HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Walter J. McNerney

WALTER J. McNERNEY

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
Lewis E. Weeks Series

Produced in cooperation with

Library of the American Hospital Association
Asa S. Bacon Memorial

Sponsored by
American Hospital Association
and
Hospital Research and Educational Trust
Chicago, Illinois

Chicago, Illinois 60611

Copyright (c) 1983 by Lewis E. Weeks. All rights reserved.
Manufactured in the United States of America

Lewis E. Weeks
2601 Hawthorn Road
Ann Arbor, Michigan 48104
(313) 662-4298

Walter J. McNerney

Walter J. McNerney

CHRONOLOGY

1925	Born June 8, New Haven, Connecticut
1947	Yale University, B.S.
1947	Yale University, Research Assistant, Labor-Management Center
1947-1948	Hopkins Preparatory School, Instructor in Advanced Mathematics
1949-1950	Rhode Island Hospital, Administrative Resident
1950	University of Minnesota, M.H.A.
1950-1955	University of Pittsburgh, Assistant to Coordinator of Hospitals and Clinics, and Medical Centers, and Administrator of one of the Medical Center Hospitals.
1953-1955	University of Pittsburgh, Instructor then Assistant Professor of Hospital Administration and Medical Administration
1955-1958	The University of Michigan, Associate Professor and Founding Director of the Program in Hospital Administration

1958-1961 The University of Michigan, Professor and Director of the Program and Bureau in Hospital Administration

1961-1977 Blue Cross Association, President

1977-1981 Blue Cross Association & Blue Shield Association, President and Chief Executive Officer

Walter J. McNerney

AFFILIATIONS And MEMBERSHIPS

(Current or Past)

American College Health Association

Member, Task Force on Program Development and Administration for Comprehensive Health Programs in College Communities

American College of Hospital Administrators

Fellow

American Medical Association

Member of National Commission of Cost of Medical Care 1977-

American Public Health Association

Fellow

Membership Committee

Member of Committee on Private Philanthropy and Public Needs, 1977

Association of Teachers of Preventive Medicine

Member

Blue Cross Foundation, President

Campaign for Yale

National Chairman, Major and special Gifts

Delta Sigma Pi

Member

Executives Club of Chicago

Member of Executive Committee

Group Health Association of America

Director

Harvard Medical School

Member of Board of Advisors on Comprehensive Prepaid Health Care

Health Service Incorporated

Member of Board of Governors

Secretary

Health Services Foundation

President 1963-

Health Services Research Fellowships Program

(University of Chicago and University of Michigan)

Member of Advisory Committee

International Executives Service Corps.

Director

International Federation of Voluntary Health Service Funds

President, Council of Management

International Hospital Federation

Member

Management Executives Society

Member

<u>Medical Care</u>

Editorial Consultant

National Academy of Sciences

Institute of Medicine

Member, Council of Management

National Center for Health Education

Member of Board of Directors

National Chamber Foundation

Member National Policy Health Study Group

National Executives Service Corps.

Trustee

National Health Council

Director 1963-

President 1972-1973

Northwestern University Graduate School of Management

Member, Advisory Council

Nuffield Provincial Hospitals Trust-King's Fund (English)

Fellow 1970

Opportunity Funding Corps

Director

Member, Finance and Investments Committee

Pennsylvania, University of

Institute of Health Economics

Member, Advisory Council

Pittsburgh, University of

Graduate School of Public Health

Director

President's Committee on Health Education 1972-1973

Member

Royal Society of Health

Member

Sigma Xi

Member

U.S. Department Health, Education and Welfare

Task Force on Medicaid and Related Programs 1969-1970

Chairman

U.S. Department of Transportation

Member, Industrial Advisory Committee

Urban Coalition

Task Force on Health Care to Residents of Inner Cities

Member

Yale Alumni

Member, Assembly

Yale University

Chairman, Development Committee

Walter J. McNerney

AWARDS

Hospital Management

Editorial Award, 1968

Justin Ford Kimball Award

1967

Life Magazine

Named one of 100 most important young men and women in the United States, 1962

U.S. Department of Health, Education and Welfare

Secretary's Unit Citation, 1970

Walter J. McNerney

BOOKS

Hospital and *Medical Economics* (with other authors)

Chicago: Hospital Research and Educational Trust, 1962.

Regionalization and Rural Health Care (with Donald C. Riedel)

Ann Arbor: The University of Michigan, 1962.

WEEKS:

Shall we begin this account with your entry into the health field?

McNERNEY:

One of the first things we might talk about is my administrative residency at Rhode Island Hospital under O. G. Pratt. I don't think there is any secret of the fact that the better students in the hospital administration class at Minnesota were supposed to have gone to that residency. With some exceptions they did. I was lucky enough to be included and thoroughly enjoyed it. There were a couple things about the residency that were of particular interest. I had the feeling--although I can't remember this totally accurately--that when the residencies were being discussed, Mr. Hamilton, the director of the Minnesota program, thought perhaps I should go to upper New York, to Rochester, with Basil MacLean. For some reason, Basil wasn't interested, I think. He wanted somebody with more experience, etc. So I ended up in Rhode Island Hospital.

What's amusing about that is that not too much later I was Basil MacLean's successor as head of the Blue Cross Association.

At Rhode Island Hospital I had a superb time although my personality and that institution had some uncomfortable fits. I was perhaps more of a gadfly

and a hair shirt than they were used to. I liked the personalities, I think they all liked me. I was given wide and unqualified exposure, but, either because of my age, or my general predilection, or my way of looking at the health field, there was some discomfort as well.

I was the only person who went there on a residency up to that time that was not asked to stay on afterwards. That wasn't with any malice; O. G. and I were very good friends. Whether O. G. figured I needed more scope and room, or whether he figured it was all the institution could take, I am not sure.

I learned a lot in a very short time. It was partly because O. G. was so free with himself and the exposure he was willing to give me, partly because O. G. had a point of view, a philosophy, and lived by it. Therefore, what he chose to do had integrity. It always related to an overall objective. This to me was a good learning experience. I didn't agree with all of it, but it was clear and it was learnable. Rhode Island Hospital was an excellent example of a teaching hospital without a university affiliation that had a good conscience, a good social awareness, a good community awareness.

I think in retrospect the residency couldn't have been better. I remember the fun I had there as much as anything else. The opportunity to poke fun at the bureaucrats in the hospital when they would write lengthy and detailed memos on, you know, the specifications for minute supplies and equipment in the new building. On one occasion I countered with a memo on the problem of the flies in the laundry from the point of view of _domesticus musica_. Whereas, I enjoyed thoroughly the intellectual and abstract discussions about the importance of hospitals, I felt deeply that one had to maintain one's sense of humor, one's balance, or else, inevitably, one would become a hospital bureaucrat and be dragged down by the institution rather than tempted to elevate it.

We can talk later about where I went from there. Suffice it to say after one year I was looking for gainful employment.

On further reflection, I should mention a few names of persons I knew well at Rhode Island Hospital.

Jerry Beiter was there when I arrived, and I became very friendly with him. He is now president of James A. Hamilton & Associates.

Frank Iams also was there. I was also quite friendly with him. He went down to Fairfax County near the District of Columbia where he has become an administrator and leader in the area.

Following me immediately were men like Ed Connors, who joined me later at Michigan, and is now head of a very large Catholic network. Also Larry Hill, who joined me at Michigan. He has been through several prominent jobs. So I guess there was some genius on O. G.'s part, or Jim Hamilton did exercise some selectivity. In any event there was a coterie of people that certainly made a mark on the field. I think O. G. always felt very good about that. In fact, that group made several attempts to get back together to pay their respects to O. G. but their very prominence and geographical disparity made that very difficult. So there never was that definitive occasion, but I am sure he understood that very well.

One of the things none of us could understand was why O. G. never became head of the American Hospital Association or of the American College of Hospital Administrators. Put it another way, I guess we didn't like what we did understand: that is, he had an old-fashioned New England board that didn't feel they could spare him, that his absence would be critical. So the chairman simply made it impossible for him to take those offices. I think it was a loss to the field. What he taught a few he could have taught many more.

WEEKS:

How did you make your next step when you left Rhode Island Hospital?

MCNERNEY:

At some point in the spring of 1950 I started looking into various alternatives for employment. There weren't a lot at that time.

After a few interviews--and I stress, a few--the search centered on a hospital in New Jersey. I was close to making a decision when at the zero hour a telegram arrived. I think it was from Jim stephan telling me to hold any commitments, that the University of Pittsburgh might be interested in me.

I held my impending commitments and traveled to the University of Pittsburgh where I was interviewed by Thomas Parran. He was the Surgeon General under Presidents Roosevelt, and Truman, and now was a very striking figure as Dean of the School of Public Health. At the very tender age of 25 I was also interviewed by Richard K. Mellon, by Alan Scaife, who was married to one of the Mellon daughters, by a person named Adolph Schmidt, and by several others who collectively practically owned Pittsburgh. It was an example of the deep interest that the noblesse oblige community had in universities and medical centers and hospitals. I couldn't quite figure out why somebody of my age and background deserved all that attention, but I enjoyed the interviews very much. The critical point to three of the people who interviewed me was that I went to Yale. The rest of it didn't matter all that much.

At any rate, Tom Parran and I got along very well. He offered me a job. I can recall it was for 52 hundred dollars. For that I would 1) administer one of the hospitals in the medical center; 2) help start a program in hospital administration in the School of Public Health; and 3) act as assistant coordinator of the clinics and hospitals of the medical center. It

seems to me if I did any one of those reasonably well, they got a good buy for 52 hundred dollars. This was the first attempt to establish a coordinator of seven hospitals and clinics in the medical center and to attach that coordination to the university in some fashion. The university was replete with medical school, nursing school, school of public health, dental school, law school, etc.

I stayed on that job until I left Pittsburgh in 1955. I worked hard on it with Glidden Brooks, who was the coordinator, but it was apparent that pulling the various hospitals together, sharing facilities, unifying policies, cutting down the jealousies between the practitioners and teachers of medicine, for example, was a tough job. It was not one that could be done quickly or easily.

It interested me that some 25 years after I left Pittsburgh I was approached by the university to see if I had an interest in being the person to do the same job. They were elevating the title, but, it is interesting to note, the same units had not come together, that 25 years later the policies were not unified, that the services still overlapped, and that they were taking yet another run at it.

So I feel less guilty than I used to for not doing more in five years as a part of that office. It's intriguing to me to watch other medical centers around the country that have struggled over a similar period of time. Often they still are not taking advantage of economy of scale or of what systems could do to make the delivery of care and teaching more efficient. One is always torn under these circumstances between admiring the viability, the vibrancy, the assertiveness of the various personalities involved in the medical teaching ranks and on the boards of trustees--torn between admiration and the feeling on the other side of it that so much more could be done if there were more reasonable accomodation to coordination.

Institutional politics, at least when I was involved at Pittsburgh between 1950 and 1955, had one very regrettable outcome. That is, the energies of the various leaders involved were so preoccupied by the institutional challenges of coordination of the hospitals that there was precious little energy and time left to address the more important questions: How did this medical center serve western Pennsylvania and the nation? What were the things it was doing that had payoff, and didn't have payoff? What were the things they were doing that were cost beneficial, or non-cost beneficial? As a result of the institutionalization involved, there was more interest as to who got the next appointment and what the relative territorial rights were of this typoe of surgeon versus that type than there was over the morbidity and mortality of the population of the surrounding area.

My second job, running one of the hospitals, was interesting in that it was largely a psychiatric institution. My job was to help move it from state ownership to university ownership so that there were a lot of transitional problems having to do with normal administrative processes. I certainly enjoyed that period very much, having had some administrative experience at a young age as an officer in the Navey aboard two ships when I was 19 and 20.

This job at the psychiatric hospital was made particularly enjoyable because it was my responsibility in small part to help recruit and settle a new psychiatric team. Here the attempt was made to get balance. The analytical school should be represented as should the biochemical approach and for the want of a better word, the "common-sensical" approach. We eneded up with Ben Spock, who was right in the middle of his writings on the child and the mother, and Prosen who was the analyst, and Mirsky who was the

biochemist. They were a challenge to handle in terms of getting them aboard and setting them up in offices.

I got to know all the members of the psychiatric team well, and relatively quickly. Mirsky, for example, and I don't mean to impugn him, was furious about some administrative decision I made. he called me in front of his staff and with very-powerful and eloquent language dressed me down. It struck me as funny, so I attempted to put the problem in a light enough perspective to save both our faces. that established a very good relationship with Mirsky. I suspect had I, at this point, taken myself very seriously we would have been in for an exhaustive series of rationlizations over less and less important matters.

Some of the administrative talent we are looking for in the health field may arise earlier than we expect. The feeling, you know, that you have got to be in the field 20 years before you are ready, I have always resisted. As I say, this is only a minor and seemingly inconsequential case in point.

As far as the teaching part of my job down there was concerned, I had a lost of fun from the beginning. I was the only one on the faculty who had been through a program in hospital administration.

Glidden Brooks, who was also the coordinator of the clinics and hospitals, made it very clear that he was not interested in it primarily, and would I please help start the program. I pulled together some sort of curriculum and did a fair amount of teaching. Somehow or another the program has survived. I must say, between starting that program, running a hospital, and being assistant coordinator, I was thankful I was 25 years old--particularly since I always insisted on having time left over to enjoy life. In this last regard I was member of an octet that sang in town and went on periodic trips to any

other gathering that would listen. There was a fishing camp up in the hills where we would disappear periodically. Played a fair amount of golf, etc.

Going back to work, I think the trio of activities simply reinforced in my mind the notion that if you are ready to go when you are young, you should go, you should be given responsibilities. Incidentally most industries totally recognize this. My 28 year old son is head of a plant in Tel Aviv, Israel for Baxter-Travenol.

The other thing I found reaffirmed in the Pittsburgh experience was that I have always been more attracted to the Renaissance idea. There's not a reason in the world that a person can't teach, can't administer, can't coordinate, if you will, and do all of them reasonably well. I am not claiming I did all of them well. However, I felt equally comfortable doing all of them. As a matter of fact, the talents involved are synergistic. A great deal of teaching is communications, and so is a great deal of management, and administration. A great deal of teaching is sensitivity to other people like employees. A great deal of coordination in a medical center is political as well as economic, so is a great deal of management. I think particularly in management, where the scientific base is only relative, it's important to tear down the walls among these parts. I think you get better parts as a result of it.

The people I met in Pittsburgh were, by and large, very interesting. Very good people. I learned the public health view well as a member of the faculty there. I was an assistant professor when I left; started as an instructor. The grounding I got in epidemiology, biostatistics, occupational health, etc., was of tremendous value to me. I went into the field initially as a person with a community point of view. The School of Public Health reinforced that

point of view and gave me some of the tools to deal with it, and some of the rationale for it. I have drawn upon those disciplines a great deal since.

Unfortunately schools of public health have not fared well over the years. This one fared well, when I was there, in part, because Thomas Parran was a towering figure. He brought with him men who also were of great stature. The personalities were forceful personalities. They made a very good mark on me. Parran was tough, able, explicit, brighter than the devil. He somehow or another took a liking to me. I used to go to his home a fair amount. Shirl and I would be included in their prestigious dinner parties. We enjoyed that very much. He argued fondly with his wife. I tended to side with her, because I suspected she was the one who invited the guests to dinner. Towards the end, I always sat next to her. I guess I pegged it right. He was amused by that.

In 1953 when the school was asked to do a study of the Indian and Eskimo health problems in Alaska, Tom Parran, Tony Ciocco, and Jim Crabtree, all of them vastly my senior, and I were sent up there to find answers to questions like: Should the Indian Service remain under the Department of Interior? Should it be moved under some other auspices of the federal government? What changes should be made? etc. It was a tremendous experience.

An interesting point I should make here: Tom Parran interviewed me at the age of 25. I had no great experience in the health field other than study in a program in hospital administration and a residency in a hospital.

WEEKS:

Possibly you want to go back a bit an talk about how you made your decision to go into hospital administration.

McNERNEY:

I do want to go back a bit to make a point. When I got out of the service and went back to Yale, I knew I liked management, I liked administration, and felt very comfortable with it. Yet I also liked the idea of community. The wedding of management and community, in my mind, was much more attractive than the hard goods industry or banking. I didn't know exactly how to link the two.

One day in the Yale alumni magazine I read that there was a program of hospital administration being offered in the department of public health at Yale University. This might be a way to link my interests in management and community. I felt pretty grown up, for I had been an officer for a couple of years and I was about to get my degree. So I went to look into it.

I was interviewed by the head of the program, Dr. Clem Clay. I remember, he was dressed in a dark gray suit, a white shirt, gray tie, black shoes. He asked me about my experience, etc. etc. To make a long story short, the impression I got was that somebody of my immaturity, my lack of experience, should go out and work in the health vineyard for a while, and perhaps, after four or five years come back. Here were two entirely different points of view: a person who viewed a school of public health as an inservice training mechanism for those with seniority versus a person like Parran who took risks.

It was after my interview with Clem Clay that I met Jim Hamilton. By then I was beginning to turn back towards something else, having been discouraged at this point. Jim, who understood Clem Clay very well, and who, I think, liked me encouraged me to sustain my interest. I asked him where the best

hospital administration program in the country was, and he said "Minnesota" without any hesitation. I didn't know whether it was or it wasn't. But he was convincing. It happened that I was in love with his daughter, but up to that point my career and Shirley were separate events. At any rate, I ended up going to Minnesota.

Here again Jim Hamilton was a risk taker, someone who would put his emphasis on what a person was like, and on what was the potential. I don't mean to put Clem Clay down--but unfortunately the sense that the schools of public health owed some allegiancy to the establishment of public health rather than an allegiancy to the larger world of which they are a part has been too long a deadening influence on schools of public health.

