had occurred in the Oregon Region. There had generally been pretty good labor relations in Oregon. When the Nixon wage-price controls came off in the spring of '74, we had health plan rates established. Our rates are established many, many months in advance. The people in the program are working very hard right now on the 1992 rates.
Those go through the end of 1992, and we're not yet to the middle of 1991, so, you see, you're kind of at the extreme. You're out there eighteen months in advance.

So our 1974 rates had actually been bedded down before I joined the program in '73, subject to the Nixon wage-price controls, et cetera. The labor wages had been held down, along with everything else, so the work force was very, very restive. The disarray in the program was not lost on the unionized workers, and they were getting up a head of steam. When the wage and price controls came off, they had very high demands and very high expectations for compensation increases. We knew that we were going to have to pay more than the rate structure was going to support, because there was some equity in the union's position.

But they got themselves fired up. I think in retrospect that they were itching for a strike. I think they wanted to have a strike, while we were attempting to avoid it but still not let compensation get totally out of hand. It was a tough negotiation— all-night bargaining sessions and things like that. As is customary, the people who really have to make the decision are kept away from where the bargaining is occurring. So I got a call about two a.m. from, I believe, Jim DeLong, and probably Jack Thompson, the IR [industrial relations] manager, as well as Jim DeLong. They were at an impasse, and would we improve our offer to avert a strike?

I did not have an IR background or experience. I was very anxious to avert a strike and I felt that it would be damaging to morale, costly in various ways, undesirable impact on membership service, et cetera. I should have played it so that they made a final offer. However, I did authorize a modest increase in our offer, and they rejected it and went out on strike. I explicitly said, "The offer has to be that this is something we will pay to avert a strike. It's not anything that we're going to be talking about in settlement of a strike."

Well, in that respect I guess I was naive. At least our IR people, during the course of the strike, said I was naive. The union struck. We'd been preparing for the strike. We had a system of recruiting volunteers. Many of the doctors' wives were nurses, and we had a lot of talent that we could call upon, and a hell of a lot of good will in the community. And we did some of the obvious things: discharged as many patients as we could, curtailed elective surgery, and generally brought the level of activity down but continued to function.
The union that struck was the Service Employees International Union. These were the janitors, licensed vocational nurses, housekeepers—that level in the organization. We functioned amazingly well with reassigning people and volunteer labor. There's a big difference, in the eyes of organized labor, between volunteers and calling in paid strike-breakers. The Kaiser labor relations doctrine did not permit paid replacements, but it did permit volunteers.

This went on for about three weeks, and people were getting tired. I was saying, "Well, back to where we were before the strike. We were offering thus and such, and that's our offer." One doctrine that's widespread in the employer community is you never reward a strike. If there is a strike, you keep it going long enough so that the union employees' financial loss exceeds what they can make up in increased wages for, let's say, two years or something like that, so that financially, they do not gain in any meaningful time frame. We were about at that point. The IR people from Oakland came in and said, "Fleming, you can't stick to your position. That will demolish the union leadership. The union leadership is no damn good, but a union that has some organized leadership is better than one that doesn't. So you've got to give them at least something."

My own reaction was, that was the dumbest thing I'd ever heard, but I was getting professional advice from people with a lot of experience in the field. I don't recall exactly what we did, but we sweetened things a little bit, and ended up with a settlement that was unduly costly because the final offer that I had made in order to avert a strike had, in effect, become a floor. That was the way it was played in the Kaiser industrial relations game. If I were the sole proprietor of a company, that's not the way it would be played. But in any event, we had the first Northwest Region strike. It was detrimental in a lot of ways, but we recovered fairly soon. Since then, they've had a much longer and more bitter strike involving the nurses that has had some long-term consequences.

Hughes: Anything else?

Fleming: No, I guess that's all. There's much that I haven't told--other events in the Oregon Region, involvement all this time on the Kaiser Permanente Committee, and the continuous discourse about national health insurance, et cetera.
Return to the Central Office

Hughes: You talked about national health insurance in the last session.

Fleming: It relates to my departure from Oregon.

In 1976, Jimmy Carter was elected. One part of Carter's platform was national health insurance. It seemed that the national health insurance (NHI) bandwagon might really begin to roll. I was certainly one of the most knowledgeable people in the program about national health insurance. I had worked on that subject when I was in Washington. I was quite familiar with all of the viable alternative proposals, and had personally developed what I think remains the best, as it's been massaged and revised by Allen Enthoven.¹

In late 1976, it looked as though NHI was going to be moving and I had a unique contribution to make in that arena. In addition, there was the understanding between Jim Vohs and me that I would be returning to the Central Office when there was an appropriate situation. I guess Jim was also thinking about some reassignments of regional managers, so Jim asked me to return to the Central Office.

By this time, Jenny and I were beginning to get settled in Oregon. It had some pluses as well as minuses. We had a lot of intensive discussion about whether I should go back to the Central Office. I felt that while my work in the Oregon Region was well started, it was by no means done, and that with a strong

medical director there, I would be able to achieve the things I hoped to achieve and hadn't been able to. So we debated, and we hadn't arrived at a decision until Jenny dropped me off in front of the Ordway Building for me to talk to Jim Vohs. When I was getting out of the car, we agreed that we should return to the Central Office and to our home here in Berkeley.

