

Group Health Cooperative — One Coverage-and-Delivery Model for Accountable Care

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“On January 1, 1947, Group Health Cooperative of Puget Sound began delivering a new kind of healthcare. Consumers paid flat monthly dues for comprehensive care. Members elected the board of trustees and bought bonds to fund new facilities. Doctors and nurses devoted as much energy to promoting wellness as they did to treating illness. Group Health Cooperative’s founders believed that health was everybody’s business and everybody’s right. They prescribed democracy to cure an expensive and inefficient health care system.”

So reads historian Walt Crowley’s description of the Seattle health plan’s birth, in his book named for the organization’s mission, *To Serve the Greatest Number*.¹ Sixty-two years later, Group Health Cooperative, whose research institute I direct, is fielding inquiries from lawmakers, journalists, and others who want to know whether the cooperative model is the missing piece required by a reformed health care system that could in fact serve the greatest possible number of Americans.

Group Health is one of just two large consumer-governed health plans in the United States (HealthPartners in Minneapolis is the other). A board of trustees composed of 11 Group Health patients, who are elected by other patients, works with management and doctors to set policies and the direction for the nonprofit organization, which integrates care and coverage. Of about

600,000 Group Health members in Washington State and northern Idaho, nearly two thirds get care through an integrated network of facilities owned and operated by the co-op; the network comprises 26 primary care centers, 6 specialty care units, and 1 hospital. The other third of the membership gets care through contracted providers.

Group Health’s governance structure makes the co-op immediately accountable to its patients (members) through transparent meetings and members’ many advisory roles. But cooperative governance is not the only reason that it is being considered a model for reform — if it were, there would be more thriving health care co-ops. Instead, dozens of co-ops that formed in the middle of the past century quickly folded because of a lack of resources and opposition from competitors and the medical establishment, which saw co-ops as a threat to private practice and physicians’ autonomy.²

Rather than attributing Group Health’s success to consumer governance, many observers give the credit to the accountability its founders built into the co-op’s charter by designing it as a prepaid group practice that integrates care and coverage. Without the inflationary pressure of fee-for-service arrangements, Group Health’s salaried doctors have an incentive to provide the most appropriate treatment for patients and to keep them well.

With its providers, clinics, hospitals, and insurance plan under the same roof, the organization makes long-term investments in members’ health and manages resources to get the best quality and value for its entire membership. In this way, Group Health resembles the “accountable care organizations” that are being proposed as a way to improve quality and reduce costs.³

This alignment of incentives has served Group Health well. Developing quickly alongside other successful prepaid plans, such as Kaiser, in the 1960s and early 1970s, Group Health grew from a curiosity that was actively opposed by organized medical societies to an irritation the American Medical Association grudgingly learned to accept. Still, most consumer-owned health care co-ops that remained alive in the 1970s and 1980s have since either failed or been purchased by traditional indemnity insurance companies. And although Group Health garnered the attention of the Clinton administration in the early 1990s, a shift that many saw as the demise of the managed-care movement soon followed.

Group Health has prospered, in large part, by adapting to its changing market. For example, in the 1980s, it quit charging the same price for everyone and, like others, began rating on the basis of experience, using factors such as age to determine premiums. It also, for the first time, began collecting deductibles and

Ten Essential Characteristics of a Health Care Cooperative

To be an accountable provider of health care, to improve outcomes, and to control health care costs, a cooperative must:

1. Be a nonprofit organization, state licensed to provide health insurance or health coverage.
2. Be governed by its members, who elect a board of trustees from its membership to provide guidance and oversight.
3. Work directly with organized medical groups so that care facilities are integrated and members receive high-quality, coordinated care.
4. Encourage high quality and value — not high volume — of care through financial incentives for well-coordinated and effective health care.
5. Use health information technology in the care-delivery system — such as an electronic-medical-record system that permits secure e-mailing between patients and providers and offers online access to laboratory results, benefits information, and prescription refills.
6. Offer health coverage and care to people in Medicare and Medicaid, as well as individuals and groups of employees.
7. Be accredited by a major independent quality-assurance organization such as the National Committee on Quality Assurance.
8. Hold itself accountable to performance standards and share its performance data, and those of its providers, with the public.
9. Have an active community presence to promote broader public health, disease prevention, and well being.
10. Support unbiased public-interest research on health care systems and treatment options.

copayments. And in the early 1990s, it introduced new insurance products that allow members to choose providers outside its system. Nevertheless, Group Health's main organizing principle remains its integrated delivery system, accountable for the full range of health care services.