There are a million stories I could tell you leading up to Pittsburgh, but maybe that suffices.

WEEKS:

You made a big step when you left Pittsburgh to go to Michigan. How did that come about?

McNERNEY:

One day when I was at the University of Pittsburgh I got three job offers. Since I had been there five years, I thought I'd better look into them. By then I had started to make speeches, started to write articles. I was actively involved in the Association of University Programs in Hospital Administration and knew intimately persons like MacEachern, to a certain extent Bachmeyer, very intimately Ray Brown, Gerry Hartman, and Andy Pattullo, and so forth. At a very young age I was exposed liberally to the early giants, so I can look back on the history in this field with a very sure sense of knowing the people involved. I caught Malcolm MacEachern towards the end

of his career when he had perfected the ability to sleep during important occasions and somehow or other stay with the discussion, a very interesting and likable and enjoyable person.

At any rate, the offers varied: they came from a hospital, an association, and the University of Michigan. Michigan was interested in my going there to start a program in hospital administration in the school of business.

I recall talking with Odin Anderson. I said, "Odin, I've got a little bit of a problem here, I've got three opportunities. I am not sure which one I want."

He said, "Describe them to me."

So I described them to him.

"Fine," he said, "you are going to Michigan."

I asked, "Why?"

He said, "I could tell by the way you described it."

I said, "Thank you very much."

He was right. I loaded the words, slanted the sentences, put a special twist on what I wanted to do. So after being interviewed by Dr. Kerlikowske, Dean Furstenburg, Vice President Niehuss, and Dean Stevenson, I decided to say yes, and I went.

This came as a very powerful blow to the octet, the poker club, and a few other important institutions in western Pennsylvania, and to even some of our friends in the medical center. We left with a very good taste and with a lot of good friends, both in a community and a professional sense.

WEEKS:

You were the developer of the program in hospital administration at Michigan.

McNERNEY:

Yes, at Michigan it was my first real opportunity to stand back and develop a program totally in my own style. At Pittsburgh I had been trying to balance several jobs at once. Also, the fact that the program at Pittsburgh was tightly contained within the department of public health practice gave it less elbow room. Under those circumstances I followed more orthodox program lines and simply capitalized on the assets of the school, of the university, and of the medical center to the extent that I could. However, I didn't really have enough opportunity to reflect on change. On the whole, I think it was a good program. It had to start quickly in 1950, but the resources were rich. I couldn't give it the time it deserved, but the compensations were many. Certainly the cooperation at Pittsburgh was unstinting, I got all I asked for.

So, when I went to Michigan I had some experience behind me; this was to be my total job, and I was able to devote more to it. I made a series of moves. The program was to be located in the school of business because politically that is how it fit best at that point. The tension between the university hospital and the school of public health, and between public health and the medical school was such that locating in the school of public health would not have been a smart choice at that point. Since you can compensate for site very easily, why wrestle with it? I said it was fine, let's set it up in the Graduate School of Business Administration. Then I asked for and got an advisory committee comprised of the Dean of Medicine, Dean of Public Health, the Director of the University Hospital, and the Vice President of the University for Academic Affairs. That committee met routinely, I reviewed curriculum with them; I reviewed appointments with them, etc. This was a very

powerful step, because I was able in good conscience to represent the program as having a firm connection with the medical school, the school of public health, as well as with the business school. It also provided a pipeline as to the practicalities of the hospital. I think that was an important step however it is expressed. These days programs in health administration should have that breadth. The next thing I did was lay very heavy emphasis on the fact that any program in health administration, then called hospital administration, should operate on three mutually reinforcing planes: education, research, community service. The education was apparent; I felt the research was absolutely necessary because both the teaching programs and the field of health in general needed desperately a firmer factual base, a firmer conceptual underpinning. The field was growing in complexity. If it were to be managed ten or twenty years ago, it needed more facts and more concepts.

WEEKS:

Wasn't the Michigan program one of the first to get into research in its field?

McNERNEY:

It has sometimes been said that Michigan was an innovator in research in the health administration field. All the programs tipped their hats to research in one form or another. They would write papers, and so forth. I think the degree of formality of research for which I took a chiding from a lot of the practitioners who led programs--I think the degree of formality here was special. It was dedicated, it was identified. It stood the scrutiny of that university community as being valid and good research.

The third critical element is community service, I felt that the faculty, particularly in administration needed to get its feet wet in community and

institutional life to enhance the teaching and also help raise the questions that should be researched. So we developed an active community service program. Of course, that had the added benefit of getting us into Michigan communities, Upper Peninsula, Lower Peninsula, Detroit area, etc.

When the deans would go to Lansing in regard to the budget, one of the things they heard the most about from the legislators was, "I understand you are helping the hospital in Charlevoix--" or such and such. This would please Niehuss, the vice president of the university.

In addition to positioning the program at Michigan to draw widely on a variety of resources in the university, and to developing mutually reinforcing tracks of teaching, research, and community service, I felt at that time that two other things were very important. One that the orientation of the program should be health administration rather than hospital administration. I gave a speech at the University of Chicago and published a paper on this. I forget what group it was but I remember Bugbee and Hamilton and others were there. The point of view I had--and I guess this was about 1958--the point of view I had was that the more challenging academic problems, as opposed to operational problems, involved the total community. One had to understand the environment of health (the problems of industry, of water pollution, of tension of family, of disease, etc.,) before one could develop intelligent goals. Intelligent goals were absolutely indispensible if one were to conceptualize institutions correctly and manage them correctly--and if outcome measures were to be developed. Towards that end I was very careful that the students in the program got exposed to public health ideas as well as to business school ideas, and as well as to public administration ideas.

Another feeling I had about that Michigan program was that the head of it

should be a full-time head. The early programs in health administration were started by prominent people who in themselves had a lot to offer--strong personalities. Actually there was no one else around, they had to do it. I admired them for it. Often the program was ancillary to a lot of other interests. Coupled with the fact that the director was not on the grounds all the time was the temptation to use a long list of visiting lecturers to pick up the slack. Some of them were good, some of them were dreary. The connections were not always that good among them. That kind of program had a vocationalism about it that reflected the experience of the strong individual and the fact that there wasn't time to work on the curriculum with the intensity it deserved. So one of my intentions was that it should be a full-time position. In that sense I devoted myself quite heavily to the program at Michigan and poured myself into teaching, research, and community service. I think since then we have seen more emphasis on health administration and we have seen more full-time course directors. I am not saying that all this has been to the good. We have lost some spark along the way, but in net I think it has been desirable. One would only wish that some of the programs today were led with some of the fire and the unobjectivity that characterized some of the pioneers in the area.

WEEKS:

Did the University of Michigan offer a good environment for a hospital administration program?

McNERNEY:

Michigan was absolutely superb as a site for a program in hospital/health administration. The university is outstanding. It has a wide variety of forces and they were put at the disposal of the program. The Blue Cross/Blue

Shield plan there was outstanding and cooperative. There were talented people in management and labor that thought a lot about health. I exchanged classes with Wilbur Cohen, I don't have to say any more than that and with Bill Haber. Bill Haber, one of the early architects of social legislation, subsequently became a vice president of the university. Wilbur Cohen also a very prominent figure, later became Secretary of HEW. These were the men who helped me out, taught in my classes, and there was a certain limited amount of reciprocity. That gives you an idea of what there was to offer there.

The W. K. Kellogg Foundation was a godsend. Andy Pattullo, Emory Morris, and Matt Kinde were all very strong figures. They helped me from the beginning. At one point they made a very, very large bet on a study for a Governor's Commission that I led. That's a story that has a great deal of fascinating aspects to it.

WEEKS:

Will you discuss this study for the Governor of Michigan?

McNERNEY:

This was the largest and most significant research we did. It involved the study I mentioned for the Governor's Commission which ultimately was published as Hospitals and Health Economics, in two volumes. The governor of Michigan, then G. Mennen (Soapy) Williams, was concerned about rising hospital and health care costs. He also was concerned about certain things he saw in the making so decided to call for an inquiry. A commission was established under the chairmanship of Judge George E. Bowles. That commission met and quickly decided that they didn't have enough information to make very intelligent decisions so they approached the University of Michigan to see if a study could be done to provide them with the requisite facts, observations,

and recommendations. Ultimately I was asked to lead the study.

I met with the Commission and a few other people in the state in prepayment, management, in labor, also doctors and hospital people. Then I sat down and wrote a prospectus, it was not very long but sufficiently detailed to attract the W. K. Kellogg Foundation. In that initial writing the general scope, objectives, and methods of the study that followed were laid out. As I have said to people since, this was a prospectus written not with an exhaustive reference to the literature, not with agonizing years off to do it, but out of an intuitive experience up to that point. I think often how that creative process is now bastardized by involving too many people over too much time with too much money.

The idea that there should be a population survey as a fact base--studies of productivity, efficiency, and effectiveness--examination of deductibles and copayment--evaluations of controls and regulation--study of experience vs. community rating--literally leapt from my experience, and I am sure as it would from that of many people. The trick was to put them down on paper and to start talking.

At any rate, I went over to Kellogg with a protocol and a budget that added up to over $300,000. Today that would be worth about a million. They worked with me, and in a very short time took a bet on a still very young man. In this case it was Emory Morris with Andy Pattullo's full backing. Instead of worrying about whether I had a doctor's degree or whether I had a distinguished research background, they sized me up and said, "We'll go."

That was particularly important because again like Parran, like Hamilton, they took a bet. Secondly, it was important because it was outside the normal traffic of the foundation. It was getting into some basic questions of a

research sort, rather than a demonstration, or an experiment, or whatever, for which I give them credit. At any rate, then I started to recruit a team. While I was recruiting, I went back over some of the ideas in the prospectus and started to refine them.

There is a whole host of stories in regard to that. I suppose the one in today's perspective that would be the most interesting is that I was trying to come to grips with the question of efficiency and effectiveness of the hospital. I remember concluding that the best way to tease out efficiency and effectiveness was to conceive some standards by diagnosis that could be enunciated by practitioners. The standards could then be laid against the hospitals not as a scientific appraisal of the quality of care but as a way of divining if there was at least undercare or overcare according to somebody's reasonable definition of good practice. I remember clearly talking that over with some of my friends in the health field and getting a lot of interesting reactions. I talked with Odin Anderson, I talked with Bob Sigmond, and I talked with Sy Axelrod, I talked all over the place. I think the general consensus, not total consensus, was against it, that is the number of variables was too great, the doctors wouldn't cooperate, the hospitals were unfriendly toward this sort of thing. At any rate it became part of the rewrite of the original prospectus. Further elaboration was also made on other sections.

Then the staff started to arrive. I was lucky to get an excellent team: Fitzpatrick, Riedel, Wirick, Spaulding, Skinner, Diokno, Payne and on and on, all super guys. With them on board it was possible to take the broad ideas and reduce them to definable projects. That was a very tough group effort. John Griffith was on board for this also. This team, and I underscore team,

took on the job of putting it together so that when we got through we had a series of projects that added up to a pretty comprehensive story.

It was a story that examined a probability sample of the population of Michigan, that asked definitive questions about the effectiveness of hospital use, that examined prepayment, etc. It looked at the consumer public, the providing groups, and the economic bridge between the two, i.e., financing. I think this turned out very well, it blazed some new trails, it showed what could be done and for the first time illuminated some important questions that had been left unanswered.

For example, there was always the question of whether a large deductible or copayment helped to reduce use. Well, you could prove it reduced use or didn't reduce use, although too little of that had been done. We did some of that. The remaining question was: Did it impair quality of care? With effectiveness criteria we were able to demonstrate that if the deductibles or copayments got too high, there was a backfire into underuse, which is a qualitative idea. We got into some very interesting stuff. We got tremendous support from the University's Survey Research Center under Rensis Likert, and unqualified support from other sectors.

In looking back, I'd like to comment on a few lessons. Number one, not only was the person who started this thing relatively uninitiated in research work, I'd had five years faculty experience but had never taken on anything very large, but not all people I hired were traditional academic types. A few were, a few Ph.D.s in economics, sociology. Many of them were just bright people with an intuitive feeling of the problem, and with definitive questions born of experience, and they went for help if they needed it. I think, if you were to reread those two volumes, you would be impressed with the fact

that not only were the questions pretty pertinent, then as now, but the writing is of pretty good caliber, the insights, the interpretation add a lot of luster to the data. Another thing, looking back, that is of great interest is that studies like this owe a great deal to front running. I am not sure that the staff ever realized the extent to which the way had to be paved. I ask you to think for a moment about going to the hospitals in 1957 and 1958 and saying that we would like cooperation in developing criteria of proper use. That took a lot of initial work, through the medical school, with the state medical society. Furstenburg and others at the medical school were superb. Once they had confidence in what we were trying to do, they were supportive. It took a lot of time, but we did get that support.

Similarly on the hospital side, Kerlikowske was very useful in getting me in contact with the right people around the state, and we got hospital cooperation.

Then we interviewed a cross section of the Michigan population, a probability sample, at home. There was work getting the news out so that people who would be interviewed would do the job well. A whole myriad of marketing activities preceded and went along with that study. You simply don't take the point of view that because the idea is good and researchable that the world owes you cooperation. You have got to be skillful in earning it. A great deal of time has to be spent.

As that study unfolded, we had troubles, some of the teams that went out to look at the records in the hospitals, to interview physicians (attending physicians) that fell within the probability sample of hospitals and the probability sample of records for certain conditions, some of those teams were inadvertently antagonistic. I'd get telephone calls in the middle of the

night from irate physicians or hospital administrators. These things had to be smoothed over or you would lose your way. There's a lesson there, and Rensis Likert saw it. I remember talking with him about it. You need research leadership as well as research substance. That often is what is lacking, and has been lacking over the last twenty or thirty years. A social engineer who can put it all together!

The staff had to be driven very hard to meet deadlines. I mean sixty or seventy hours a week. Intensive strife had to be dealt with. That element of research is worth commenting on.

Another thing to consider is, once you complete the work, which we did reasonably on time, what happens to it? One of the regrets I had about leaving Michigan was that I was not there to follow through. The studies on effectiveness dealing with 18 diagnoses were published and then Bev Payne, Don Riedel, Tom Fitzpatrick and others translated them into a workable manual that would be usable by hospitals. When they tried to implement it, the idea was shot down by the state and county medical societies. Instead of making some of the recommendations stick with Blue Cross/Blue Shield and with management and labor and with hospitals, the idea went underground. When the Commission went out of existence some of its recommendations lay fallow. So a report whose dimensions were impressive and whose potential impact was great had only a relative impact. Some changes were made and were useful, but a lot of it went underground and emerged years later. When the Senate Committee on Finance started pushing PSRO legislation, measurement of effectiveness was viewed popularly as a new idea.

I regretted leaving, in the sense that I could not stay to see through the implementation process. I think we have got to give more attention to the

implementation of research recommendations even today.

There was another reason I regretted leaving. Out of that study for the Governor's Commission began to flow a whole host of subsidiary and supporting ideas which the staff translated into research proposals and sent to HEW. HEW was beginning to constitute itself to support health administration research about that time. The initial advisory committee had some friends on it. There was a remarkable correlation between service on the review committee and who got the money. A lot of self-dealing. I thought our projects, and I had a chance to look at other projects, were more sophisticated, had far more downstream significance. We were getting a hard time, frankly, while some pedestrian stuff was being approved by committee members for themselves. One regret I had in leaving was not staying and fighting it out. I would have loved to have faced a few of those people down and made a _cause celebre_ out of it and to have attracted more money to the natural offshoots of the major study. As you know, any good study unfolds as many new questions as it answers, and even more. I was very frustrated that I had to walk away from that battle. That again is a battle that is won or lost on the basis of a whole host of factors that have precious little to do with technique.

One other thing that sticks in my mind, that I feel warmly about, was that about 80 percent of the way through the study it was perfectly apparent that we didn't have enough money. Partly it was due to the fact that we were spending a little more than we anticipated, although I stressed that the buck was being stretched through sixty and seventy hour weeks. Partly, there was a new wrinkle that I thought had to be added. So I marched back to the Kellogg Foundation and asked to see Emory Morris. No, I didn't. I asked to see Andy Pattullo, and told him my problem. He said I'd better see Emory. I went to

see Emory, he was alone in his office.

I said, "Emory, for the following reasons, I'd very much appreciate $47,000 more," or something like that.

He said, "Young man, we have already given you $383,000," or whatever, "an enormous sum. At the time we made it clear that this was to do the job, and I think I was particularly clear that this was about as far as the Foundation expected to go. Now you are coming back here and asking for more money. Now, what reason have you got for that?"

I said, "Emory, this is the first time I have ever done a project this large. I have had a little bit of research experience, but on this scale, it's my first venture. Frankly, I didn't know any better."

He looked me right in the eye and said, "You've got the money!"

When you contrast that facility in dealing with s situation with the ad nauseum number of applications that have to be spent in agonizing site visits to get money these days, particularly from HEW, it's a refreshing breeze I can hardly describe to you.

There was a lot to do with the study beyond what I have said, but at least I have told about some of the broad dimensions. I know for sure that when some university people got a look at what we were doing that the program in hospital administration began to be taken a lot more seriously by the university as a whole. We were sort of an experiment, but the quality of the research work, the quality of the community service work, and the fact that our students were doing as well as other students at the graduate level, all began to add up. I think by 1959-1960 there was no question that the University of Michigan had a commitment on its hands. They thought it was a worthwhile commitment. They offered me a full professorship with tenure.

That was sort of a signal that they were serious about it.