Miscellaneous

Hughes: What do you think of Rickey Hendricks's hypothesis that the direction and speed of Kaiser Permanente development was determined by the alignment and conflicts of corporate, labor, medical, and government interest groups?¹

##

Fleming: The cause of history has been done a grave injustice by the apparent professional necessity of historians these days to develop a hypothesis and either support it or demolish it, instead of simply recording what happened. I think that this search for hypotheses to play with, seriously distorts the presentation of history.

I also am a little skeptical about this historical determinism which seems to be implicit in Rickey Hendricks's approach. Of course, everything is influenced by the socioeconomic environment and by important forces around it, but I don't see a great deal of meaningful validity in the hypothesis that you quoted.

Certainly the desire of some elements of organized labor in California to have group practice prepayment health care coverage was an important influence on Kaiser Permanente--Joe DeSilva of the Retail Clerks Union in southern California, the ILWU [International Longshore and Warehousemen's Union] on the Pacific coast and in Hawaii, the Steelworkers in northern California. However there was going to be a blue-collar work force somewhere, and this work force would represent one of the logical markets for prepaid group practice, so I don't see them as having a larger-than-life role. They were an important market and they were an important source of political support, but they were not the only market and not the only source of political support.

I don't know what Rickey means by the "corporate element." Of course, the Kaiser Permanente program grew out of the Kaiser industrial activities during World War II. The decision—and it could have gone either way—to open the program to the public, the determination of Mr. Kaiser and his business associates, as well as of Garfield and the senior Permanente physicians, to make something work once they've made a commitment to it, involved influential people doing what they felt they should do.

Government was important, primarily as a customer, in the early days. We had lots of government enrollment. In a sense, the most significant government development, the choice-of-plan nature of the Federal Employees Health Benefits Program, was something that the Kaiser Permanente program initiated. We certainly had to and did both respond to and, to some degree, influence Medicare, which has been the most important government involvement in health care to date.

I think all Rickey's hypothesis says is that the important elements of the socioeconomic environment since World War II have influenced the development of the Kaiser Permanente program; of course, they have. [laughter] I don't see much substance here.

Hughes: All right. May I try another one?

Fleming: Sure.

Hughes: Again, Rickey Hendricks, and I quote: "In contrast to the self-conscious conservatism of the Kaiser organization, HIP [Health Insurance Plan of greater New York] and GHA [Group Health Association] founders both were more willing to go out on a limb to effect social changes. Others continued to fight Kaiser Permanente's battles against medical conservatives."

Fleming: Again, I think Rickey's looking at the picture through very distorted glasses. HIP was brought into being by Fiorello LaGuardia, primarily to serve the municipal employees of New York City. It was basically a labor-sponsored program. There were a few consumer cooperative group health associations; Group Health of Washington, D.C., and Group Health of Puget Sound were the most significant on the national scene. Group Health of Washington, D.C. was generated by federal employees of the Federal Home Loan Bank in the late 1930s. It was then, I believe, an avant-garde, liberal kind of movement. Group Health Cooperative of Puget Sound was another manifestation of the consumer cooperative movement, which has had a modest degree of success in a few parts of the country.
"The self-consciousness conservatism of the Kaiser Permanente program,"--I don't know that I entirely understand that. Many of the medical group leaders were and are politically fairly conservative, but they strongly believed in prepaid group practice and certainly fought their own battles with organized medicine. Of course, it was the Group Health Association of Washington, D.C. that was involved in a leading antitrust case with the American Medical Association. That was a product of circumstance, not self-conscious conservatism of Kaiser Permanente leadership.

I think that Kaiser Permanente leadership has avoided battles where they were avoidable, and has generally functioned in a relatively low-key way, for example, providing amicus curiae (friends of the court) support in the important California case of Complete Service Bureau vs. San Diego County Medical Society. That case was initiated in San Diego. We didn't initiate it, but it was very important to us, and after it was initiated, we participated in it.

We took the lead on federal employees' health benefits legislation. We took the lead on the prepaid group practice aspects of Medicare legislation. We parted with the conservatives in opposing certificates of need and similar legislation. I don't really know where these other organizations "fought our battles for us," except that the antitrust precedent established by Group Health Association of Washington, D.C. was important. We "fought our battles" as quietly as possible--and with considerable success.

Hughes: Do you see the Kaiser Permanente Health Maintenance Organization concept as a prototype for national reform of our medical care system?

Fleming: No. I see it as having been and continuing to be influential. I think there are many forces at work moving in the direction of a greater degree of integration and organization in the delivery of health care services. It's still predominantly a rather traditional cottage industry, a fee-for-service system.

I don't know what shape this animal called national health insurance will take. I suspect, based upon the general nature of the U.S. body politic, that it will be a pluralistic system in which various alternatives will be able to function. I think that prepaid group practice has intrinsic efficiency advantages that will gradually attract a larger portion of the population into organized systems that are more or less of the prepaid group practice nature. However, many versions of "managed care" are variations on fee-for-service medicine, and these, together with
traditional fee-for-service, are still decidedly dominant nationwide. Barring a rather radical kind of national health insurance legislation, I suspect they will continue to be in the majority for an extended period of time.

Hughes: You are an historian and a chronicler of Kaiser Permanente history. Why do you think this history is important?