Now, with health care costs threatening the solvency of the U.S. economy, the spotlight has again turned to organizations such as Geisinger, Intermountain Health Care, and Group Health, which are recognized for built-in incentives for cost containment, systems that emphasize well-coordinated care, care that leverages health information technology, and a stated commitment to adhering to evidence-based guidelines for promoting prevention and reducing chronic illness.

That's not to say that systems like Group Health have solved the cost problem. In fact, Group Health's rates are comparable to

those of competitors, largely because of spiraling expenses that all providers and insurers face. The cooperative draws from the same labor market and pays competitive wages. Its physicians follow the same professional standards and practices as those in the surrounding community. It faces the same regulations and must contract with more expensive providers when members use services outside the system. On the insurance side, Group Health aligns its price structure with those of competitors, because in the absence of insurance-market reform, not doing so would put it in an unsustainable, disadvantaged position of attracting sicker, higher-risk patients. And like all providers, Group Health is challenged by intense market pressures to provide an ever-increasing array of services — not all of which produce better outcomes. Our recent analysis of content of care within our own

system reveals that unintended variations in practice and their associated costs — problems that the Dartmouth Atlas Project has uncovered nationwide — are also widespread at Group Health.

Still, Group Health may be gaining ground on the value front, especially through innovation in primary care. A new “patient-centered medical home” model of primary care, which borrows heavily from the chronic care model developed on the basis of Group Health research, is one example. In a pilot study, medical-home patients had 29% fewer emergency room visits than patients in other clinics and 11% fewer preventable hospitalizations.⁴ Preliminary results obtained 2 years after the model's implementation show that these trends persisted and probably reduced overall costs.

Meanwhile, a huge capital investment in health information technology is paying off with re-

gard to efficiency and health outcomes. Having converted, in 2000, to electronic medical records, Group Health now has a fully integrated system, including an online portal through which patients can view their own records. Some 25% of all physician-patient encounters in the co-op are now conducted through secure e-mail. Medical practice is enhanced by the use of fully digital medical records, including diagnostic images, electrocardiograms, call logs, and notes from multiple practitioners. A recent randomized, controlled trial involving patients with hypertension showed the value of combining the use of medical records shared with patients with coaching from a pharmacist over the Web.⁵ As compared with usual care, the Web-based intervention nearly doubled the percentage

of patients whose blood pressure was controlled.

Online care, the patient-centered medical home, and other important innovations are happening at Group Health not because it is a consumer-governed cooperative, but because the consumers who govern it have long demanded that it be accountable for the quality and cost of health care it delivers. That kind of accountability drives innovation. After 62 years of lessons learned in an integrated health care system, Group Health leaders recently outlined 10 essential characteristics of a health care cooperative (see box). As our country deliberates over solutions to spiraling costs and faltering quality, it might well look to these characteristics as design principles for providing accountable, integrated

care and coverage that benefits individual patients and serves entire populations.

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When Diseases Disappear — The Case of Familial Dysautonomia

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The success of genetic-screening programs raises an intriguing possibility: some dread diseases of the 20th century may soon become history. A representative example is familial dysautonomia, a severe neurologic condition, the incidence of which has decreased precipitously since population screening began in 2001 (see graph).

By giving prospective parents the option of terminating affected pregnancies, screening is doing exactly as was intended, but the disappearance of diseases such

as familial dysautonomia should also give us pause. On a practical level, will interest and funding shift away from these conditions, leaving affected adults without advocates or the possibility of scientific breakthroughs? And philosophically, is the disappearance of a disease always an unmitigated good? What does it say about — and to — people currently living with a severe genetic disease when prospective parents would rather abort than bear a child with the same condition?

Although we strive to learn

about the biology of diseases, the way we understand them is a social process. As the historian Charles Rosenberg has written, “In some ways disease does not exist until we have agreed that it does, by perceiving, naming, and responding to it.”¹ Thus, although some infants born before 1949 surely had what would become known as familial dysautonomia, it was not until Conrad Riley and Richard Day of the Columbia College of Physicians and Surgeons identified five cases of what they first termed the “Riley-