After I left Ann Arbor and came to Chicago and started work with Blue Cross, Ed Crosby, who looked at some of the manuscript, thought it should be published. Jack Masur did too. Men with a tradition in public health saw some of its potential.

So, after a great deal of work, it was published by Hospital Research and Education Trust, an excellent job. I'd like to say in that regard that Marjorie Lawson did an absolutely beautiful job of editing.

What interested me is the fact that the two volumes have been put against my name and others for many years in a sort of "he's a booky type", you know, in a semi-put down way and I doubt if I've got one friend that ever read it. I know some university people did, I know some government people did, I know some people from industry, and some people from labor who did, but my friends from hospitals, I am not sure any of them did, I would say that most of them didn't even dip into the book.

It is interesting how that two volume report is still referred to. I was testifying before the Moss Oversight Committee of the House recently now as President of the Blue Cross and Blue Shield Associations. The chief staff person, in questioning me, said, "I'd like to go back to..." to page 1276 (or some other number) in volume one (or two) "...in it you said... Do you still believe that or not?"

On the one hand it was very refreshing that he recalled that there was something interesting in _Hospital and Medical Economics_, but on the other hand it was a little embarrassing that I had changed my mind on the point he was raising.

WEEKS:

Your next move was to the Blue Cross Association, wasn't it?

McNERNEY:

In 1961 I was asked to be President of the Blue Cross Association. In fact, I was in Hawaii with some friends on a Ford Foundation grant. Specifically in Hilo. The phone rang, on the other end was Bill McNary.

He said, "How would you like to be President of the Blue Cross Association?" I thought about it for about ten seconds. Up to that point I hadn't even thought about the possibility of it. I had no inkling of what was going on, but I said, "Yes."

It was interesting because Bill spent another two or three minutes convincing me that it would be a good idea.

I said, "Bill, I said yes."

He was pleased, at least he said he was pleased. In fact, what had happened, my guess was that the people within the Blue Cross plans who were "logical successors" to Jeb Stuart either knocked one another off or somehow or another didn't fit, so the search committee for Blue Cross turned to the outside. They didn't move outside the health field, obviously.

On reflection, either subconsciously or consciously, I still don't know which, I think they were preparing for the contingency of the time that Jeb Stuart would retire and a replacement would have to be found. Two years previous to that I started getting some invitations to appear before Blue Cross plans and some Blue Cross national meetings. I would get up and talk big language and be full of misson, full of zeal. One day, I remembered at the Mid-Atlantic Hospital Assembly, getting up to speak. There sitting in the front row were van Steenwyk, Rorem, and Colman. This was in advance of the

telephone call to me in Hawaii, say by six months. Why would Rorem, van Steenwyk, and Colman be sitting there? I thought it was strange. I was conceited enough by then to think I was such a good speaker that almost anybody would show up, and enjoy it. Later it occurred to me that they may have been tracking me. Now, maybe none of them would admit it. Only Rufus is still alive. I have the feeling that in an institutional sense Blue Cross had the survival instinct to start considering other people in case a natural leader didn't emerge from the ranks. It showed that the pioneers, and I have just named three distinct pioneers, had the foresight, the sense of continuity of survival, to attend to things like that.

At any rate, I said yes and left Ann Arbor with my family and came to Chicago at the ripe age of 36 to assume the presidency of the Blue Cross Association. The main office was in New York at that point. One of my first decisions was to move the office to Chicago. I was convinced that the guts of Blue Cross, and for that matter also Blue Shield, was the service contract. That is to say the contract that flowed between Blue Cross and the hospitals as well as the subscribers. This made it possible to give the subscriber a predictable commodity called hospitalization in simple, understandable terms. That being the guts of our product, it would be well to have good communication with the AHA and the doctors, the AMA. The leading health institutions were in Chicago. A lot happens on an everyday basis in most industries. Why not be near these people? At the same time, a national association with plans in every state is well located in Chicago for travel and othr purposes.

There were some at that stage who said we should move it to Washington. I resisted it then, I do now, because what I think Washington needs are forces within the nonprofit sector or the private sector that look at the country

from a different point of view from that one gradually assumes when he or she moves to Washington. People who move to D.C., I have observed, become preoccupied with the Congressional process, what Teddy Kennedy is going to do next, almost unconsciously react to government, anticipate government, mold their lives in a reaction to government. What government needs in the health field, I think, is a force or forces that have decided what their mission is, where they want to go, and then negotiate with that government not reactively but assertively, procreatively, whatever word you want to use. So Washington was rejected. As I say, there were good and solid reasons to be in Chicago.

When I got there the staff was a tenth or less of what it is now. There were people with a lot of experience who were very conversant with Blue Cross and very loyal to Blue Cross, very dedicated to it. It was a rather loose association, held together by a lot of people who respected one another, but not, at that point, well tuned to some of the things that were going to lie ahead. So I had a job to do.

It was interesting that when I got here Jeb Stuart, to his everlasting credit, said "There's your chair, I'll see you later." He didn't stay around to second guess me even though I was obviously wet behind the ears. Nor did he, beyond a limited point, test me out. We had done a fair amount of talking before we got here and he liked what he saw and heard, I guess. So he just said goodby and good luck.

Jeb had one qualification. He said "There are three people in the field you have got to get with fast, because they are tough to begin with and they are not sure where you are coming from. You had better get out to see J. Philo Nelson, down to see Walter R. McBee, and also see Robert T. Evans. [Nelson was in San Francisco, Oakland technically; McBee was in Texas, Evans

in Illinois.] Make your peace!".

That was it. That was my portfolio. Well, I got to see those three and a lot of others. Then I started the process of helping to move the Blue Cross Association from essentially a trade association to what it had to become: that is, a combination of that plus an operating arm of the total Blue Cross system.

With the help of the staff, I began to think of how the Association could: represent the Plans vis-a-vis Washington, or industry, or labor when there was a national situation; do some research and report some statistics that could be interesting and essential for operational and educational purposes; convene meetings to discuss topics of common interest; and, importantly, begin working with the Plans to strengthen them as operational and management entities; and further begin to debate with a little more forcefulness at the national level about what Blue Cross should be doing and why. More specifically this meant some dialogues about whether Blue Cross simply traded money or whether it intervened to shape the delivery of care.

In those days the state of the art was such that we had a very preliminary knowledge of utilization review and alternate delivery systems, etc. So I would underscore the fact that staff conversations were necessarily general, but we did focus on matters that gave a sense of collective destiny to Blue Cross, I think. Also we began to interest the Association in plan performance, i.e., the development of very preliminary plan performance review activities out of the Association that would look at the plans, identify problems, and through technical assistance begin to strengthen the problem areas, or solve those problems. We began to look a little more intently at the inner-plan bank, the transfer programs, the telecommunication systems that

welded the plans together. So, the trade association idea began to get translated into some sense of collective operational destiny. This was in a very preliminary way, in the early sixties.

In the mid-sixties the debate intensified in a very serious way in regard to the aged and the low income groups. There for a three or four year period from approximately 1963 through 1966 the Association was deeply involved in the strategy of the private sector in the problems of the aged and the low income groups. That whole period has not been well documented. Specifically there is no good documentation of what went on in the private sector in those critical years.

WEEKS:

I understand you and BCA were very much concerned with the problems of the elderly in the pre-Medicare days of the early 1960s.

McNERNEY:

It would take a long time to spell out what happened. In general terms, I think the American Hospital Association under Ed Crosby and the Blue Cross Association took some very responsible steps. We made mistakes but, by and large made very responsible steps. When it became apparent that both the low income group and the aged were a very distinct problem, we took the initiative and wrote two volumes identifying the dimensions of the problem and then talking about some resolutions. We were the ones who came out during the debates and said there is absolutely no question that the aged are in a unique position. At a time in their lives when they can afford it the least, they have the most health expenses and documented that was true, and that there was an obverse relation between income and incidence of illness and that the private sector was incapable of producing through subsidizing the working

groups enough money to bring the rates down to the aged. Something had to be done about it. Clearly there were quarrels about the best way to go about it, but AHA and BCA were on the line saying we have a problem here and were also saying that the low income group, whether they were aged or not, had a similar problem that had to be dealt with as well.

I said we made some mistakes. When the debate dragged out and it wasn't clear what was going to happen, I particularly took the point of view that since we don't know when this is going to be resolved, how about Blue Cross making a special effort? So we talked about a national program that would improve our offerings to the aged. By that time we were doing better than any of our competitors. If everyone had the same percentage of aged enrolled as we did, there would have been less of a problem. There would have been a problem, but a far less problem. I encouraged the plans to have some special open enrollments to make it possible for the aged who hadn't been enrolled to come on board, and to do a better job for those who were on board. This was interpreted as an effort on my part to be solving the problem naively through the private sector, undercurrent, if you will, the legislative process. I don't think I was dumb enough to think this effort would solve the problem. On the other hand, I was a bit naive in the timing and in the encouragement of this effort. I didn't anticipate fully that it would be used against us the way it was, but that passed.

WEEKS:

After BCA's early concern about the aged, did the association then take part in the process of planning and Medicare and Medicaid programs?

McNERNEY

We became a very integral part of the discussion in Congress in regard the

design of Medicare and Medicaid. We were fairly well known at that point. We had a good relationship with Wilbur Mills, and Wilbur Cohen who was in there consulting. I found that as both Titles XVIII and XIX came into clear focus I was spending a lot of time in Washington, and in a very interesting way representing Shield (because of some very close connections) as well as Cross.

I don't know how to characterize in simple terms the hammering out of Titles XVIII and XIX. I think the best way to put it is that together they were a typically pragmatic resolution of the two issues that were identified. One reflected the desire of government to implement some programs to redress the balance of social justice among income and age groups. Also the influence of the private sector was reflected in determining the way it should be done i.e., mainly through the instruments that are there and usable. The debate was largely free of doctrinaire points of view or extreme points of view. After the extreme liberals had their kicks, and the ultra conservatives theirs, shortly and quickly came the business of negotiation of the various interests in ironing out the resolution. So you had an involvement of the private and the public sectors, the traditional institutions as well as some new institutions, and HEW. What I want to underscore is that our Congress on any issue, whether it is Medicare-Medicaid or something else, is pragmatic. It's our way of doing business. I don't think anybody should take credit historically for having invented Medicare and Medicaid. No one person, no one group. It evolved through a series of gutsy negotiations.

WEEKS:

One of the outstanding developments of the Medicare process was the fiscal intermediaryship under Part A. Will you discuss this?

McNERNEY:

The particular design of the nomination process for choosing fiscal intermediaries under Medicare A and the prime contract involving Blue Cross Association as intermediary had this negotiation factor as a backdrop. It was a very good way of getting the cooperation of the American hospitals--giving them the right of some say over the intermediary. The intermediary position itself was a compromise between those who wanted HEW to pay claims versus those who wanted private carriers to do it as private carriers. Once that pragmatic compromise was resolved, the hospials said quite rightly that the use of intermediaries suggests that there are two ends. You have one end, we want the other. If you are going to have the right to administer the program, we want some say over who the intermediary is. It's two-way street, it was almost a natural outgrowth of that realization. Some of us put it in more concrete terms that others, but, at any rate it became an attractive way of eliciting the support of hospital and easing the interface between the public and private sectors while crystalizing on existing and inplace institutions and expertise.

Blue Cross represented an attractive candidate for that intermediaryship. There were no profits to inure to individuals or groups of individuals. It made sense that intermediaries be largely community-oriented institutions. The fact that Blue Cross was there in that mold made it more or less a natural to get a lot of the nominations. The other side of the coin was that the nomination process became realistic because Blue Cross existed. There are a lot of details about who felt how about what, but I was impressed that Wilbur Mills, who at that point was playing a very prominent role, was simply trying to sift through a series of ideas that could be put in a work-

able framework, not trying to moralize on any perfect arrangement.

WEEKS:

Somewhat similar to the fiscal intermediary in Part A of Medicare were the carriers in Part B. Please discuss that.

McNERNEY:

The Medicare Part B side reflected a slightly different situation. A distinction was made between the carriers under Part B and the intermediary under Part A. It is interesting that the carrier had an extra function or two. Therefore, the buffer zone between the doctor and the government was presumably a little broader. It didn't take a lot of intelligence to see that didn't mean anything extra special because, whereas there might have been an extra function in the report, and bill language seemed to give the carrier a slight more independent status, the Secretary of HEW was empowered to designate the carriers by state and the physicians were not in the position to nominate by state. So it was about equal: What you lost in one variable you gained in another. There were some interesting byplays in what nominations the Secretary would make. What happened? The number of states that went to Blue Shield as carrier was roughly proportionate to their percentage of population enrolled. It is interesting that the nomination design reflected in a way the history of hospitals versus doctors vis-a-vis the government.

WEEKS:

Compromises were worked into Medicare to satisfy those who wanted deductibles, copayments, contributions from employees and employers; and state administration and federal sharing of costs according to the needs of the particular states in the case of Medicaid--isn't that correct?

McNERNEY:

In the nature of compromise under the general banner of pragmatisms, there were arguments about whether there should be deductibles or copayments when planning Medicare. Some felt there should be for no other reason than to keep the program financially sound. It's wonderful to watch the government in action in this regard. I don't say this with disrespect, it's simply factual. When legislators and members of the administration saw the figures, they became concerned about the impact on the trust funds and on general tax revenues and began to talk deductibles and copayments. Evangelists for comprehensive coverage suddenly got very practical about matters and forget the bad things they have said about indemnity or other forms of "inadequate" coverage.

As a matter of fact, one of the earliest breaches of the community rating line in Blue Cross-Blue Shield was by the state of New York whose employees wanted community rating for everybody because it helped the poor, etc. When their costs came up they wanted experience rating.

The big issue over deductibles and copayments, aside from the precise design and amount, was could these be filled by private carriers in the public market. There was a very short debate with those who felt these should not be filled in the public market. Wilbur Mills tested that market and found out very fast from other members of Congress and from the general public that the public didn't want anybody stepping in the way. If they wanted to fill them, they would fill them and to hell with the doctrine of whether deductibles and copayments curb use. That water hasn't been tested since, because it came back so emphatically clear what the results would be.

There were compromises on payment, you know, whether there would be this type of reimbursement or that type of reimbursement with the hospitals going for a fuller formula under Part A and HEW going for a leaner formula. There was a lot I could talk about here. You recall the 2% (above cost) factor that was removed because suddenly the government became conscious of spending a lot of money. Well, the hospitals suddenly discovered they were not getting as much from the government as they were from private sources. That led a series of papers back and forth and negotiations which resulted in the nursing factor for Medicare patients which in the baldest terms was a way of getting some of the 2% back. It could be demonstrated that the aged needed more nursing so the government could rationalize making that extra payment.

I'd like to make one comment here. It's very popular these days to say in prefatory language that part of the bargain under the Medicare and Medicaid acts was that very little would be done to interfere with the practice of medicine or the operation of hospitals. You can point to it in the bill and in the committee reports. The implication is that in order to get the deal swung it had to be largely a financing operation so hands off medicine and hospitals. It becomes very convenient to say that's why we ran into inflationary problems, that's why in the seventies we have so many beds, etc., etc. I want to offer this small historical note, there was a fair amount of discussion about controls, not with the sophistication we do it today, but there was a fair amount of discussion in those days. The state of the art differed. We didn't know as much about how to exercise control. But don't let anybody kid us the question of how to negotiate formulas, of how to define qualified hospitals, of the desirability of strengthening areawide planning were all discussed at that point in the sixties. The polite language for the

sake of the health establishment, that things wouldn't be touched, was a front piece. There was already concern about how to shape things so this program wouldn't get out of hand. I just want to offer that note. There were certain "controls," if you read the bills closely, that were actually instituted. However, the action was along an evolutionary path. For example, the private sector at that time was beginning to shift gears from a passive financing system to a more active financing system. When the beginning of Medicare and Medicaid is thought of as a juncture or sharp turning point, it should be thought of as more evolutionary in its connotation.

WEEKS:

There was only about a year to set up the Medicare and Medicaid programs after the passage of the legislation. The programs were to serve millions of beneficiaries. How did it work out?

McNERNEY:

The implementation of Medicare and Medicaid led to a lot of work. Here it was, it had to be made to go as of July 1. I spent a tremendous amount of time with Bob Ball and Art Hess ironing out more precisely what our relationships, our relative roles, would be. That led to a lot of gutsy, protracted discussions. Obviously, there were differences of opinions. The Social Security Administration, as far as this program was concerned, envisioned itself as _the_ administrator and Blue Cross, for example, as one agent getting the thing done. We at Blue Cross as intermediaries thought of ourselves in little grander terms than that. Because we were nominated by the hospitals, for example, we felt we had a dual accountability, that we could be quite useful in shaping the destiny and the goals of the program as well as carry out its administrative provisions. Bob and Art are highly capable

people. Whereas that tension existed they were bright enough, and I trust we were too, to overlook it and get down to practicalities to get Medicare off the ground. I don't think there is a serious doubt that the program couldn't have gotten off the ground as it did if it hadn't been for Blue Cross and others in the private sector. I am very proud of the fact that with 90% of the business on the Part A side, therefore a huge accountability, we were able to move in and get it going with little friction as far as the American public was concerned. Not that everything went totally well, but my God, it was impressive!

We had some trouble with some of our elderly subscribers who didn't want to give up their Blue Cross coverage because they trusted us more than they did the government. We finally talked them into that and developed some supplementary coverage even in those days and eased the transition into Medicare the best we could. What has followed in the implementation of the program since 1965 has been a series of encounters, contracts negotiated and renegotiated, a perfecting, and a honing of relative roles.