Fleming: It's important for the reason that any history of significant developments is important. I think it is valuable to people to have some understanding of how their nations and institutions grew, how things have come about, how they've changed over time. Although you can't transpose the past to the future, I think there are important lessons to be learned from history, if it's validly reported and reasonably well interpreted. As for the history of the Kaiser Permanente program itself, I think it has been, and probably will continue to be, a highly influential aspect of the development of health care in the United States and will have some broader influence.

Hughes: Final question: What do you consider to be your greatest contribution?

Fleming: Well, in many ways, I was the principal architect of the post-Tahoe reorganization. Art Weissman and I together were the primary conceptualizers and developers, within the parameters provided by Gene Trefethen, of the reorganization that followed the Tahoe conference. I believe my part was a very, very major part and probably my most important contribution.

I think perhaps my most important continuing contribution has been mainly through the Kaiser Permanente Committee in providing a thoughtful, informed, and analytical viewpoint of what was happening in the country in relation to health care and helping to formulate Kaiser Permanente adaptations to such developments.

The Kaiser Permanente Government Relations Department, which I established and which has flourished, is another very important contribution. I recruited Bob Erickson, Jerry Phelan, and Mark Blumberg into the program, and they're all highly important members of program leadership.

I've been in a position to call it as I saw it. Although I have reported to Jim Vohs and to Cliff Keene, neither of them ever told me what I should think, what positions I should take, or what I should say in any situation. I've been my own person in the intellectual aspects of my work. I believe I've made
important contributions in steering the program in vital policy areas. I played a significant role in program expansion.

I think my last major influence involved my interview with the search committee in the process of selecting the successor to Jim Vohs. I was among the relative few who advocated selection of Dave Lawrence instead of Wayne Moon. This was not an easy thing to do because I regarded both Wayne and Dave Lawrence very highly. However, my belief was that the program has a wealth of reasonably good management and it also has some good leadership, but there's much more scarcity of leadership than there is of management. I believed that Dave Lawrence offered much more in the area of leadership than Wayne Moon. I have good reason to believe that I was highly persuasive with the search committee in advocating selection of Dave Lawrence.¹

Hughes: Thank you very much.

###

¹In retrospect, reviewing this interview in mid-1994, I acknowledge substantial disappointment in Dave's actual performance to date. Kaiser Permanente is not an easy organization to lead or manage. A strong underlying culture--mostly but not entirely good--is hard to change. With "times a changing" that is not good, but it is not all bad.

The jury is still out on whether my advocacy of Dave Lawrence for CEO was a contribution. If I could replay my "search committee" interview, I would support Dave Lawrence--but with less exalted expectations.
TAPE GUIDE--Scott Fleming

Interview 1: May 29, 1990
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Tape 1, Side B 22
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Tape 2, Side B 34
Tape 3, Side A 40
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Interview 2: August 9, 1990
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Tape 14, Side B 178
Tape 15, Side A 184
Tape 15, Side B 190
Articles/reports authored by Fleming:

ALTERNATIVE DELIVERY AND FINANCING MECHANISMS: A CONCEPTUAL PAPER.
Lane, James A.; Lairson, Paul; Fleming, Scott.
Dec. 1985
21, 2 p.; 28 cm.

KP 8512-3

GROUP PRACTICE PREPAYMENT: AN APPROACH TO DELIVERING ORGANIZED HEALTH SERVICES.
Phelan, Jerry; Erickson, Robert; Fleming, Scott.
1970
[21] p.; 26 cm.

KP 7000-1

HEALTH CARE COSTS AND COST CONTROL: A PERSPECTIVE FROM AN ORGANIZED SYSTEM.
Fleming, Scott.
Dec. 1977
20 p.: ill.; 28 cm.
"Initially prepared as a discussion paper for the HOPE Committee on Health Policy, Project HOPE."

KP 7712-1

HEALTH MAINTENANCE ORGANIZATIONS.
Saward, Ernest W.; Fleming, Scott.
Oct. 1980
7 p.: ill.; 28 cm.

KP 8010-1

A PERSPECTIVE ON COMPETITION IN THE HEALTH CARE SECTOR.
Fleming, Scott.
Nov. 1979
34 p.; 28 cm.

KP 7911-1
A PERSPECTIVE ON KAISER-PERMANENTE TYPE HEALTH CARE PROGRAMS: THE PERFORMANCE RECORD, CRITICISMS AND RESPONSES.
Fleming, Scott; Gentry, Douglas.
Jan. 1979
13 p.; 28 cm.
KP 7901-1

REPRINTS OF PRESENTATIONS BY CECIL C. CUTTING, M.D. AND SCOTT FLEMING AT THE KAISER PERMANENTE MEDICAL CARE PROGRAM SYMPOSIUM 1971.
Cutting, Cecil C.; Fleming, Scott.
1971
32 p.: ill.; 26 cm.
Contents: Historical development and operating concepts / Cecil C. Cutting; Anatomy of the Kaiser-Permanente Program / Scott Fleming.
KP 7100-3
HEW Secretary Elliot L. Richardson today announced the appointment of Scott Fleming as Deputy Assistant Secretary for Policy Development, effective today.

Mr. Fleming, 47, will serve on the staff of Assistant Secretary for Health and Scientific Affairs Dr. Merlin K. DuVal. He comes to HEW from Kaiser Foundation Health Plan, Inc., and Kaiser Foundation Hospitals, Oakland, California, where he was Executive Vice President and Corporate Secretary.