Before I get off 1965, I want to remark that the negotiation as to who would do what (HEW vis-a-vis Blue Cross and the hospitals) often involved many HEW lawyers, six or seven or eight staff members from HEW, and a lesser but, nevertheless, large number from Blue Cross and other private institutions sitting and talking. On a few occasions I would call Bob Ball and say, "How about you and I going into a room alone?"

To his credit he would agree even though he didn't know the health field well. A very bright, able, trusting person. We'd shut the door and decide things. It took that because many were watching their territory and rationalizing their sentiments, and so forth. There just had to be some gut

decisions made. I never felt uncomfortable making them with him, because his eye was on performance and he had a concern that the aged not get lost in the process. That's about all it takes to make decisions after you have gone through a series of negotiations of one type or another.

WEEKS:

How has the fiscal intermediaryship worked for Blue Cross and the government in the years since 1966?

McNERNEY:

Over the years the Medicare contract has changed. You could guess what would happen. The government got into it newly informed on some health matters. As they became increasingly informed, they felt they should have more and more to say over the program, that the intermediary role should be lessened. So each year the contract negotiation revolves more around that basic point. In recent years we even hear: Thank you so much for helping us get this started, but now that we have got it established in Washington and in regional offices around the country, outside of a few inconveniences, we can handle it. That isn't said publicly because it would be politically inflamatory, but in a sense, it's an unspoken word behind contract negotiations. Things haven't come to that, and they won't. I think we have too much to offer for that. That's the path these things tend to assume. There has been some reduction in our prime contract role because the plans have gotten more sophisticated about the program. They don't need as much surveillance as they did in the early days. I've got to say that the people here did quite an outstanding job. Through the prime contract Part A there is no question our performance is better than anybody else's both from a cost point of view and from a quality point of view. That holds true the moment we are sitting

here. It will have a lot to say about the next steps under national health insurance.

The government itself has had to admit that our performance is good. HEW, as you know, can be nominated as an intermediary, and they have performed as an intermediary. Our performance has been superior to that.

WEEKS:

Has the intermediary role of BCA had any effects on the nature of your organization?

McNERNEY:

Because of the prime contract under Part A Medicare the mid-sixties projected the Blue Cross Association into a major administrative role while it was evolving towards a more operational role in general working for the plans. In effect, the transition from a trade association to something more than that was accelerated by Medicare, and to a certain extent, by Medicaid. Since then the plans have turned to the Blue Cross and Blue Shield Associations for government business leadership. It's not only about the prime contract. When it comes to bidding on Medicaid by state, plans expect technical assistance through the associations. We are now talking about a national EDP capacity for government business. Maybe we will regionalize it, but it is being discussed.

WEEKS:

In the post-Medicare implementation period were there changes in the Association-Plan relationships?

McNERNEY:

Through the late sixties and early seventies the Blue Cross Association got into more administrative, operational factors by virtue of the fact that

plan performance really began to blossom. We go now into plans on a periodic basis to examine specific aspects of management, write reports where there are discrepancies, and work with the plan in strengthening them and in closing gaps. Where a plan is reluctant to act, the executive committee of the national association might talk to the board members of the plan. There is a discipline there, a sense of striving for excellence.

Other programs are emerging on a systemwide basis. For example, cost containment. I emphasized its importance in the sixties. Fresh out of Ann Arbor, I had a lot of ideas about how to improve the delivery system through the financing process. A fair number of those ideas ended up as polite policy statements or worse as exhortations. In the seventies however, cost containment standards were developed which were made a condition of plan membership in BCA. It happened also in Blue Shield. Under the program certain cost containment activities would have to be implemented by the plans. These would include utilization review capacity, developing relations with areawide planning, etc.

The Associations have been quite active in urging the plans to get into alternative delivery systems, into HMOs. We have developed a national network of HMOs now, which we are just surfacing. The Associations are growing to a new and different type of maturity.

I want to hasten to add that the end result is not going to be a monolithic Blue Cross, that is to say a national underwriting capacity that takes care of all national business and all local business, or some combination of the two. Unquestionably part of our strength is our ability to walk both sides of the street to be strong nationally when we have to be, but importantly, to have strong local connections through plans, politically,

marketwise, laborwise, and communitywise to reflect the kaleidoscopic patterns of tradition, income groups, etc., around this country, in effect to be an integral part of a manageable community. We need to preserve this balance.

The question, therefore, becomes: To what degree do we centralize to strengthen the system where it's needed without replacing valuable local capabilities? What's emerging in that context is that we may centralize or regionalize certain functions like data processing and actuarial work but leave intact provider, professional, and community relations, etc. It's a practical admixture of economy of scale and standards on the one hand and local nuance, political and market relations economic attachment on the other.

Nobody that I have discovered yet has a pat answer to the balance required. We are seeking our way in a competitive market influenced greatly by what it takes to get and keep the business and to do a good job. We are being controlled, in effect, as much by outside practical forces as we are by our own aspirations. If regionalization, a case in point, gets stronger, as it inevitably will, it will be because we will have to drive our retentions down, our administrative costs down, to stay in the market with Aetna and Prudential and others. If we get into the alternative delivery system capabilities, it will be the realism of Kaiser-Permanente and others that will influence us. I don't mean to drain out of our history the desire to do a good job to serve the community better, but I do underscore the fact that we are continually shaping and reshaping ourselves in a pluralistic, competitive market in response to the environment, as well as we are trying to achieve self-stated objectives. We are not yet institutionalized to the point where we are not plastic and experimenting.

WEEKS:

Today Blue Cross and Blue Shield are consolidated at the national level. Does this mean the two groups are coordinated?

McNERNEY:

There came a point in the relationship between Blue Cross and Blue Shield when certain things became an issue. The two organizations have always worked closely together. However, that basic statement has to be qualified. In a few sections of the country Blue Cross and Blue Shield competed. In some sections of the country the two were allied but not coordinated well. In some sections of the country they were one corporation.

Almost from the first there was some competition between Blue Cross and Blue Shield. It was distinctly in a minority of the cases, less than 10%. There was a fair number of the corporations where there was one administration and two boards, in some cases there was one corporation and one administration, and of course, we say cooperative but separate plans.

This type of variation was sustainable when life was a little less complicated. The markets were less competitive. There were virgin markets that could be attacked. It was a time when to gain market one wasn't always taking business away from somebody else, when the government was a little more relaxed about its demands on the system, when subscribers were less sophisticated, when even accounts like General Motors and U. S. Steel were less sophisticated. Health insurance was just another fringe benefit. Many were concerned, but not deeply. In the 70s, when the environment shifted, to wit: When consumers were more informed and had more opinions about how care should be rendered, when consumers were more critical of how well the carriers did, when accounts got more articulate and experienced, when the economy moved from

a supply economy to a demand economy, when it wasn't a question in the 70s of more beds more doctors but how do we develop productivity to meet an increasingly apparent cost problem, when the federal government was faced with the same general cost problems and started to grapple with these things, and when the number of competitors to Blue Cross and Blue Shield grew even more, then you found a more businesslike environment that was much more demanding, much more critical, much more highly penalizing of weaknesses.

Then not only did Blue Cross have to start to examine concepts of centralization and regionalization, to make better use of limited resources, but also had to ask the question: What about the relations between Cross and Shield? Were there redundancies and overlaps that were hurting the system? When a few of the plan presidents looked at the national associations, they found redundancies. Not only were there people in the Blue Cross Association and in the National Association of Blue Shield Plans doing similar things, overlapping, but the national voices, were not synonymous. They weren't saying the same things in Washington. Thus we were hurting not only from an efficiency point of view, but also from an effectiveness point of view.

WEEKS:

How did it happen that the two national associations combined?

McNERNEY:

Initially some plan presidents got together informally to talk about combining the two associations. Rump meetings wer held, I would be invited and in those days, Ned Parish would be invited. I think it is fair to say that from the very beginning Blue Cross Association thought combining the two associations was a great idea, that there was a need to bring the two together. But the Blue Shield Association, as it is now called, with equal

enthusiasm at first thought it should not be done. There was a fear on the part of the Blue Shield Association that in any consolidation they might not come out equal. Some physicians behind the Association feared that through such consolidation the physician might be subordinated to the Cross idea which is a combination community idea and hospital idea. When the plans started to explore it, two different signals came back to the Association. One, quietly, it's a good idea. The other: This is a frightening notion.

The rump meetings started to formalize. I won't take you through it all the way other than to say the issue did not die. It went from semiformal meetings to formal meetings then to the members plans discussing it openly. It involved the appointment of committees, the conduct of formal surveys, the formulation of formal recommendations and finally a vote on the issue. During that time, I was encouraged to keep a low profile because I was potentially part of the problem. What would happen to Blue Shield if McNerney were to become the chief executive officer? If I were to get too assertive at that point it could have prejudiced that question, so I played a less visible role. I offered my opinion when asked, and I was asked.

Considering market forces, the need to have a more collectively organized posture toward the government, the outright need to save dues and cut out redundancies, taking into account the fact that the public viewed the two associations as the same anyway, wasn't it time that the two became the same? The evidence became overwhelming, and the consolidation was voted.

WEEKS:

A CEO for the combined organizations had to be chosen.

McNERNEY:

The question of who would become chief executive was resolved. There was

a search committee that interviewed people. They asked me to take the job. Maybe I shouldn't be this personal, but it is reported that when the search committee asked a lot of people about the new position, both the hospital and the doctor representatives, in addition to various consumer and public representatives, told them they should move in my direction. That sounds bumptious, and certainly opposition was expressed within and without the systems, but I want to make the point that by then the American Medical Association had changed. Several years ago I had been cited for malfeasance by the AMA House of Delegates. (It had to do with HMO development and ideas that are now popular.) There were memories about that. When the chips fell, the AMA and some of the specialty societies were more concerned about reasonably articulate spokesmen representing the private sector who could negotiate and who were not orthodox, than they were about some difference of opinion. One has very mixed feelings as a person being supported by that many diverse forces. Is there any personality left? My guts tell me that the transcendant emotion was the need for leadership. Whether I qualify is a debatable point, but I feel that with national health insurance looming on the horizon that the bigger ball game was more important.

WEEKS:

Wasn't there a question of operation style?

MCNERNEY:

There was another aspect to the consolidation. Namely, did one use the Blue Cross Association style? It was purported to be a "more businesslike environment." Or did one use the Blue Shield Association mold which was more like a medical society mold: reference committees, several board committees, etc? The difference wasn't total; often it is exaggerated. In fact, the

plans decided to keep two associations, because one could not be pulled off, but with a joint executive committee and the understanding both boards would meet jointly on all matter of mutual interest. This executive committee in effect now performs a lot of the functions of the board, also board committees are structured dealing with such items as cost containment, audit, government programs, private market, etc. This gives the plans a structure through which to participate in the management of the national associations at the policy level and at the monitoring level. What we are doing now is feeling our way through this new structure. I am getting the feel for it, they are getting the feel for me and my staff. We haven't got it licked yet, but, I have to say, the transition of putting the two together is going remarkably well. There is no question--I can't find anybody to disagree--we are a more effective organization. It costs less money to do the same thing, which is important to note. A unified posture vis-a-vis Washington and the sense of working closely together which is developing in the field across the country is very wholesome, so we are very happy about it. There are a few residuals that haven't been dealt with, but they are in a minority pattern.

WEEKS:

What do you see for the future for the consolidation?

McNERNEY:

Looking ahead I would say that what we are going to see here is stronger, unquestionably stronger Blue Cross and Blue Shield organizations. The Association will assume a leadership role both through staff and the Joint Executive Committee which represents both boards. The Joint Executive Committee is already addressing some issues that were not addressable years ago, such as: how to better define the need for discipline under the system;

how to upgrade performance, etc. What we are looking at prospectively is a continuing evolution towards tighter standards, at not just corporate planning within the associations but systemwide planning and systemwide allocations, and at the ability to produce uniform products at much more competitive rates by virtue of computers that are shared among the plans. Although the 130 fiefdoms are there, and there are territorial considerations and reluctance on the part of some to recognize the need for collective action, the majority recognize that need. If there is any concern at the moment, it is, are we moving fast enough? For the first time in my life recently I felt a slight nudge from behind. Of course, that's partially relateable to the two years of negotiations that surrounded the consolidation and inevitably affected progress. But we're going, we're moving.

WEEKS:

We hear a lot these days about VE, Volunteer Effort...

McNERNEY:

It is interesting that one of the major things that's happening is the Voluntary Effort, and the implications surrounding it. For the first time in years collective conversations among doctors, hospitals, management, labor, Blue Cross, Blue Shield, and others are about how to reduce costs or decelerate expenditures, cut back on bed development, reduce capital expenditures, cut down on full-time equivalent employees per bed, etc. There were a lot of adversary relationships that developed during the sixties and seventies between Blue Cross and hospitals, between doctors and Blue Shield on these subjects. Now in a fascinating way, the Voluntary Effort has put all this in a common context, and there is an attempt being made to thresh out these things within the voluntary sector.

Hospitals are beginning to ask themselves if it is better to be smaller or larger, to be sharing services rather than duplicating services, to change objectives. At a time in the evolutionary path when one would have thought that Cross and Shield were on the edge of more government agencyship, we seem to be reinstating the importance of voluntary effort. It is an exciting force, beyond regulation, government, market and competition, and that pursues programs because they are "right," and one that keeps to issues because they are in the community interest.

There is some prospect that this Voluntary Effort will re-establish again the type of camaraderie that existed in the thirties when doctors with the communities of which they were a part created Blue Shield, and hospitals and communities collaborated around Blue Cross Plans. Although then it was a question of more beds, more doctors, and getting money out there so the system wouldn't die--a different orientation, to be sure. Now a similar camaraderie seems to be developing around the notion of productivity in the public interest. It may very well be that what we are seeing is sufficiently forceful, sufficiently satisfying and motivating that instead of the 1970s version of a straight line evolution of NHI we are going to see a new millenium. It may be that "ultimate" national health insurance resolution will contemplate a very strong role for the private sector, and not have all of the program dominated by government regulation.

This Voluntary Effort is subject to all sorts of cynicism and attack, but it's an idea that won't die quickly. I suspect it's going to do well. I for one am delighted to see it. Fractures that occurred between Blue Cross and the hospitals, and between Shield and the doctors during the late 60s and 70s were aggravated by the intermediary role, aggravated by the constant threat of

national health insurance and the politicking surrounding it and regulatory zeal totally overlooked and badly underestimated the potential of Blue Cross and Blue Shield, the hospitals, and the doctors.

The finger pointing from Washington tended to suggest that there was some thing mischievous when doctors started Blue Shield, and there was something sinful in the hospitals helping communities get Blue Cross going. What was completely overlooked was the fact that in the case of hospitals and Blue Cross, both were community institutions. Their futures both lay in serving the community well. That was a commonality of interest. If it was a partnership, it was in the public interest. Both were tuned more sensitively than the government ever could be in serving real people with real faces in local settings. They could make ideas come alive. They were not monolithic, they could do things and with reasonable facility. On the Shield side, although a little different, there was a lot of common potential as well. I think that the nervousness about the finger pointing and the uncertainty about the future led to a rupture of those Blue Shield-doctor relationships in some parts of the country. Now we are recovering the potential. I am very optimistic, I am very pleased. I, for one, never wanted to be just reactive to the government.

WEEKS:

There are often statements made suggesting something worth suspicion in Blue Cross-hospital and Blue Shield-doctor relationships.

McNERNEY:

The whole question of doctor-Blue Shield, hospital-Blue Cross relationships has another dimension: Who should control these corporations? When I was with the Blue Cross Corporation I, and others, often came to the conclusion that the public was best served with a majority of public members

on a Blue Cross Plan board. Several years ago no a resolution was passed by the Blue Cross Association that there should be majority public representatives on Blue Cross boards. It took cognizance that some state laws wouldn't make that possible, but then the determination was to change the laws. The shift has been marked. Now the vast majority of Blue Cross boards have majority public.

You always have these arguments: Is a hospital trustee a public member or not? Recently I found myself testifying on an issue that was precipitated on the Shield side when HEW put out "an intent to regulate" that all intermediaries would have a majority public on boards also, the FTC launched a full--scale inquiry. The Moss subcommittee of the Congress held hearings on the subject, whether the "domination" of doctors over Blue Shield was inimical to the public interst.

I simply went on record in my testimony as saying that I thought it was in the best interest of the community in the long pull for there to be public majorities on Blue Shield boards, and that we would work toward those ends. That was an interesting statement to have to make as a new CEO of Blue Shield as well as Blue Cross, but most of the plans were behind it.

More specifically, I testified "Look, there is not one scintilla of evidence that doctor representation on the bard has exploited the public either in terms of price, keeping competing forms like HMOs out of the market, in terms of cost containment, or the enthusiasm to do it." In fact, if there was any leaning, the plans with more doctors on the board have been more competitive on price and even more innovative. I added that even though we know we should evolve in the direction of public majority, there isn't a reason that a rule, a regulation, or a heavy-handed imposition has to be made

in the government. Give us some time, we'll get there. Mark a date, 1982. Check us out, we are willing to be held publicly accountable on it. Whether they will do this or start a series of legal maneuverings that would cost millions of dollars and many years, I don't yet know. But that's where we are going. An important caveat that I want to put into it is this: In any event, we want a strong minority hospital representation on the Blue Cross boards and doctor representation on the Blue Shield boards. Only through that can we hope to achieve strong service contracts.

If providers are going to commit themselves to these organizations, clearly they must have some input. To everybody's credit, government and otherwise, I think most people see that. If you didn't have that, the service contract would be undercut. The service contract is an essential option in the market place. It is necessary to protect that option so people who want it can choose it. This point of view is now being sustained. I think we can retain our connections with doctors and hospitals, too, through advisory committees, and task forces. To remove any doubt as to whether enunciated policies are in the public interest, we are strengthening our conflict of interest reporting for all board members. If a vote involves any aspects of conflict, the person on the board would disqualify himself or herself.