"This is an appointment of great significance to HEW's rapidly expanding effort to improve the Nation's health care delivery system," Secretary Richardson said. "Scott Fleming brings to us talent and experience that will greatly strengthen our capacity to carry out President Nixon's program of health initiatives."

He said, "I am confident that as Dr. DuVal continues to strengthen his staff with experts of Mr. Fleming's caliber, we will make substantial progress toward meeting the staggering health needs of this country."

In addition to his responsibility for policy development, Mr. Fleming will initiate and coordinate long-range studies to determine national health strategy and needs.

He joined the Kaiser industrial organization in 1952 as an attorney and, in 1955, became legal counsel for the nonprofit Health Plan and Hospitals corporations which are separate from the industrial companies.

Mr. Fleming filled a central role during the 1950s in the reorganization of the overall health care delivery system known as Kaiser Permanente. He was (More)
deeply involved in developing the contractual arrangements between the Health Plan and the six independent Permanente Medical Groups.

"The Administration considers health maintenance organizations a critical component of its plan to alleviate shortfalls in the quality and distribution of health care services. Mr. Fleming's years of experience with Kaiser Permanente constitute an invaluable resource for the Department," Secretary Richardson said.

Kaiser Permanente provides health care to more than 2,250,000 Health Plan members in California, Colorado, Hawaii, Ohio, and Oregon.

Formerly Vice President and Associate Manager of the Health Plan and Hospitals organizations, Mr. Fleming was named to his latest positions in 1970. During the last year, he has had responsibility for legal affairs, governmental relations activities and corporate planning for Kaiser Permanente.

Born in Twin Falls, Idaho, and raised in Nevada, Mr. Fleming is a graduate of the University of California, the University of California Law School at Berkeley and the Advanced Management Program at the Harvard Graduate School of Business.

He and his wife Jenny, and their daughters, India, 16, and Hilari, 15, will make their home in Bethesda, Maryland.

###
BIOGRAPHICAL SUMMARY

DATE May 1, 1987

NAME Fleming Scott

LAST Fleming

FIRST Scott

MIDDLE ---

HOME ADDRESS 2750 Shasta Road Berkeley California 94708

STREET 2750 Shasta Road

CITY Berkeley

STATE/ZIP California 94708

OFFICE LOCATION One Kaiser Plaza, Oakland, California 94612

BIRTHDATE October 17, 1923

PLACE Twin Falls, Idaho

DATE MARRIED March 5, 1954

PLACE Reno, Nevada

SPOUSE'S FULL NAME Jenny Skinner Fleming

HOMETOWN Born Lindsay, California

Lived mostly in Glendale, California

NAMES OF CHILDREN AGES CITY OF RESIDENCE (If not same as above)

India Christie 32 Seattle, Washington

Hilari Lanice 31 Chapel Hill, North Carolina

U. of Nevada, Reno 1941-42

U. of Calif., Berkeley 1942--43; 1947--1949

U. of Chicago, Chicago, Ill. 1946--1947

MILITARY EXPERIENCE, HONORS OR SPECIAL DUTIES A. U. S. March 1943--June 1946;

Commissioned 2nd Lieut., Anti-aircraft Artillery November 1943; transferred to Infantry

July 1944; released from active duty as First Lieutenant June 1946.

LIST PROFESSIONAL, CIVIC OR FRATERNAL ORGANIZATIONS, OFFICES, MEMBERSHIPS.

ACADEMIC APPOINTMENTS HELD, BY YEARS:

See "volunteer activities", below.
LIST POSITIONS IN KAISER PERMANENTE BY YEAR (Current assignment first):

<table>
<thead>
<tr>
<th>DATE</th>
<th>JOB TITLE</th>
<th>DEPARTMENT, LOCATION, REGION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1977--Date</td>
<td>Senior Vice President</td>
<td>Executive Department, Central Office</td>
</tr>
<tr>
<td>July '73--Dec. '76</td>
<td>Senior Vice President</td>
<td>and Regional Manager, Oregon Region</td>
</tr>
<tr>
<td>Sept. '71--June '73</td>
<td>Leave of Absence -- See Below*</td>
<td></td>
</tr>
<tr>
<td>1970--Aug. '71</td>
<td>Executive Vice President</td>
<td>Central Office</td>
</tr>
<tr>
<td>1966--1969</td>
<td>Vice President &amp; Secretary</td>
<td>Central Office</td>
</tr>
<tr>
<td>1961--1965</td>
<td>Associate Manager &amp; Assistant Secretary</td>
<td>Central Office</td>
</tr>
<tr>
<td>July '55--1960</td>
<td>Assistant Secretary &amp; Legal Counsel</td>
<td>Central Office</td>
</tr>
</tbody>
</table>

(Note: Above from Executive Dining Room Directory and memory; personnel dept. has more accurate records.)

EXPERIENCE PRIOR TO JOINING KAISER PERMANENTE:

<table>
<thead>
<tr>
<th>YEAR</th>
<th>JOB TITLE</th>
<th>ORGANIZATION &amp; LOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>June '49--Sept. '52</td>
<td>Attorney</td>
<td>Law Firm--San Francisco</td>
</tr>
<tr>
<td>Sept. '52--June '55</td>
<td>Deputy Assistant</td>
<td>Henry J. Kaiser Company, Oakland</td>
</tr>
<tr>
<td>*Sept. '71--June '73</td>
<td>Secretary for Health Policy Development</td>
<td>Dept. of Health, Education; Washington, D.C.</td>
</tr>
</tbody>
</table>

Various part-time and summer jobs pre World War II--mostly in photography and construction.