It is interesting to note that some of the plans are beginning to draw a distinction between public and subscribers. That is a distinction that has some merit in certain situations, but in most Blue Cross-Blue Shield communities the number of subscribers is so large and so diverse and represents so many large and small groups and individuals, direct pays, etc., that actually the difference between "subscribers" and "public" isn't very great. There is a temptation to talk "subscribers" because, perhaps, the regulatory author-

ities might view interested subscribers with a little more restraint than they have viewed the more amorphous group called the "public" up to this point.

WEEKS:

You are often pointed to as an example of excellent leadership. Will you discuss the qualities of leadership?

McNERNEY:

Leadership is a very precious commodity and, inevitably, it is in very short supply. That is not as evident, perhaps, to some of the younger people entering the field as it is to the people who have been in the field and have had relevant experience.

When we are talking of leadership, we are talking of a very demanding role. It's not enough just to want to be a leader. There has to be some capacity there to see as well as act, to do things in a way that ultimately succeeds. This is another way of saying that everyone should not aspire to this position. Some would be very bad at it. Some would be uncomfortable with it either because of a personality quotient, or because of lack of capacity. However, there are more qualified to play this role than are playing it.

It's to the qualified not playing the role that I appeal when I make this statement. These individuals are underachieving because through some combination of family, education or through early institutional experience they have lost their zip, their passion; they have become complacent. Some of them have become despondent, down without fully recognizing it. Perhaps an awareness of this can at least be a kind of spark to get people to think of themselves differently, possibly in a grander style and in a larger framework with fuller potential.

To what degree the programs in hospital and health administration get into the areas of leadership I am not sure. Some of it was built into the earlier programs in health administration because the teachers involved had been leaders in practice, and some were charismatic, not all of them but a fair number of them, so they didn't actually have to talk about these things, the role model was there, the mentor was in the classroom. There was a subconscious identification and some repetition of it, or replication of it. Now, the teacher has often come up through the academic ranks and is more of a spectator or observer. To what degree this gets built in, I don't know. Maybe the health administration residency provides ample opportunity, ample exposure to the role model. I am not sure. Every once in a while I reflect on medicine and I am struck with the fact that the doctors have built the real life situation into the educational process early, sometimes in the freshman year in medical school, sometimes the sophomore, certainly in the junior year. They put models out there, begin to energize the person for more than technical competence, not always correctly, admittedly. When one reflects on how much of management is practice, is doing, is art, then the fact that we are talking about two years of abstraction in many of our HA programs is something to think about. I understand fully that this argument has gone on for years. I am just calling for a re-examination of it periodically, not because I think anybody is right or wrong. It's just that, at the moment the field is calling for more leadership and doesn't understand fully why it isn't there.

The question always arises when a person is the CEO of an organization as to what degree does that person concern himself with relating the institution to the larger scene of which it is a part. (I am using the male reference for economy's sake.) This is a difficult decision. Obviously, the degree to

which the CEO spends time on internal operation, he's got to be sure he has somebody on board who will pick up some of the slack externally. Obversely he needs somebody for internal operation to the degree he is outside relating his institution to the larger field of which it is a part. When I say relating the institution to the outside, more specifically this would mean relating the hospital, for example, to the community it serves and such parts as: industry, schools, labor, management, social and welfare agencies and so forth.

My own view is that only recently have a healthy number of health administrators begun to exploit the potentials of relating their institutions to the larger scene of which they are a part. For too long the self-image of the administrator has suffered. Too often he felt lucky to survive with a medical staff and a board of trustees in sort of an aberrant administrative situation where nobody was in charge, where everybody was in charge, where he, the administrator, was, in effect only, a facilitative force that kept the situation reasonably on track. That was the most that could be hoped for. That administrative formulation was a secretariat concept, not a presidential concept, or a CEO concept. So I think the problem started with the administrator's self-image, his self-perception.

If you think about it, the self-fulfilled prophecy is a valid notion. You are what you think of yourself. In fact, it's such a strong force that even when things are favorable you are apt to fulfill your own prophecy even at your own expense. That is to say, unless you perceive of the job more grandly, even though the potential is there, you can drag it down. At any rate, with that perception there was little cause to be thinking of making the hospital system something else.

Now we are beginning to see administrators routinely meeting with major representatives of the community. By talking health matters over with these people and seeing the hospital through their eyes, their expectations, their wants, their satisfactions, their complaints, one is then able to think of the bigger idea of the hospital. To what degree is that hospital fulfilling the larger purpose, meeting the community needs? Once one begins to think in those terms, one begins to act in those terms. That leads to agendas of the board of trustees that have to do with objectives and with the corporate planning that is so important. Then one begins to think of the cost benefit questions and on outcomes or results. That kind of action, of course leads to sharper focus and ultimately to a better institution. It leads to proactive as opposed to reactive management.

I would add another element to the concept of being a good executive. It's essential that you consciously improve yourself as a person, irrespective of your institution. You can say that going to the symphony, pursuing other cultural interests are good means toward that end, certainly reading is. I personally make it a point of reading a large number of periodicals that are outside the field of health and outside of the things I am interested in on an everyday basis. Whether it's Saturday Review or Commentary in addition to Time, etc. It's stimulating, it definitely enlarges one's view of the world, but more importantly of one's self. In that line it is important to be on a modest variety of boards and committees.

For example, I am chairman of a committee that has a deep interest in the whole third sector. My thesis is that the one undeniably unique part of our society is that it is divided into three sectors, not two. In addition to the government and the private sectors there is a third sector populated by

not-for-profit institutions, that are neither public nor private, yet they play an essential role. I happen to believe in that role and do a lot to support the growth and nourishment of those institutions whether they are foundations, universities, hospitals, or whatever.

Involvement in outside things leads to the type of forward thinking and sensitive thinking that makes it possible periodically to evaluate where your own institution is in the world, and more importantly, you are more inclined to ask questions where it should be. This in turn leads to a re-examination of goals and new ways of doing things. There is peril here clearly. You can get so enamoured with your contacts and your newfound friends, that you can forget that you are running a corporation. I frankly acknowledge that peril. Like everything else, you have to live through some mistakes to gradually learn how to handle it.

You learn not to take on too much at one time, and then what you take on you have to learn to handle reasonably quickly. Some of one's best contributions over a lifespan are done with dispatch. Particularly I would quickly call to the attention of the younger people the hazards of putting things off under the thesis that if they simmer for a while you are going to do a better job, or insisting on having to have everything right before sitting down and doing something. You have got to free your mind to operate much more quickly, more intuitively, more honestly, more openly than that. Once you discover that, you move much more incisively, more attractively, and in fact, more qualitatively.

WEEKS:

You have had a connection with AUPHA since its early days, haven't you?

McNERNEY:

I can't recall exactly when AUPHA [Association of University Programs in Hospital Administration, later Association of University Programs in Health Administration] started. My recollection is that it was around 1950. That's a little suspect because that's when I happened to come on the stage in education. At any rate, I went to my first meeting in 1950. Incidentally, I went to most AUPHA meetings from 1950 to 1961 sitting around the table with names you would know: Malcolm MacEachern, Jim Hamilton, Ray Brown, Dwight Barnett, Gerry Hartman, and others. Jim Crabtree and I represented Pittsburgh as two more or less outsiders in 1950. Dick Stull was involved, Bachmeyer might or might not have been involved.

The meetings were fun. Few at the table were full-time educators. All had emerged from an operational field that was still young, and had had their fling. Many of them were consultants on the side. So they sat there as experienced practitioners most with a flair. They all earned more than a normal income through outside activities, either writing or consultation, or both. They didn't take themselves endlessly seriously. As a result the meetings were sometimes stimulating, always social occasions, and generally fun.

I suspect that if a full-scale educator sat in he would have choked on some of the discussions. We were in a transitional state between the practitioner as teacher, and then 10 or 15 years later the Ph.D.s taking over. The questions and arguments at the early meetings were timeless. Was it more important to study the environment, or was it more important to teach institutional techniques? There were champions of each extreme and it was more fun to argue than to come to sweet and reasonable conclusions. We spent a lot of time on that issue.

I recall Jim Crabtree, who came up through the Public Health Service, saying that the critical factor was to understand the dynamics of the community, its morbidity, its mortality, the processes of disease, host-environment relationships. He said only then could one decide on goals and objectives. Then he said the second burning question becomes: If you have to make a choice, given a year or two in which to do your teaching, what can you most safely trust to experience? Obviously it's institutional management. What you are less likely to get on the job and therefore need in the unique university environment are factors relative to goals and objectives. So he expoused that point of view. That appalled some of the persons in the room who had not given a thought to goals and objectives, perhaps. Then there would be the espousal of the opposite point of view. Let's learn to run these institutions correctly. The goals and objectives stuff sounds great--pie in the sky! It's self-evident what the goals and objectives are!

We had not only personality conflicts, but also an early wrestling with whether the health field was essentially a business or something else. That led to fights about whether these programs should be in schools of business, schools of public health, medical schools, or graduate schools. Then there were questions such as whether there should be two academic years or one academic year and a residency. In the residency what were the relative values of rotation versus projects, etc. These things had to be worked through. They were never worked though completely in that they still are being debated. Then in perhaps 1954 or 1955 we all decided we had to get people in from the outside . Some very well known names joined the AUPHA meetings and talked about the educational process. The W. K. Kellogg Foundation played a very important role throughout not only overall in the person of Andy

Pattullo, who attended a lot of these meetings, and made it possible for us to get very good outside advice. Included were first rate shcolars: Wally Sayre from Columbia talking about teaching management in the academic setting, how to teach; Taylor, a human behaviorist, who talked about learning, teaching, etc. We sat, listened, and learned. It was a very good group.

I was very young in those days, convinced that I knew more than anyone else in the room, but that probably was the typical bumptiousness of someone at that stage. The association performed a useful function, it had no full-time secretaries. We just took turns being president and in deciding where the meeting was to be held. To date myself, I can remember going on the train with Miss Jackson and Malcolm MacEachern down to Texas where the military program [Baylor University (U.S. Army)] was and is. MacEachern worked all the way down on something, as did Miss Jackson. Of course, the trip was an adventure to me and I wanted to get a little more out of it than that, but I learned that Malcolm was not inclined to waste time. On the other hand, once we got there he played well, too. By and large the evenings were relaxing. The atmosphere was freer, less pretentious than we find today. Today there is a full-time secretariat, there are annual meetings, there is accreditation. We didn't have accreditation then. Each one thought he had the best program and used to lie about it unmercifully. What we have seen here has been a normal, evolutionary development.

The spontaneity, the lack of formal educational training, the intuitive thrust that accompanied the early days offered many assets. The people involved were interesting people. On the other hand there were some poor programs. There was some weak teaching. Now we've got more consistent, more defensible teaching, more orderliness, and, possibly, more dullness. So it goes.

I do want to say that I am happy that the orientation moved from hospital to health administration. I think that was a very desirable step. It was talked about in 1955, fairly seriously. It became currency in the mid-60s. One watches these lags, probably they are inevitable.

WEEKS:

The American College of Hospital Administrators in another group I wish you would discuss.

McNERNEY:

The American College of Hospital Administrators has been an interesting institution. It still hasn't achieved its full potential. In the early days it was more informal than now. The college was easier to get into. I remember my admission test. We took a written examination, and then went before a panel of three people. In my case, one of them was Bob Buerki. I walked into the room and sat down. I forget exactly what his questions were, but they didn't have a lot to do with health issues. They were jocular, more to test my personality than my knowledge. It was all over in a very short period of time. I could have passed the test without having gone to a program in hospital administration or ever having been in a hospital, or whatever. It had a breezy aspect to it. The written test itself, however, was one of the early signs that things were going to be taken a little bit more seriously in the years ahead. So the college was more informal, as I mentioned. It imitated some of the professional societies of medicine by using the word "college" and by attempting by all costs to be professional. It wanted its members to be known as professionals. Over time the College developed ceremonies and awards, but they weren't highly structured. There was an uneasy alliance between those with master's degrees and those who came up the

hard way already intimidated by degrees.

Today the college has more ceremony and takes itself more seriously. The evolving role of the College is interesting to note. Somewhere along the line, probably now about 15 or 20 years ago, the College decided that the subject of management was its quest, so there have been innumerable meetings about management from every conceivable point of view: the behavioral, the technical, the philosophical, etc. A series of outside speakers have teased that subject literally to death. It was in the vein of let's become professional, let's learn to manage. There was a stuffiness about it that always bothered me. It was such a self-consciously dedicated adoption of process. The speakers that came in from a wide variety of fields and universities were perceived as oracles. In fact, some of them were sad. The question arises of whether the college's role should have been something a little bigger than that.

WEEKS:

You have discussed AUPHA and ACHA. The other professional group...

McNERNEY:

That brings in the American Hospital Association. The American Hospital Association has its territory. Its territory includes representing the hospitals in Washington, educating the hospitals, doing research--the three traditional association functions. It was pretty protective of those functions. Ed Crosby and George Bugbee and others have watched that turf, Alex does now. They were proud of the fact that generally they were able to attract the cream of the field on to the board and into the presidency, whereas the College made that sometimes, and sometimes it didn't. If the College yearned to broaden its activities beyond professional teaching and

management to maybe some slight representation function, to testifying in Washington or getting active in the Joint Commission for Accreditation, or whatever, that was talked down very quickly. That's where we are today.

I personally hope that Stu Wesbury, who is the new head of the College, will establish a dialogue that is more forceful and candid with Alex McMahon and Gail Warden to see if there can't be more cooperative effort. There's a lot to be done. My fear is not that there is going to be overlap, but that gaps that develop are not going to be filled. One can hope that there will be less self-consciousness about relative roles and a lot more dedication to the task at hand. Having lived through an interesting early period of dynamic amateurs, a middle period of highly self-conscious address to management, the College may now begin to reflect some of its new membership. We have some very bright young people in the field who may want to do some new, interesting, and different things, i.e., address the role of the modern health institution in a rapidly changing environment and swirl of surrounding forces. I certainly hope so.

WEEKS:

What about the talk that Blue Cross has lost some of its former share of the market?

McNERNEY:

The statement has been made that the Blue Cross share of the health insurance market is slipping away to the commercial insurance companies. I'll start on the defensive. We have lost business, share of market, to some small degree to insurance companies and others. There are two reasons. When we started in 1929, or whatever date you want to choose, the market was largely untapped. In fact, commercial insurance companies protested that you couldn't

insure against health hazards. It was a foolish thing to do, it was unthinkable. In those days clearly Blue Cross and Blue Shield had a lot of running room. In fact, there are some very amusing stories: for example, in Cleveland the plans supposedly would make employers stand in line to get enrolled. They were enrolling so quickly and their concept of where they were going was so modest that they literally would say: "We'll get to you later, we'll try to get around to you next month."

This indicates there was a pentup demand that was unleashing. It wasn't until the late thirties and forties that the commercial companies saw the market potential and started to get geared toward it on a group basis as well as on an individual basis. They had written a modest amount of indemnity coverage on an individual basis that went back fifty years at least. When the Supreme Court said it was all right for industry to make an expense of health benefits as a cost of doing business and not subject to taxes, and further during the wage price freeze of World War II fringe benefits were exempted, you got two kickers that significantly energized the market. At that point the commercials became seriously interested in it. During this time, what we now call HMOs in various forms comprised 5, 6, or 7% of the market. In the fifties, sixties, and seventies coverage expanded at a decelerated rate. It was clear that the American public wanted to be protected. They wanted to share risk. All this nonsense that illness was an uninsurable risk was well behind us. More insurance companies more enthusiastically entered the market. Add to that a variety of other competing forms: IPAs, foundations, HMOs, Safecos, etc.

What Blue Cross/Blue Shield faces now is: (1) greater competition; and (2) better competition. These are the major reasons why we have lost some share of the market. Having said that, we went until 1976 growing each year

in absolute numbers. It wasn't until 1976 that we lost some enrollment in absolute numbers. There was more loss in Shield, less in Cross. The loss in absolute amounts in Shield might have been 1.2% and in Cross might have been 0.4%. That's not what you call a major loss, but it is a symptom that the competition is heavy indeed. That's where we are.

Whatever the loss, once you get kicked like that, you really look things over. That loss in business was somewhat like what AT&T experienced earlier. Like AT&T, we are doing a complete analysis of our operations and where we are going from here. In that regard you are going to see Blue Cross/Blue Shield talking more of regionalization and more of economy of scale, tighter systems, national capabilities for government business, much tighter discipline on national accounts, etc. We will emerge from this a leaner and tougher organization. The competition will remain tough; we'll have to work very hard to keep our percentage of market. At the moment that's in the high thirties.

I should say just a bit about the nature of the competition. It's interesting to reflect on it. Most commercial companies offer indemnity for illness, that is to say when a person is ill they will give that person so much toward the costs of illness. That is a very efficient way to operate, in that you take money in, and under certain stipulated circumstances you pay it out. We at Blue Cross/Blue Shield are more apt to get involved in how we spend the money. More extensive utilization review is built into our software. Generally we bargain over how we pay hospitals and doctors. We relate our payments to areawide planning. We are now getting into screening for preventive services, etc. I don't want to make us sound too sanctimonious here, but we do get more substantively involved. We pay our money to the providers of care when illness comes and, in effect, produce service for our

subscribers. But it costs money (administrative) to save money (claims).

On the extreme are the HMOs that wrap a lot up in one package, and charge a per capita amount.

Leaving the HMOs aside for the moment, it's a highly competitive market when your competitor can go in with a retention that's pared way down because the competitor is simply trading money and not getting deeply involved in how care is delivered. That puts a lot of pressure on a service scheme such as Blue Cross and Blue Shield. Under those circumstances you have got to keep your administrative costs and reserves under control as well as being productive, i.e., affecting the 95% of costs that lie outside the retentions. It's a neat trick. We find employers ambivalent on this issue. One moment they are buying their insurance on the basis of the retention, almost a cost plus deal. The next moment they are hollering because the bottomline, i.e., overall costs, retentions, and claims, are too expensive. Back and forth you go. It's the American way of life. These ideas do and should contest with one another. In trying to have our cake and eat it too Blue Cross/Blue Shield will be sharing facilities across this country so that we can experience economy of scale and drive our administrative costs down without at the same time compromising some of our other capabilities, notally the service contract.

WEEKS:

Would you like to say more about HMOs?

McNERNEY:

The HMO is an interesting concept because it has persistently demonstrated that the hospital admission rate can be approximately one-half of either commercial insurance or Blue Cross or Blue Shield programs in general. They are considerable savings in that and thus for comparable benefits often they

can charge less. Kaiser-Permanente happens to be one of our major competitors, and one of our best. I have thought for years that the HMO was a fairly attractive idea, and said so fairly forcibly as President of the Blue Cross Association. This led to my being cited on the floor of the House of Delegates of the American Medical Association were saltily on a couple of occasions. It was anathema for a member of the Establishment to call for such a scheme. Later I got a policy statement passed by Blue Cross Association board that HMOs were good and supportable alternatives in the market place. The Blue Shield Association, then known as the National Association of Blue Shield Plans was more than mildly concerned. I was subject to some internal pressures from within sections of the Blues system. About five years later the Blue Shield Association made a supportive statement about HMOs. Today we in the Blues have started or have helped to start more HMOs than anyone in the country, either through wholly owned subsidiaries, or through marketing contracts, or through supplying up front money. So we are into the business. Organized medicine has come to accept this concept. It has simply taken time, but the Commission on the Cost of Health Care of the American Medical Association in its recent report included HMOs as an acceptable alternate form of delivering and paying for care. There are still a significant minority of physicians who would rather not have HMOs around, but it is now a part of the scene. I think it is a part of the scene because it has became painfully evident that certain physicians and subscribers wanted that scheme. You can't resist that type of grassroots pressure. It became acceptable also because in the last analysis what you are talking about is whether the public should have an option or not. Anybody who argues against a viable option in the market place isn't conservative, he's fascist. When I pointed out to some of the

medical groups who consider themselves arch conservatives what they were really doing, it was a very sobering thought. I further told them that if they fought HMOs and similar schemes long enough they would sanctify them. The schemes would become bigger than they are. Now that the HMOs have a clearer track, they are falling into sharper and bolder relief. What do they look like? Some are very, very good. Some are bad. Some have failed. Clearly, it's not a takeover concept that will compromise the practice of medicine henceforth. They haven't captured a remarkable percentage of the market. They are performing a very useful function and they will grow some more, but they are not a takeover idea. Their major contribution may be their ripple effect. They are a constant reminder to the rest of the system that the use of the hospital is often excessive. This has stimulated many of us in our regular business to drive the use of the hospital down. In one major eastern plan, New York, the use of hospital patient days per 1,000 population is approaching the HMO usage rate. If they ever touch, the basic and redeeming rationale of the HMO will have been blurred. The HMO or something like it will not be transient, because the very idea and how it operates is attractive to some people. But it hasn't swept the scene.

What is interesting to observe is the institutional lag involved here. You may recall that for fifty years after Harvey discovered the circulation of the blood, bleeding patients as a treatment went on, as if they were dealing with an open and unlimited system. Today there still are a lot of battles being fought in Washington about HMOs. Some of these battles are very reminiscent of battles of 20 years ago when HMOs had to claw their way into respectability. Legislation now provides: extra money at the front end to start them up; qualifications procedures; dual choice (promulgated so that the

employer must offer them as an option); etc. There is a religion behind the idea still. It has had a very forceful impact on Mr. Kennedy and others in Washington.

Some feel that the whole system of medical care should become a series of HMOs in a wonderfully cellular pattern like the combs in a beehive, that we really would have arrived then, because all of the incentives would be flowing in the right way. Enthoven in his current remarks doesn't go quite that far, but he expresses a lot of hope about reorganizing the system into new delivery forms that have parameters to them like HMOs. I think, whereas the HMOs will continue and grow that we are also going to see schemes develop like: consortia; shared services; networks; a rediscovery of the individual institution. In the future I see more of a kaleidoscopic pattern. The neat orderliness that some of the pioneers of the HMOs envisioned is not likely to happen. There will not be a prototype with a series of stereotypes behind it; there will be several forms.

New delivery systems that are evolving (multihospital systems, networks, consortia, HMO development) are posing some fascinating questions to Blue Cross and Blue Shield. It doesn't take a lot of brilliance to project the fact that some of the hospital networks, some of the multihospital systems, will be tempted with going into the market directly, attaching a per capita or some sort of prepayment schedule on to services, and marketing them. So what does Blue Cross/Blue Shield do under the circumstances? After all, the role of Blue Cross/Blue Shield is to market the services of providers of care. How do these things fit together?. Should Blue Cross retaliate by buying some hospitals and running them? Where we seem to be going at the moment and, incidentally, these things have to be talked out is that Blue Cross will

develop further HMOs and market them as part of their offerings in the market place. We have done this in approximately one-third of the plans, and we have offered an HMO network under the federal employees program, as one of the federal options. So the HMO is definitely a part of our future as it is of others.

WEEKS:

What do you see as the future relationship of Blue Cross and the multi-hospital systems?

McNERNEY:

In regard to how we relate to the multihopsital networks, I hope that we can work out an accomodation where we can be the marketing agent for those groups. There comes a point where an employer, particularly a large one, or a labor union, doesn't want to face a hundred options involving employee selection. The administrative paper work, the inevitable bad choices, the elements of selection get a little chaotic after a while. On the other hand, if we can intermediate so that we can reflect some of the big buyers' prejudices and yet reflect some of the growing changes in the delivery system, undoubtedly this areawide function we represent can be a very useful force. Suffice it to say that it will mean some new exploration, and some new ways of looking at things. Right now I have asked for a meeting of my executive committee with the executive committee of AHA to get at precisely these points.

Looking ahead at what is the best way to proceed, Blue Cross has been tempted with the idea of buying some hospitals and running them as prototypes to show what could be done if industrial engineering and other efficiency matters were brought into play. The idea has not yet surfaced. It may. I don't think it will become a dominant pattern, but as a prototype that could

be referred to, there are some possibilities there. It may be in the offing. I see AHA getting more interested in working with hospitals to develop the type of efficiency I am talking about here. It may be unnecessary to buy one to do the job. It might be possible to have one or two designated and to help finance a demonstration.

WEEKS:

You have been the principal spokesman for Blue Cross and Blue Shield in Washington, haven't you?

McNERNEY:

My role in Washington is inevitably quite extensive. The Blue Cross and Blue Shield systems are huge, pervasive. Health is a major political issue. The only interface with Washington the plans have are their national associations. It has been agreed that the state politicking and legislative liaison would be through the plans. The Washington contacts, White House, HEW, and Congress would be through the association. As the national spokesman as well as the association(s)' CEO, I have been projected into a fair amount of traffic and activity, I've been going to Washington fairly regularly since 1961, I've been in meetings with White House representatives, HEW representatives, congressional representatives. Through these contacts I have been intimately connected with a great deal of legislation over the last almost 20 years. It brings back a lot of poignant memories. It has been a very enjoyable part of my career.

When Medicare and Medicaid came to fruition in 1965 I had the privilege with Wilbur Cohen of working very closely with Wilbur Mills representing the Blues, getting right down to the specific nature of the legislation and its provisions. I then had the pleasure of working with the Secretary of HEW on

the implementation of the acts including the contract that ties Blue Cross and Blue Shield to the system. At that time I also did a fair amount of work on the roles of the providers since I was acquainted with both sides. So it has been with a whole series of health legislation whether it was HMO, PSRO, perfections of the Medicare planning act, and so on out. I don't want to bore anyone with the details, but suffice it to say, there were a lot of opportunities to be a substantive part of the shape of the legislation that emerged.

I have a couple of feelings about Washington that are not shared by everybody who works with or for other associations whether AMA, AHA, specialty societies, proprietary groups, or whatever. They have their own personalities, and do their own thing. I have always felt very strongly that we should be open and unrestrained in our willingness to cooperate in Washington. In that vein, when national health insurance heats up, we find ourselves providing a lot of detailed data, not only to someone who is on the right of the issue but also to someone who is on the left of the issue. We are a semipublic institution. Certain of our experience doesn't exist anywhere else. We feel an obligation to share it. So there are times during the debate on national health insurance when we are working closely with several committees and differing parties in a factual way trying to make it clear what the strengths and weaknesses of the data are, and to point out some of the foibles and weaknesses that are involved. Beyond that we add value judgments, and are willing to criticize specific pieces of legislation. The fact that we have been open and professional about things has meant that, when a serious piece of legislation comes up, we are consulted. Our staff is used, that puts us in a position to help shape the course of events. I think that has made it

possible for Blue Cross and Blue Shield, silently to be sure, but effectively, to have guided a fair amount as opposed to being in a polarized position.

Another feeling I have had is that overexposure in Washington is bad, so I don't spend a lot of time down there just to be down there. We have a Washington staff that are competent, and there are people from the plans who can be brought in for particular issues. So I stand back until it counts. I have found, at least in my own instance, that this is a good idea, because there is a certain magic about the CEO, but if you see him all the time it's no longer magical. At any rate, I believe in selective intervention and hitting when it counts and not wearing out my welcome. I think that has been a useful way to do things.

In talking of Washington, I had to learn that not only do people there want professional help, not only do they welcome not having their doorbell punched all the time and being harassed for favors, but also they genuinely respond to the grass roots. There is nothing more persuasive to a member of Congress than somebody from back home.

What we have done is develop a Washington task force which has regional representatives on it that work closely with George Kelly, my senior Washington representative. There are about 15 on the task force. Under each regional representative there is a representative of each plan in the region. When we want to communicate on issues we get to the congressman back home. Under the supervision of the regional representative but in the direct hands of the plan representative, we talk to that congressman in language he can understand related to local problems. Since Blue Cross/Blue Shield are so pervasive, so deeply involved in communities there are a lot of things we can talk about in terms that person would find easy to grasp, to relate to, so,

it's not just a question of me going in then with abstractions that we ought to do this, or this is bad, or this is good. When something comes up that's inimical to the public, let's say, again I don't want to sound too grandiose here, but this can happen, some very bad legislation can come down the pike--when something comes up, we are able to move in very quickly.

I have another thing I'd like to add. Blue Cross/Blue Shield have not written a bill, nor do we generally support a bill per se. There are reasons for this. We represent eighty-five million people in the private market and we are agent for the government for twenty odd million more. One-half the population is included. Our constituencies have some pretty deep-seated feelings about national health insurance, as an example, or HMOs, or planning acts. Organized labor might feel one way, management might feel another way. Texas might feel differently from New York in the matter of political persuasion. For us to pretend to represent those constituencies with one magical piece of legislation is a bit pretentious. There are other reasons. Once you promulgate presumably with self-interest at stake--once you promulgate a bill you are forced to defend it and to go out and solicit a lot of support for it. You are polarized. You are no longer able to be in the position of communicating with a wide group of people and of shaping their points of view. In very technical but true terms the very annunciation of the ultimate piece of legislation means it can't be passed because the chairman of the critical committee ultimately is going to want to have his name on it and his personality on it. If you preempt the territory, he's got to come up with something else. So it's better, when you are working with a variety of people, to pick the ideas that are the most promising and shape that most promising person, who is backing them, into the proper mold. That may sound a

little bit tricky, but it's not. It is responsive to how the Congress operates.

For reference, we have annunciated a series of principles we think should guide any legislation. We test legislation against those principles. Beyond that we've got a whole series of technical issue papers (500 or 1,000 pages) covering issues that arise inevitably in any health insurance legislation whether it provides pooling of the carrier in the private sector, methods of reimbursement, etc. We do have some profile. We've got a lot of interesting material and backup facts which take some of the debate that goes on once in a while and brings it down to earth and addresses it to practicality. We've got one thing few else have got: We know the practicalities of getting things done.

I am intrigued after ten years of watching AHA with its bills, and AMA with their bills to note AMA coming off a bill, or at least taking inventory, and so has AHA. So are some others beginning to think it is better to operate on principle. I don't want that to sound too smug, but that is what is happening. This has led to a fascinating result: A representative of the National Association of Manufacturers said, "For God's sake, one of you guys step forward. We can't just go up there and pontificate, we've got to have something to sell, to be for or against."

Washington is a fascinating town, it's disillusioning to a certain extent, but it's also exciting. By and large I have learned my way around, and I hope I've got some respect there and some usefulness. I come away with some feelings that are purely personal, but I have testified as much as anyone in the health field over the years. Some of it is fun, it's light, it's informative. It was particularly so when Wilbur Mills was in the chair and he was

joined by persons such as Governor Carey. There was excitement, packed rooms, a lot going on, when I say, fun, let me give you an idea. One of the standard techniques employed when you have limited time in which to operate in a highly adversary type of hearing, is for your Washington man to load the situation by planting one or two questions with selective committee members. I'll never forget one time testifying before Wilbur Mills at a very critical point in the national health insurance debate. There was a lot of tough questioning. My Washington office had loaded a prominent member of the committee with a question which was to help McNerney at some point. Well, I had a very good day at bat. Even though I was dealing with tough questions, I was reasonably on top of it, I was riding high and I was doing well. The puckish Irishman with the loaded question decided I was doing too well.

Right in the middle of things he said, "Mr. McNerney, I would like to ask you a burning question."

I said, "What is it?"

"Is it true that Blue Cross of Michigan buys the bowling shirts for the bowling team of a hospital in Grand Rapids, Michigan?" "Is it true?" Well, he gave me a couple of these shots and I answered him in a puckish view, everybody laughed.

Some of the testimony is to me alarming. In the testimony process you sit there and you are questioned but you have no right to question in return. That forces you to take the questions and elaborate on them a bit, or twist them around to where you want to go and take off in new directions, which may be unresponsive to the question, but it's your only recourse.

This becomes gutty at times. For example, at one point an investigator for a congressional committee went to one of our plans, showed up on a

Thursday, left a young assistant, and then disappeared for three or four days, showed up at the plan for a half hour then went back. This particular person, we happened to know, went to a recreation center for 3 1/2 days and the person left at the plan didn't know what to do or what to ask. Here I am testifying before a certain congressional committee; and this investigator is alleging all sorts of things on the basis of "thorough plan visits." If I state that I know that the person who went out there did such and such, I would be a character assassin. On the other hand, if I had the right of counter questioning, I could have very politely asked: Could we discuss your review of the plan? How long did you spend there? What did you do? Simple polite questioning could have shown the allegations as unsupportable. The very fact that I tried to answer their questions made Blue Cross appear guilty. The misuse of the legislative process, a victory at all costs.

I used to enjoy Ted Kennedy. He had a engaging temperament that was interesting. It was open. There were times when he would ask me questions, and I would fire back, and he would fire back at me. It was fun. Then he would sometimes come down afterward from the chair, and even though we had been in violent disagreement at times, would extend his hand.

WEEKS:

What do you think is the status of the drive for national health insurance?

McNERNEY:

As to national health insurance, I think we are on an evolutionary path, unquestionably, and that we will remain on one unless there is an extraordinary spasm in the economy that I can't foresee. I think we will ride through some tough recessions without changing the evolutionary path. That's true for several reasons. Inflation is a problem we cannot ignore any

longer. The expenditure of a lot of federal money on health would be inflationary, more so than if those dollars were spent in the private sector. Our problems of international trade, the value of the dollar, unemployment, energy, etc., are of transcendent importance. They've got to be attended to as a matter of priority. It is also true that, since the rest of the world has gone first to grand government schemes, it is possible for us to look around the discover that nobody has any magical answers. Health costs are going up in the rest of the world too. There's a lot that just has to be muddled through, there is no magic wand. Add to that our Congress is pragmatic not doctrinaire, it is responsive to politicking of various types, and again you come to an evolutionary path. Also I would point out that labor in this country is not doctrinaire either. One hears about labor's NHI bill. Labor's not a monolithic force. There is as much division among labor as you find among management. There are splits between the line and the staff people in given unions. Though a few spokesmen get up and pretend they represent all of labor, one has to step back and reflect that even John L. Lewis with all of his charm and all his exciting rhetoric couldn't deliver the mine workers on a vote basis. Here we have a situation that is precisely the same. No spokesman can deliver all of labor on NHI. I might comment that labor is not gaining membership.

The most important point to be made is that health service is a reflection of the personality of the country. This country has its personality, it's practical. It's technological. It's not doctrinaire. It's not going to come up with a national health insurance scheme that is taken from Britain, that is taken from Canada; it will be pieced together to solve selective problems over time. I think it will be well if we finally accepted that, because then maybe

we could begin taking manageable bites and getting things done. At the moment we do not have all the population adequately covered. They should be covered. Let's do that, let's stop arguing about whether the Kennedy bill is going to pass, at least make coverage more universal. We have some problems with the health of mothers before they bear children and immediately after. We know how to turn some of those situations around and discover in utero some problems in the child. Let's do that and stop talking about all or none, and the big bill or nothing. It is happening, but it's happening with this hushed sense of expectation, that there is something bigger around the corner. The bigger thing isn't coming in one fell swoop, it may never arrive. Let's think in more practical terms. Perhaps we will.