LIST VOLUNTEER OR COMMUNITY ACTIVITIES, INTERESTS:

- 1965--1971  Active in Sierra Club--River Conservation and River Touring
- 1967--1971; 1977 to date  Member of Board of Directors
- 1983 to date  Planning and Conservation League, Member, Board of Directors

LIST MAJOR PROJECTS OR UNUSUAL DUTIES/ACTIVITIES:

Substantial role in post-Tahoe reorganization, start-up of Hawaii Region and other expansion activities; Chairman of Kaiser Permanente Committee at time of decisions to expand to Ohio and Colorado. Established Legal and Government Relations Department; influential on several key legislative issues; influential in development of HMO Act; influential on a number of Kaiser Permanente policies and policy changes; major role in starting prepaid dental program in Northwest Region.

(Please return this form to your local Public Relations/Public Affairs Department)
TAHOE AGREEMENT: July 14, 1955

DECISIONS OF WORKING COUNCIL

I. The Advisory Council should be formed immediately and commence to function. Its membership is to be made up of key members of the Board of Trustees of the Health Plan (or their designees), the Board of Directors of the Hospitals (or their designees), and representatives of the several Medical Groups. The Medical Group representation shall be selected by each Medical Group and each group shall in general designate one person for each 100,000 members of the Health Plan in its area or fraction thereof. Under the present Health Plan membership, there would be two persons from the Southern California group, three persons from the Northern California group, and one person from Portland. However, since each of the Southern California and Northern California groups are about to qualify for an additional member under the formula, their initial membership will be three and four respectively.

The initial membership of the Advisory Council will be:

<table>
<thead>
<tr>
<th>Trustee Representation</th>
<th>Medical Group Representatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Messrs. Henry J. Kaiser</td>
<td>Doctors Frederick H. Scharles</td>
</tr>
<tr>
<td>Edgar F. Kaiser</td>
<td>Herman Weiner</td>
</tr>
<tr>
<td>E. E. Trefethen, Jr.</td>
<td>A. LaMont Baritell</td>
</tr>
<tr>
<td>George Link</td>
<td>Morris F. Collen</td>
</tr>
<tr>
<td>Doctors Sidney R. Garfield</td>
<td>Cecil C. Cutting</td>
</tr>
<tr>
<td>Clifford H. Keene</td>
<td>J. Wallace Neighbor</td>
</tr>
<tr>
<td>Ernest W. Saward</td>
<td>Raymond M. Kay</td>
</tr>
</tbody>
</table>

The organization designating a member shall have the right to replace such member at any time and of its own volition.

The functions of the Advisory Council are: (1) All of the functions of the Advisory Council are to be solely advisory in nature and are therefore not binding upon the Medical Groups, upon the Trustees or upon the Boards of Directors. (2) The Advisory Council is to serve as the top level management team. All administrative and operational functions involved in the overall medical program will be conducted with the advice of this Council. (3) The Advisory Council is to be the direct and sole channel between the regional management teams and the various Trustees, Directors, and Executive Committee of the Medical Groups. (4) It will serve as an initiating body which may of its own volition raise matters for presentation to the Trustees, Directors or Executive Committee of the Medical Groups. (5) It will review all matters to go before the Trustees and the Directors, and will make recommendations to them with respect to such matters. (6) The appointment or removal of individuals in key positions shall be reviewed by the Advisory Council before action is taken in such cases by the entity to which such person is responsible so that the views of each of the several entities may be known. However, no entity other than the one to which such person is or will be responsible shall have any right of approval or disapproval of the contemplated actions, such right being solely vested in such entity.

Notwithstanding the foregoing paragraph, all hospital staff
appointments shall continue to be subject to the approval of the Board of Directors of Kaiser Foundation Hospitals.

II The local administration of the Health Plan shall be under a local Health Plan Manager who will be directly responsible to the Trustees of the Health Plan through the Advisory Council for the local management of the Health Plan affairs.

The local administration of Hospitals shall be under an administrator of each hospital, who is to be directly responsible to the Board of Directors of the Hospitals through the Advisory Council for the local management of the Hospitals' affairs.

The representatives of the Health Plan, Hospitals and the Medical Groups are to cooperate together in each local area as a team to accomplish an efficient and workable relationship. To that end, they shall work together in regional and unit management teams.

There shall be a Regional Management Team for each region and its functions shall be: (1) The prime objective of the Regional Management Team shall be to maintain a medical care program in the region of high quality at a reasonable cost. (2) It will review matters arising in the region to go before the Advisory Council, and it will serve as a direct channel between the regional personnel and the Advisory Council. (3) It will serve as a coordinating body with respect to activities of the various entities within the region. (4) All activities within the region of the Hospitals, Health Plan, Foundation, Permanente Services, and other associate entities, shall be subject to the review of the Regional Management Team. (5) The basic responsibilities of each of the entities shall not be altered by the establishment of this management team.

In the Southern California Region, the initial composition of the Regional Management Team will be as follows:
Raymond M. Kay, M.D., Chairman
Frederick H. Scharles, M.D.
Herman Weiner, M.D.
Paul J. Steil
Karl Steil
Dorothea Daniels
Vera Lund

In the Northern California area, the initial composition of the Regional Management Team will be as follows:
Messrs. Hal Babbitt, for the Health Plan
Felix Day, for the Hospitals
Doctors A. LaMont Baritell, for Permanente Services
Morris F. Collen, for West Bay
Cecil C. Cutting, for East Bay

One of the doctor members shall be selected as Chairman, to serve for a term of six months in the Northern Region.

There shall also be a unit or area management team, which shall consist of the Unit Hospital Administrator and the Unit Physician-in-Chief.
The doctor in each team shall act as Chairman.

The functions of the Area Management Team for Northern California shall be as follows: (1) The Hospital Administrator shall be responsible for all hospital administrative actions in his hospital unit, including the educational and charitable programs, and is solely responsible for such activities to the Board of Directors of the Hospitals through the Regional Management Team. Similarly, the Area Physician-in-Chief shall be responsible for the administrative activities of the Medical Group with relationship to the hospital operations. However, in the conduct of such activities, no action shall be taken by either the Hospital Administrator or the Physician-in-Chief without consultation with the other, which consultation shall be evidenced by writing. (2) At the local area level, Kaiser Foundation activities, including research and charity, and all activities at the local unit of the Permanente School of Nursing, the women's auxiliary (if any), California Rehabilitation Center, and other associated entities, shall be discussed with the Unit Physician-in-Chief prior to any action, and the fact of such consultation shall be evidenced by a writing. (3) Any differences between the Hospital Administrator and the Area Physician-in-Chief are to be referred to the Regional Management Team for consideration.

The functions of the Area Management Team in the Southern California Region are the same as those in the Northern California Region, except that there shall be no requirement that the fact of consultation be evidenced by writing.

III The following matters should be worked out in new contracts between the several Medical Groups and the Health Plan: (1) The Medical Groups should have the right to approve persons and groups with whom the Health Plan enter into contracts. (2) The Medical Groups should have the right to approve the methods utilized by Health Plan representatives in relations with Health Plan members and the public. (3) The Medical Groups should have the right to assist in the formulation of, and approve terms and conditions of, proposed contracts with individuals and with groups of prospective members. (4) A means should be devised whereby the Medical Groups may be assured that they will have security insofar as patient members are concerned and insofar as the composition of their Medical Groups is concerned. This method should assure them that so long as the medical care they are providing is of a high standard, their contract will remain in effect, and that the Health Plan will not seek to establish new medical groups within the area now served by the respective doctor groups. (5) The Medical Groups are to have the responsibility of handling claims and complaints and the servicing of groups. It is understood in this connection that all reimbursements emanating therefrom are to be allocated properly and equitably between the Hospitals and Medical Groups.

IV The Advisory Council shall consider the development of a proper contract price between the Medical Groups and the Health Plan and the Hospitals and the Health Plan.

To this end, Mr. J. F. Reis is to be asked to develop the necessary
financial information, based upon assumptions to be worked out between him, Mr. Trefethen, and the Medical Groups, on each of the two following methods of determining these contract prices: (1) There would be paid to Hospitals a sufficient portion of the Health Plan revenue to compensate it for the costs of its operations, the costs of its research, charitable and education programs, and the amortization of loans with respect to facilities in contract areas where such loans exist, plus an additional fixed percentage of the gross income which may be used for expansion, and for the amortization of loans in those areas which do not produce sufficient income to amortize their loans. (2) There is to be established the base needs of the Medical Groups, the Health Plan and the Hospitals. Any excess of revenue over the aggregate of these base needs would be shared in by the Medical Groups and the Hospitals on some negotiated percentage basis. The portion of such excess paid to the Medical Groups would be used by each of the groups at their discretion for the improvements of medical care. The Hospitals would use the excess paid to it, at the discretion of the Trustees, for additional research, charitable care, construction of additional facilities, and such other matters as are within the purposes of the Hospitals.

It is understood that the foregoing methods are not the only methods that may be explored or utilized.

V. Permanente Services, Inc. is to be jointly owned by the Medical Groups and the Hospitals, and the Medical Groups will consequently have representatives on the Board of Directors. A plan should be worked out whereby the decisions on matters in the Southern California Area are the responsibility of the Southern California Medical Group representatives and the Directors representing the Trustees, and a similar plan should be worked out with respect to the problems of the Northern California Area. This may involve two corporations or some other method within one corporate form.

Permanente Services in the Northern California Area will continue to carry out its present functions.

In the Southern California Area, the position of Director of Permanente Services will be expanded to include advisory, counseling, and special administrative project work for all entities. The Director will possibly be the financial officer of local Hospital and Health Plan operations.

VI. The Advisory Council is to work on the matter of the formation of smaller units to serve logical service areas within the larger areas now served by the respective groups, through the utilization of a sub-partnership procedure.