Certainly nothing big is going to come through Congress this year or next. What comes after the elections in 1980 will be modest. What we need here is a new term. Perhaps rather than "national health insurance" we need new national health policies with supporting programs (plural). We may be on the verge of recognizing that. One more thing I should say is that the current debate is influenced a great deal by a shifting of the mood of the country: Proposition 13, counterculture, small is beautiful, going back to older ways of doing things in more manageable settings. This mood has led to a conservative House populated by younger people in the Congress. It has led now to a reappraisal of the effectiveness of regulation. We see a new examination of regulation, resulting recently in some deregulation of the airlines industry, inevitably, I think, in some deregulation in the health field. The attack on regulation is not simply against regulations, it's beginning to be for something. The "for something" is a restoration of the market, greater use of option, selection by the individual from among

competing schemes, greater reference to providing tax incentives. What these ideas say is that you can't run the ship from Washington with omniscience, with some far-sighted, magical knowledge. It just won't hang together that way. What you have got to do is set some goals and some standards, establish some priorities but then let the system operate and run. Be assured it has purging mechanisms. The intellectuals who came out of the Ivy League colleges during the Johnson era were filled with solutions to these problems. What we see now is the intellectuals like Enthoven and Feldstein coming out of the colleges saying we don't know the answers but we do know this business of talking about the country doing things from the top down just doesn't work and adds up to a lot of paper. Let's ventilate this system. To the extent that the feeling presists as an influence, added to the other things I have said, keeps every- thing on an evolutionary path. We will be thinking less in religious terms of a deity in a little town on the Potomac who will be solving all of the country's problems and more in terms that we have all got to pitch in. That's evolution again.

WEEKS:

I recently heard the statement that by 1985 the ratio of physicians to population will be double that of 1960. If this is true, what effects may this have?

McNERNEY:

With the great increase in the number of medical graduates in recent years, the question has been raised as to what effect this change of the ratio of physicians to population will have on the health care picture. You could speculate that if the manpower product keeps cranking out more and more doctors, yet people are "weller", that busy work is going to start. My

response to that is that those of us who pay the bill have got to crank into our software even more information that we've got, so that, if repetitive tests related to a diagnosis appear or if counterindicated drugs are given to the same patient, that these are teased out and questions are asked. I think we have got to enlarge our programs that, for example, say certain procedures shouldn't be done at all by anybody, and that few tests should be routine. Next we are going to have to resist repetition of testing outside the hospital and in. Further, we are on the verge of identifying 700 surgical procedures that can be done safely on an ambulatory basis. This all adds up to: Whatever we are paying for we are not only going to look at to see if it is effective but also we'll have a set of standards alerting the physician up front that there are certain conditions and settings under which these things should be done. By promoting alternate delivery systems, ambulatory surgery, group practice, by promoting broader use of the hospital, we are going to have reference points so that, if a doctor in a middle-sized community, for example, is making work in order to keep his income up, he will be comparable to another doctor on salary who is faced with the same diagnosis. If that disparity gets unreasonable, we could be in a position then to force an issue. I can't possibly sit here and tell you that our instruments will be that discriminating, next year, but it's coming.

Any time there is an oversupply of a producer of a service, there is going to be some bleeding off. In other words, more doctors may go into administrative work, or research work, or pursue other alternatives, other things. There also will be some make work. We will suffer through a 10 year period during which the conventional wisdom will gradually declare that we've got too many doctors and the federal government will reduce its support, the

number of graduates of medical schools will go down, and a new adaptive process will start. We are not nearly as naked as we were 10 years ago. I think we can come to grips with the subject of appropriate use much better today than yesterday.

WEEKS:

Will you comment on second opinions on surgery?

McNERNEY:

We don't know a lot about second opinions on surgery. Several of our plans have that benefit. It's not a mandatory program, it's a voluntary one. In other words, we pay for it, but it's up to the individual to use it. So few people are using it that we don't have a big enough population on a longitudinal basis to come up with impressive results. The New York Plan is our largest. It has the best information, and it's still puzzling over that information. I don't have enough good information. Although some information has been released saying that second opinion in 42% of the cases say surgery is not necessary, that information is not good enough. First, you want to know the characteristics of those who elect and of those who don't elect to seek second opinions. Of those who elect to ask for a second opinion (here you come to another branching on the decision tree) to confirm the diagnosis and prescription. How many challenged? What happens to the person who gets or doesn't get the surgery? Who comes out better in terms of mobility, recovery, lost time, or whatever? Of those who go to a third opinion there are similar questions so this is an issue that is surrounded by qualitative questions as well as quantitative questions. This is why it has taken so long to speak out on it. We are not yet sure, when we get the data, we'll be up front about it. I am perfectly happy to leave the program on a voluntary

basis, but I am a little bit reluctant about going around bragging about the process.

WEEKS:

Will you talk about some of the persons in the health and political fields with whom you have worked or associated?

McNERNEY:

It's enjoyable to reminisce a little about some of the leaders I have known in the field.

Ray Brown comes to mind, I was extremely fond of Ray, saw an awful lot of him. We were on government commissions together. We were teachers at the same time, he was a member of the Illinois Blue Cross board, we had a lot of conversations about that. Ray was, without serious doubt, one of the brighter guys in the field. He was genuinely, intellectually smart. He was widely read, and well informed. He had his feet on the ground in the sense that he was interested in the details of implementation as well as the concept. He was fiercely loyal to the people he knew and liked. He was the guy who would be chosen by a state association, a regional association, or the AHA when they wanted someone to evaluate a situation, who would be unfailingly fair, or even-handed, a person they could trust. He refused to say anything bad about anyone, as Bachmeyer did before him. If you wanted a fight, just start picking on somebody he knew well, and he'd be defending him. I liked a lot of these qualities about Ray. The only criticism I had about Ray was that he threw his arms around some persons who were weak. I believe his loyalty misled some people into thinking they had something on the ball. That's a human emotion we all can understand. He was a classic example of a person who is self-destructive. He had an insatiable appetite for work. He reminded me

of MacEachern in that regard. He worked literally all night on occasion. He'd be overcommitted in terms of papers and books. He couldn't say no if somebody asked him to do something. He began to look bad about three years before he died, and he died with his boots on. I wish he had slowed down because he would be with us if he had. Literally, he couldn't.

Of course, I saw a great deal of Ed Crosby. He and I communicated very well over the years in ironing out the relationship of the hospitals and Blue Cross. Together we took both organizations through a change in orientation. I attended his board meetings, he attended most of mine. We got along well and I think it was a very productive relationship. Ed had a background of public health from Hopkins. I taught in a school of public health for five years and interestingly enough it was a new school of public health started by a lot of Ed's old friends from Hopkins: Thomas Parran, Tony Ciocco, Jim Crabtree and Paul Densen among others. They all knew Ed so we had a commonality of background and in ways of looking at things. We respected each other a great deal. There is no question that our work together helped shape Medicare, Medicaid, had a lot to do with the nomination process as a way of doing business and helped to forge, through Medicare, a lasting public private partnership. There is no question that when it came to the private sector, the working relationship that existed between our two institutions was very productive. I probably knew Ed as a family member better than most excepting Jim Hamilton. Shirl and I saw a lot of Hat and Ed so there were a lot of personal ties there that were binding. Ed had very good instincts. He thought of the community as well as the institution. He was willing to take risks. He took them, made decisions when it hurt. On the other hand he was impressed with the systematic, methodical, and administrative way of doing

things. Again he was a person who was very hardworking and ignored symptoms and went on.

Wilbur Cohen, I think, was the best secretary HEW ever had. I don't mean to depreciate others who had the job, some were outstanding people, for example, John Gardner. In terms of the particular ability to do that job, Cohen was the best. He was practical, hardworking, humorous when he had to be, didn't take himself infinitely seriously, had a tremendous fund of knowledge, a likeable person. I first met him at Michigan. We were both on the faculty. He taught in some of my classes, I taught in some of his. I didn't get to know him well then, but knew him. We respected each other. So, when he went to Washington, it was natural for me to see him. I must say I was saddened when he left with the change of administrations because he had on the drawing board a lot of useful ideas for the future. He was misunderstood by medicine for a long time. I think a lot of people in medicine think Wilbur has changed, but I don't think so. I think he always was a straight shooter, a person who wasn't going to go all out for national health insurance for the sake of some grandiose notion. He was very practical, he knew how to horse trade. He knew when to give and when to take. It just became more apparent when he got the job of Secretary of HEW that he was willing to be practical about things. As the AHA and AMA and others saw that, they were more relaxed, they began to talk to him more candidly. So it's not only a tragedy that with his ideas he had to step down, but his relationships were solidifying too. He is still quite a guy, and I think one of the major figures.

Wilbur Mills was an excellent Congressman. I saw a great deal of him for a 10 year period. I knew him well, met with him often in his private office. He responded to good facts, he responded to good staff work, and we did a lot

with him. He knew how to run a committee. He was tough but, my God, did he know how to get things done! What everybody has said about him is true, he was a superb legislative leader. It was sad to see what happened. Several of us could see changes but didn't know fully what was going on. I think the Congress lost just a tremendous amount when he became disabled and then left. The real tragedy is that the last year or so clouded his previous brilliance. But if you go back it's there. Now, incidentally, he's recovered and he is doing well.

Bob Ball is one of the best civil servants I have ever met, or will ever meet, I am sure. He and I did a lot of negotiations over the Medicare contract. I recall being very impressed with his capacity to learn. After all, he didn't come up through the health field. Suddenly he was confronted with implementing Medicare. He learned fast with Art Hess's help. He was extremely articulate, had high integrity, and fought toughly for what he believed in. When we first met I knew more about the health field than he did. When sitting in a room with him and thirteen other people got unproductive, I suggested that we meet alone to negotiate. He took that challenge. He did as well alone as with all the others. Probably better, I've always trusted him. He believed deeply in Social Security but he wasn't one of those people who thought it would take over the world. He was a pleasure to work with.

Malcolm MacEachern was a grand old man, that's what everybody said about him, and that's what he was. I say "old man" because I saw him in his later years when he was a little less dynamic than he was when he was younger but fair, kind, and considerate, hard-working to a fault. He worked days, nights weekends. I don't know of anyone who didn't like him. Perhaps he lacked a little bit. His major book was descriptive not interpretive. I don't mean

that unkindly. It was systematic and thorough at a technical level. He was less the flamboyant and more the patriarchal.

Arthur Bachmeyer I knew the least of the people I am talking about. Here was a reserved and circumspect individual, he, like Ray Brown, was uncritical of other people. He did not delve in gossip and rumor, or in innuendo. He was up front and he was able. One got the feeling of great solidarity from this man's respectability, credibility, accountability.

Basil MacLean. Interestingly enough, when I got through the program at Minnesota the program inquired whether he wanted a young resident at his hospital, Strong Memorial in Rochester, NY. He didn't. He could be imperious in manner. I am not sure that he felt that way, but to a young man he looked a bit that way. I was interested in him because he was purportedly bright, one of the leaders of the field. It was interesting that later, not a lot later, I took the job he had at Blue Cross. By that time his health was failing pretty badly. I didn't know Basil very well, so I shouldn't say very much about him.

Ig Falk is the doctrinaire member of the group. He is not considered a leader by the hospital field or the medical field. He's on the Social Security side with an overlap. Ig is extremely bright, articulate, an opinionated person who has an idea that the system has got to be rigorously changed, changed now, and changed dramatically, or the world is going to come to an end. He has a fervor that won't quit. People who felt differently were his adversaries. He would take great delight in outsmarting them and out-talking them. He is a wonderful character and very human behind it all. As much as he would attack and attempt to demolish people with other points of view, after it was all over he could sit down and enjoy breakfast, enjoy

lunch, or whatever, with you. He had the type of self-righteous indignation that just put doctors teeth on edge. Nobody bothered much to get behind it. Ironically, as good as he was with concepts, going back to Social Security and all the rest of it, when it came to running an HMO in New Haven, he was not an outstanding administrator.

Jim Hamilton is my father-in-law. I know him intimately and well. He's a genuine character. There is no question about it. A guy I am very fond of. He and I, strangely enough, get along well. I am not as intimidated by him as some. He knows it and we have some very straightforward conversations about things. Jim has always enjoyed talking to me about his early days in the field, people in the field, and what he has done. It has been very helpful. I have gotten to appreciate some of the contributions he has made not only to AHA, but also interestingly enough to Blue Cross/Blue Shield in the early days. He was one of those guys out on the stump supporting prepayment in New England when this new idea was formulating.

When I was going with his daughter, Shirley who is now my wife, I was at Yale and went to see Clem Clay who was head of the hospital administration program there, as I mentioned before. I remember Clem telling me in effect that I wasn't ready to take on a program of hospital administration, experience was desirable, the class would be terribly competitive, a lot would know more than I, so I spoke to Jim Hamilton about it, a little self-conscious that I was going with his daughter. He said, "It's a wonderful field, an exciting field." He made it come alive. I had already decided that I wanted to go into it, but he made it sound like a damned good decision indeed.

I said, "Where is the best program?

He said, "Minnesota, without any doubt."

I said, "Are you serious now?"

He said, "There's no question about it."

That's Jim Hamilton. I enjoyed that program, got a lot out of it, and got a lot out of him. Behind a sometimes intimidating demeanor there is a talent for acting, a talent for projection, a talent for expression, an ebullience, an affirmity that is attractive. Furthermore, he is very loyal to his students and people he knew. I can't say in the same way as Ray Brown because Jim Hamilton got into fights with people he knew, some of whom haven't forgiven him, nor he they. For who survived the fight, he has a very intense sense of loyalty.

Rufus Rorem first had the job I hold, he was the head of the Blue Cross Commission. Rufus was an indispensible figure as far as Blue Cross and Blue Shield are concerned. He realized that these separate, fledgling plans needed a unifying idea and concept. He expressed it in terms of permissive principles, an approval program and a licensure of a name and mark, in effect a franchise. He welded things together when they could have been flying apart. He gets a lot of credit for what Blue Corss is today and for that matter Blue Shield also because Blue Shield keyed off Blue Cross and used the same pattern in a slightly different way. Rufus was the straight and narrow man with the ethical mind. He did things because they were good and they were right. His intellect was such that he was able to anticipate the future. His sense that this thing called prepayment was right for the country was a very forceful part of the growth of Blue Cross.

He wasn't an administrator, I think if he were now with the administrative challenges and the operational challenges that the Associations have, he would be somewhat uncomfortable. He was in his element conceptualizing, providing

the reasons for, as well as the leadership for, concepts. In that capacity he did extremely well. He is still with us, I still see him. He comes around and says to me, "I don't know why in the devil you are still in that job." I think most recently he has concluded that what I have done hasn't taken a lot of brilliance, it's just taken persistence.

He came back here a little while ago, and it's fascinating that the people who were turned on the most by him were the younger people. They wanted to talk with him, they had a seminar with him. They picked his brains because he still had some of the messianic fire. I think that's a real compliment. I hope someone can say that of me some day.

SIGMOND:*

One of the topics I didn't seem to find discussed was your views on the changing concepts of the role of the hospital. This is the kind of question I scribbled out 25 years ago when you moved to Michigan. The community hospital seemed destined to evolve as the organizational focus for personal health services, with an ever expanded role in health services. Today, you would agree, the hospital is increasingly viewed by public policy spokesman as the enemy of the people. What you think happened?

McNERNEY:

My first exposure to the health field late in the 40s and early 50s came at a point when public health still had some valiant warriors, Tom Parran being one of them. There was still a contest at that point between the public health department, or some of its ideas, versus the hospital as to which was the better place to center health strategies. I got a glimpse of public

---

*Robert M. Sigmond was invited to join and participate in the session at this point.

health making a serious try to establish itself as the orchestrator of community health using planning, using communicable disease, environmental conditions, sanitation, chronic disease, etc., as functional arms. But, because public health got captured by the universities, and once within the universities, got encompassed by medicine, the intellectual leadership got seriously compromised leaving the track pretty much open to the hospitals as the only alternative. In that same period, early 50's and late 40's most thinking people felt seriously that the hospital was the logical center for community health. This was partly because of the default of public health as an idea, partly there was no alternative. It was where the major resources were.

Importantly, even then some of us felt the hospital should not only concern itself with inpatient care but also outpatient care; not only with organic illness but also functional illness; not only with acute care but also with long-term care; not only care on the site but also in the home. There should also be connections with industries, with the school system, etc.

Now we talk about these things a lot, but even then I recall very clearly that several people with whom I chatted saw the logical connections between the hospital and the local industry. Not all local industries could afford doctors on the payroll, not all industries had the expertise to have screening or whatever.

Well, where could they get it? They could get it from the hospital. Why didn't the hospital, therefore, go on the initiative and make something out of that? Although the hospital has made tremendous technological program since the early 1950s and has matured in the sense of better internal discipline, better training, etc., in many communities it still is not much closer to the

real outreach type ideas that were talked about even then. I am beginning to see some evidence that maybe this will come about as some of the new heads of hospitals and the new people in medicine are getting more aggressively interested in the community.

The voluntary effort gives lip service at least to outcomes in addition to input, to community orientation as well as managerial orientation. Usually where there is some smoke there is some fire. So, with some national talk about it, and with some examples at the local level--being partly optimistic and partly romantic--I think something is coming. Why? I attribute the long period without a faster development to the fact that medicine was on a scientific, technological outburst where the best and the brightest were more concerned with biochemical research, with dramatic surgical interventions, with heroic diagnostic achievements. There also was the fact that prepayment insurance loaded the deck to pay for one type of thing and not pay for another. There also was the fact that the partners, industry and school systems and others, were still quite unsophisticated in their thinking. I mean, the average industrialist didn't like to talk about health strategies. Now he begins to see some payoff about health as it translates into productivity. Therefore, he is more inclined to think maybe some bridges are worthwhile.