George E. Link, Secretary
The Beginnings Of 'Competition'

The precursors of competition are many. But the origins of today's competitors are in prepaid group practice: multi-specialty group practices that contracted with employment groups and individuals to provide a comprehensive set of health care services in exchange for a periodic per capita payment set in advance. The pioneers of the prepaid group practice movement introduced the "limited-provider" or "closed-panel" plan as a significant competing alternative. They survived strong opposition by organized medicine and proved the acceptability of prepaid group practice and its economic superiority over the traditional model. They successfully advocated dual or multiple choice by individual subscribers of closed-panel plans, as an alternative to guild free choice. The flagships of this movement included Ross Loos in Los Angeles (1929), Group Health Association in the District of Columbia (1935), Group Health Cooperative of Puget Sound (1945) and Kaiser Permanente, with roots in the 1930s.

In 1960 the federal government adopted health insurance for its employees. The Blues and commercial insurers sought a noncompetitive guild model. But federal employees who were members of prepaid group practices were sufficiently numerous and vocal that a compromise was adopted under which the federal government would offer a range of plans for individuals to choose from and a defined contribution. The Federal Employees Health Benefits Program (FEHBP) that emerged had both good and bad design features. On the good side was price-conscious individual choice; on the bad, nonstandard benefits and lack of a design to manage biased risk selection. But it did demonstrate on a large scale that choice-of-plan arrangements were feasible and comparatively economical.

These practical achievements, which were of fundamental importance, came to be reflected in the writings of scholars and public policy analysts. Paul Ellwood, Walter McClure, and colleagues proposed a national "health maintenance strategy" in 1970 that would deal with the crisis in health care cost and distribution by promoting "a health maintenance industry that is largely self-regulatory." Their work led directly to the HMO Act of 1973. In 1972 and 1973, while serving in the Department of Health, Education, and Welfare (HEW), Scott Fleming designed and recommended a proposal for national health insurance that he called "Structured Competition within the Private Sector." His proposal emphasized practical ways of extending the successful experience of the FEHBP to the entire population. In 1977 I designed the Consumer Choice Health Plan (CCHP), "a national health insurance proposal based on regulated competition in the private sector," and recommended it to the Carter administration. CCHP built on the ideas of Ellwood, McClure, and Fleming and added design proposals to deal with such issues as financing, biased selection, market segmentation, information costs, and equity. In 1978 Clark Havighurst attacked "professional restraints on innovation in
health care financing" from the perspective of antitrust law. By the end of the 1970s the idea of a competitive health care economy had attained intellectual respectability and a significant following in Congress.

An additional departure from the guild free choice model occurred in the 1980s, starting with enactment of A.B. 3480 by the California legislature in 1982. A.B. 3480 overturned the previous prohibition on selective contracting with providers by insurers and authorized preferred provider insurance (PPI). Under PPI, the patient obtains better coverage if he or she receives services from contracting "preferred" providers. This creates an incentive for providers to accept the insurer's fee schedule and utilization controls under contract. Many other states followed California in subsequent years.

From Early Competition To Managed Competition

Experience has shown that Fleming's "structured competition" and my "regulated competition" did not quite describe what we had in mind. Under our inflexible form of government, it is difficult and time-consuming to change such things as the Medicare law and regulations, which have been negotiated with financially and politically powerful interest groups that can block efficiency-improving changes that are to their disadvantage. Civil servants are not allowed to use judgment; they are supposed to administer regulations, and they can act only on evidence that can stand up in court. The intent of both of our terms was interpreted as structuring the market by a set of rules laid down once and for all, with purchasing by individual consumers and a passive regulatory agency. Whatever set of rules one proposes, critics could and did dream up ways for health plans to get around them to their advantage. As critics identified actual or hypothetical problems, I would often reply, "I think that problem could be managed using the following tools...." This led me to believe that a more accurate characterization of what actually works would be managed competition.

Managed competition must involve intelligent, active, collective purchasing agents contracting with health care plans on behalf of a large group of subscribers and continuously structuring and adjusting the market to overcome attempts to avoid price competition. I call these agents "sponsors"; they play a central role in managed competition. A sponsor is an agency that contracts with health plans concerning benefits covered, prices, enrollment procedures, and other conditions of participation. Managed competition also connotes the ability to use judgment to achieve goals in the face of uncertainty, to be able to negotiate, and to make decisions on the basis of imperfect information. It takes more than mere passive administration of inflexible rules to make this market work.

NOTES


HIGHLIGHTS OF SCOTT FLEMING'S CAREER

Scott Fleming, senior vice president of Kaiser Foundation Health Plan and Kaiser Foundation Hospitals in Oakland, California, recently received GHAA's Distinguished Service Award. Started in the mid-1970s, this award honors individuals who have made significant contributions to the HMO industry. Past Kaiser Permanente recipients of the award include Arthur Weissman, former senior vice president and member of the Board of Directors, and Ernest Saward, MD, former medical director of Kaiser Permanente's Northwest Region. While Scott has had a varied and rich career, the following highlights help explain why he deserves the Distinguished Service Award.

Contributions to GHAA

In 1969-70, Scott Fleming played a key role in negotiating Kaiser Permanente's entry into the Group Health Association of America (GHAA). While he and many other Kaiser Permanente personnel had been individual members of GHAA for many years, some physician leaders objected to organizational membership because of GHAA's reputation for liberal political views, opposition to the AMA, and consumer control of medical care organizations. Scott finally gained approval from the Kaiser Permanente Committee to join as organizational members if GHAA amended their bylaws to moderate their "consumer control" position. GHAA was eager enough for Kaiser Permanente to join that they reworded their bylaws to read "in the interest of consumers" instead of "under the control of consumers." GHAA and Kaiser Permanente both saw the importance of the largest prepaid group practice organization (Kaiser Permanente) belonging to the professional organization that represented prepaid group practice.

Scott was a member of the Board of Directors of the Group Health Association of America from 1974-1981. He spent several of those years (around 1976) chairing a committee that addressed dilemmas posed by the shift in GHAA membership from all nonprofit or cooperative organizations to proprietary and profit-making HMOs. Scott's committee came up with a formula for the combined membership dues and allocation of GHAA Board positions among the member plans. This formula stayed in place for about 10 years.

Contributions to the HMO Industry

In 1959, Scott, then heading government relations for Kaiser Permanente, played a major role in making multiple choice of plans part of the Federal Employees Health Benefits Program (FEHBP). At the time the insurance industry, the Blues, and the Eisenhower Administration were all against this. However, the Chair of the Senate Committee handling legislation (Senator Richard Newberger) was a former journalist with a newspaper in Portland, Oregon, that had been one of Kaiser Permanente's earliest dual choice groups. He supported Kaiser Permanente's effort to write choice of plan into the FEHBP legislation. The Chair of the House also supported
multiple choice, so it became part of the FEHBP. That was a watershed event in prepaid group practice in that it gave equal recognition to our type of plan and set a vital precedent for choice-of-plan programs.

In 1970, Paul Elwood contacted Scott Fleming to discuss a dissenting opinion Scott published in an HEW report on hospital effectiveness. Scott and Paul met with several others one Saturday in Oakland, California, to discuss what kind of initiative might be needed in the health care field. This meeting and the concepts developed that day led directly to introduction of the HMO Act to Congress in 1971 and its enactment in 1973.

During Scott's tenure with HEW (from 1971 to 1973), he pushed hard to make sure mandatory choice became part of the HMO Act. Many people wanted to take this out of the legislation, but Scott convinced then Secretary of HEW Elliot Richardson that startup HMOs wouldn't be able to break into the market without mandatory dual choice. While Kaiser Permanente did not feel a strong need for this provision, Scott believed the HMO Act would have little value in encouraging new HMOs without mandatory dual choice.

In the early 1960s, Scott represented Kaiser Permanente in connection with the legislation that later developed into Medicare. He obtained some preliminary amendments and introduced some concepts that ultimately led to the alternative payment systems for HMOs, including the "risk contract" arrangements that finally evolved into workable forms in the 1980s.

Contributions to Kaiser Permanente

Scott came to work for the Henry J. Kaiser Company in 1951. In 1955, he was assigned to work full time with the medical care program. That same year, Scott and Arthur Weissman worked with the Southern California Permanente Medical Group to develop the conceptual framework for the organizational and management structure and contractual and financial arrangements between the Permanente Medical Groups, Kaiser Foundation Health Plan, and Kaiser Foundation Hospitals. This was put in place in Southern California in 1957, in Northern California in 1958, and later adapted to every Kaiser Permanente Region. Scott wrote the original contracts and related documents that, with some modifications, continue to provide the basic structure of the Kaiser Permanente Medical Care Program.

A long-time advocate of the expansion of prepaid group practice, Scott chaired the Kaiser Permanente Committee when it decided to expand to Ohio and Colorado in 1969. In addition, he authored the Expansion Policy agreed to by the Kaiser Permanente Committee in 1980, which led to the expansion of Kaiser Permanente to the Mid-Atlantic States, the Northeast, the Southeast, and the Midwest.
SR. VICE PRESIDENT
SCOTT FLEMING
RETIRES
IN JUNE

Scott Fleming, senior vice president in the Central Office, will retire June 30 after 38 years of service with the Kaiser companies. Fleming started his career with the Henry J. Kaiser Company in 1951. In 1955 he was assigned to work with Kaiser Permanente where he has been a key participant in guiding the development of our Program over the last three decades.

A lawyer by training, Fleming was a principle author of the medical and hospital service agreements that continue to provide Kaiser Permanente’s basic structure. He is a long-time advocate of the expansion of prepaid group practice, and was chairman of the Kaiser Permanente Committee when it decided to expand the Program to Ohio and Colorado in 1969. In addition, he was a principle author of Kaiser Permanente’s Expansion Policy in 1983, which led to the Program’s presence in the Southeast and the Midwest.

In 1971, he took a two-year leave to work with the Department of Health, Education and Welfare (HEW) under Secretary of HEW Elliott Richardson. Upon his return to Kaiser Permanente in 1973, Fleming served as the Northwest’s Regional manager for two and one-half years. In 1977, he returned to the Central Office, where he is a member of the Executive Department.

This month, Fleming was selected by the Group Health Association of America (GHAA) to receive its Distinguished Service Award. Established in the mid-1970’s, this award honors individuals who have made significant contributions to the HMO industry.

President and Chairman Jim Vohs comments, "As one of three individuals who originally formed the Program’s Central Office, Scott Fleming has, for over 35 years, played an integral role in the formulation of Kaiser Permanente policies. While his recent selection by the Group Health Association of America as the recipient of its Distinguished Service Award is long overdue, it does recognize the important contribution Scott has made to the growth of prepaid group practice on a national basis. Few individuals in this country can match the impact Scott has had on this country’s health care system."

Molly Prescott
25 O.B.
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Sally Smith Hughes

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