The school system is beginning to say, "Maybe sex education isn't all that bad. Maybe it's right to worry about whether children can see and hear in the normal range and beyond that are reasonably well fed and can listen and think." A growing sophistication there is beginning to help.

I think, too, there was no real actor on the stage for that fifteen-twenty year period. After the medical administrators like the Buerkis, the

Goldwaters, the Crosbys passed--passed in the sense of going on to do other things such as consulting, association work and so forth, there was a gap. These guys were emotional, they were visceral. They didn't put up with any restraints on what they said and how they felt. They were public health oriented essentially.

After these passed there was a serious gap as to what figure would orchestrate, presuming the environment was right. It is only recently that a Stan Nelson steps up to the plate at Henry Ford Hospital and develops satellite units, HMO's and develops a very close intercourse with Ford Motor Company and the universities, or a Ray Woodhams starts to talk about regionalization, and controlling eight hospitals or more. People are beginning to emerge now with management training but still with some of the old desire around which ideas could coalesce and around which they could turn into a program. In my mind I guess this says that the idea was there early, had a twenty to thirty year period of sifting and changing when technology won out over community. I see, partly because of economic pressures and a lot of other things, a chance that we will get back to where we should go.

SIGMOND:

It seems that some of your students are attempting to pick up the old concepts and adapt them to the new era. People like Gail Warden...

McNERNEY:

I've got to tell you that it feels very good to me to have Gail Warden taking a point of view that the AHA does more than uncritically represent the majority of the hospitals. That would be a fine way to perpetuate himself in office, but I think he has taken the point of view that hospitals are something special and deserve to be led. In that vein it's very warming to see his interest in the peer program; developing standards, focusing on

management. Similarly, Ed Connors, with whom I was associated closely at Michigan, stepping out. And, of course, there were others. Stu Wesbury now sits in a very important position at the American College of Hospital Administrators. His instincts are good, we'll see what happens there. I am encouraged that Wesbury and Gail are talking and attending one another's meetings. That's new.

It makes a point though, that is you feel lucky if one-third of the HA graduates have the insight and the scope and the philosophy, and of that one-third if five percent have both those qualities and the guts and leadership qualities to do something about it.

SIGMOND:

One last question on that theme unless Lew wants to pick it up. You indicated you think there is a chance, and I gather you are hopeful that it's more than a long-shot, that the old concepts of the role of the hospital as a social institution can re-emerge in years ahead. What alternatives are there other than two or three new HSA formulations or in the growth of HMOs? What alternatives are...?

McNERNEY:

I think the best way to answer that is to look at what the hospitals fear will happen, because that's usually the most realistic appraisal. As you listen to the informal chatter of hospital administrators, their concern is that the HSA will become a very strong orchestrating mechanism that will, in effect, have a lot to say about who goes on, who starts, who changes--and with all the advantages of unrestrained breadth and opportunity to interface with other planning agencies, whether they be transportation, education, and so forth. I think there is a concern among administrators that HMOs, under which

the hospital is a subordinate unit, will become the transcendant theme. There, in a very fascinating way, the concern is almost the opposite from the HSA. The HSA is seen as something with tremendous advantage of breadth and comprehension, but a weakness of thinness. The HMO, on the other hand, is seen as having tremendous depth potential, but not able to serve large areas. Yet both are viewed with apprehension. Of course, the hospital is concerned that it will become a subordinate part of a network, or a chain, either proprietary or not-for-profit.

The fear beyond that is that when you get together and aggregate management talent in a chain and pay them very well, they'll stay with the hospitals just so long. Then the networks will extend to nursing home care, then to home care, etc., if for no other reason than to perpetuate the interest and tap the managerial talents of people involved. That has a direction to it that is fascinating. That is, a managerial elite that is over the health establishment for maybe neuter purposes. No necesary sense of mission, but an acute sense of bottom line. The bottom line of the nonprofit side might be size, prestige; the other side might be money. What's going for the hospitals are: 1) institutional societal inertia, we don't change that fast; 2) it's a more adaptable idea to a pluralistic country than alternatives. It exists and can be built upon, but, you know, one can enjoy that advantage just so long.

SIGMOND:

Would that suggest that this is a period for a well-grounded hospital executive who wants to further his career in terms of special accomplishment, that this is a time where a certain amount of adverturesomeness maybe is even the most conservative approach?

McNERNEY:

I agree, I have always felt that as far as the programs in health administration are concerned that the number one challenge to the faculty was to describe and evaluate the environment of health. That is to say, the community, its dynamics, its needs, the political forces, the economic forces, the social forces, how they interact, how they relate to morbidity, mortality, and so forth.

Out of this educational approach, the special advantage graduates of these programs would have would be that they could develop goals and directions of importance, but, of subordinate importance, how to implement goals. As I have said several times, if you have to establish priorities, you can learn accounting, finance, and so forth, fairly well on the job. You might go for 20 years on the job without being exposed to the philosophical, to the conceptual. So, I have always felt that the primary job of HA programs was to interject people, perhaps more selectively than some of them are now being chosen, into the system whose instincts are to focus on the larger picture and to be the gadflies, to be the provocateurs, to be the interventionists. Your question prompts me to say that as important as that was in the 50s, when I started thinking in these terms, it's more important now because in the 50s the competition for the hospital was less, public health had phased out as a major force. Now these things I have outlined are real. They are there, and, my God, that idea has become even more important. Where are our risk takers? That is the question this is beginning to be asked.

SIGMOND:

Let me pick up on that, I think a lot of people think of the risk takers as individuals who, by the very nature of that approach, would be moving from

position to position. You yourself have been in the same pressure cooker position for going on to two decades.

McNERNEY:

I think you need both. I think you need risk takers who move from one position to another, presuming they're worthwhile positions and that the contributions are effective. It is clear that you also need people who provide continuity while taking risks. I think it is important to recognize that one of the major problems HEW has suffered is that there's changing of the guard continually at the top level down to a sufficient depth that there is a continual relearning, getting used to things, or kneejerk reactions and thinking, "God, I've got only two years to do something to make my mark!"

The penalty of excessively adventuresome activity is pretty clear for all of us to see at HEW where all of the strands come together in the health field: public, private, congressional, and so forth. Here rapid changing has not been productive. Califano is gone; he was dramatic. What is left? The planning act isn't working very well. The HMO act isn't working well. PSRO? What did he do? If you asked the average person he would say, "Talked about smoking." Or, "Talked about sex in schools," or something.

On the other side of it, look at what some of the more adventuresome hospitals are doing. The odds are the administrator has been there for more than five years. So, while I am admitting that you should have guts to get out of the situation that's untenable, you should have the guts to keep your hat in the ring when there's real opportunity. The middle ground, perhaps, is terribly important.

I happen to be in a position that involves 87 million persons in the private market and 100 million people for public and private programs, 50

states, North, South, East, and West prejudices, trying at the same time to maintain a community idea and a certain amount of central conscience. The challenge is unparalleled. Blue Cross and Blue Shield do not respond generally to a highly dramatic, precipitous leadership. Here the leadership has to be expressed by a very firm sense of where you want to go, but with enough of an institutional appreciation for what is practicable to make your compromise, your changes, as you go along. The chief test here in my case is not, I find, of my flexibility, which is reasonably good. I think, if I get frustrated, it is to once in a while realize what gap remains between what I know has to be done and what is being done. When I say what I know has to be done: what we could do for the health of this country if we really got with it, so to speak, and what we are doing.

SIGMOND:

Analogies for chief executive officer of a major hospital or health center are pretty good that way, aren't they, in terms of risk assessing versus risk taking?

McNERNEY:

Yes, right. I think the analogy is good, to take a hospital or medical center from where it is to a diversification that interfaces with industry, schools, as well as chronic disease institutions, homes, hospices and so forth--to do that and do it well is not a two or three year job. It's more than that. I am afraid that given the complexity of it and the toughness of it, a fair number just sort of dance around the edges of it and pass on.

The terribly important thing to recognize when one discusses this subject, I think, is that it can't be discussed well in an incident sense. For example, a medical center could be brought by figure A to a very right point,

figure B could move in and precipitate it in a three year period, and everybody would be happy. Or one could conjecture that the environment suddenly takes a strong turn. For example, in our case, the Kennedy bill passed in the middle seventies and suddenly McNerney's got some leverage that otherwise wouldn't be there and zap! Some things happen. Perforce they had to happen and everybody recognized it. But those are specifics that shouldn't ruin the validity of some of the general points.

SIGMOND:

I want to pick up on your comments on HEW, which I assume apply just as well to HHS. Do you feel that...?

McNERNEY:

What do they call it?

SIGMOND:

H_2S they call it. Do you feel the fact that H_2S now has major programs, particularly Medicare and Medicaid, that it has to have a special interest in plus the new type of budget constraints that are emerging at the federal level--does that create a special kind of conflict within H_2S in terms of the role you were outlining as the place where all the forces come together...?

McNERNEY:

Right. I think that since the middle 60's the potential of HEW for leadership--and I define leadership in terms of setting national health goals, undergirding these with support of selective programs, developing standards, protecting social justice by making it possible for "low" income people and other disadvantaged to get care that otherwise they wouldn't--the access problem. I think HEW's potential for leadership in that sense was compromised a bit when they became part of the action, a major part of the action, through

Medicare and Medicaid. This put them in the position of everyday concerns about systems, details, rules, administrative consideration. Under those circumstances it drags the head down to a preoccupation with the here and now. It pulls the agency into an almost subconscious situation that if it exists is must be good. It's only a question of how you pay for it, as opposed to being a more detached, removed position of maybe we need to change the whole system or the whole way we are going. Let's worry about how we do that without being too oppressive.

So, yes, HEW has been affected, not only by rapid turnover, but also by the fact that it's got so much administrative detail that it's got to deal with that it finds itself in a schizophrenic position of being object and critic at the same time. Now, one could go beyond that which would take you into politics. A White House that had a clear notion about health could go a long way towards straightening that out. The opposite side of that statement is that a President who has a relative disinterest or ambivalence about health is simply going go let that situation linger and get worse. I don't see any recent President or prospective President who puts health very high on the agenda. I mean in a substantive way. I am talking about the health of the people, not political conveniences. So this given procompetitive forces an added measure of attractiveness at this point because as part of the procompetitive ideas you return the decisions closer to the problems: the individual, the community, to competing ideas. That becomes much more attractive in the light of the default along the other line of...

SIGMOND:

Does this situation in which HEW has this dual role, the operating role and then the larger goal-setting role which could become subordinated--does

that suggest to you that there might be some structural change like development of the counterpart of the Council of Economic Advisers outside the department? You are serving on the Health Planning Council which obviously has had pressures on it. Why don't you take it from there? Is there some structural change that would preserve that special role for government that you were outlining?

McNERNEY:

Let me say that the challenge first is to take the same point of view that I made earlier about the importance of leadership--emphasis on goals and standards, access and justice--and apply it to the operational programs as well. In which case, instead of aspiring ultimately to take over Medicare, HEW would play the role, even though this is an administrative role, of goal and standard and leadership, encouraging the participating elements of the private sector, evaluating them, but not trying to cast them in one oppressive and pedestrian mold. In other words, the idea that fits the big picture also fits the way HCFA should orient itself towards its operational responsibility. Getting them there is a function of President and Secretary, and to a certain extent, of course, Senate Finance, House Ways and Means, and Commerce Committees.

As I understand the situation, I think an added force is needed as well, which makes your question very pertinent. When a few people got together several years ago to select the advisory council on the planning act, the initial design was a committee appointed by the President, with its own staff, that would use the planning idea as a way of rationalizing the health services of this country without being excessively oppressive. The secretaries, Califano and those before, fought this and watered down the idea, feeling

threatened that such a group would really become a sort of committee secretary. What came out of it was a committee on which I served that has been largely ignored, rarely visited by the Secretary. Therefore, it's sort of a mild voice in the background that can muster a little congressional support here and a little staff support there, but, by-and-large, it is not a prime force.

My experience coming out of that is--I'm leaning back towards the idea that some distinguished group needs to sit there and look at health with an opportunity to report to the Congress, with an opportunity to report to the President, with an opportunity to get to the press. I am attracted to the idea that would be a good thing to do. We are not making it the other way. One could quarrel about the size of it. I wouldn't make it large. One could quarrel about the way it was appointed. I think I lean toward the White House as opposed to the Secretary to give it real prestige. I think it should be backed up by a congressional statement, a permissive act making it obligatory that there be a report to the Congress. Certainly it's worth trying. It wouldn't hurt, and maybe it would do a lot of good.

SIGMOND:

I was at a meeting yesterday in which somebody was tracing the history from the Federal Hospital Council that was set up in connection with Hill-Burton which, as you may recall, actually had administrative responsibility. They could overrule the secretary HEW to HIBAC, which didn't have that, but which had the kind of status you are talking about plus some administrative functions, or close to it, to the planning council. There has been a slippage there. I gather your emphasis is not to go back to giving these people authority, which the Hospital Council has, but giving them an

independent visibility.

McNERNEY:

I don't think going back to giving them...I don't think that's practical in today's world really. I really don't, the other may be possible, but we'll see. I have to make the point that who chairs and what personalities are involved have a lot to do with the seriousness with which committees are taken. There are some particular accidents of fate in the regard about which I don't think I want to elaborate.

SIGMOND:

Does staffing play a key role?

McNERNEY:

Staffing always plays a key role. I happen to chair a committee on Medicaid at one point. My chief staffer was Art Hess. I don't need to say a lot more. I think that the two of us worked exceedingly well together. Out of it came a reasonably good report. Yes, staffing means a lot.

SIGMOND:

Following up on this line, would you want to comment on the intermediary relationship, which you had a major hand in formulating? At this point it almost looks as though it's impossible for the federal officials to accept that notion anymore. On the other hand it doesn't look like it's going to go away.

McNERNEY:

I have very peculiar feelings about the intermediary relationship like a lot of people. I have no qualms at all about whether it was a good thing to do in 1965. I think it was a very effective way of getting Medicare going, both on the A and B sides. It was the best compromise. Even in retrospect I

think it was the best compromise. On the A side being an intermediary, on the B side being a carrier with slighlty different characteristics, mollifying different interests. Without these concepts the program couldn't have gotten underway or done as well as it's done.

Now, we've got several things going. The natural inclination of HEW, once it got the thing started, was to want to get more and more into details of administration and calling all the shots. The current antiregulatory, procompetitive feeling of the country as a whole wanting a lot of things to be the result of competition, the suspicion of monolithic influences and all the rest--all of these things are bearing on the concept. If I had my preferences, I would like to see HEW--let's just take Part A to keep it simple. I would like them to be quite explicit about the goals of the program. I would like them to develop standards so that any participating intermediary could be judged. Then I would like them to let the system play a bit, judging performance by standards. Let innovative ways of doing things, within parameters, be expressed. In terms of fixed price bidding, I don't think, from what we know about it, we are warranted to go to it wholesale. Not only can the intermediary as currently constituted do a better job, based on an already good job, but what limited exposure we have had to fixed price bidding indicates that taken in the extreme the aged might suffer. As the winning bids change more and more rapidly and change to more of a bottom line unit cost mentality instead of a service mentality, there are a lot of traps in that area.

I would encourage the use of selective experimentation with evaluation, but not a takeover with an untested scheme that's obviously got some traps in it. The interesting thing to note is that these adjustments don't take place

logically. They don't take place by virtue of the Secretary of HEW and me and Senator Long and others sitting down and saying, "Look, we've got some interesting things going here. Let's talk about them and let's challenge one another. Let's go out and get some facts where we are uncertain. Let's make some good public law."

In fact, such a group has never sat down. So, what happens is that there's a contest, pressure groups bearing on the Congress, pressure groups bearing on HEW, we and others protecting our territory. Rather than a reasonably sweet give and take, it is more in the realm of power play. Maybe that's inevitable.

In the future I would like to see a secretary whose natural instincts would be, at least periodically, to convene the major forces not in a conference, 200 people or whatever, but involving a few well-meaning and accountable participants, to have a lot of issues out. As things stand now, a staffer of a major congressional committee or a third level appointment in HEW will be talking the big things and, God knows, at that level, what happens!

It's a little hard to see what's ahead. I guess my ultimate faith, having said all that, is that the aged will be sufficiently articulate about their needs and their wants so that mischief is going to be reasonably contained. In that context, I rather feel that some of the elements of the current program will persist, not because Blue Cross had them and wants to keep them as a prerogative, or the hospitals want to keep them as a prerogative, but because it's working and it's serving, and it's doing. That's extremely hard for anyone to take on, no matter who's President or who's in Congress at the moment.

SIGMOND:

I'd like to draw you out a bit, if I might, on the analogies, if any, and the differences, in terms of the role of Blue Cross as intermediary with the Medicare program, and Blue Cross as intermediary, let us say, with a major national corporation like General Motors or Ford which is developing not in the same bureaucratic way. (I don't use bureaucratic in a pejorative sense, but meaning without government trappings.) I wonder. I wonder if there are the same kinds of interest on the parts of government and corporations. I am thinking back to the first time I ever heard the word intermediary, or saw it in print, is when in the early days Justin Ford Kimball said there should be no intermediary between a hospital and its subscribers. He changed his mind on that later when they made him president of a plan.

McNERNEY:

That's a good reason to change.

SIGMOND:

Thinking of the intermediary generically as having a relationship with a hospital and a relationship with the representative of the subscribers, beneficiaries, what are the analogies and what, if any, are the differences? What are the lessons of looking at it that way?

McNERNEY:

The analogies between the two are pretty clear. That is, in the case of the government under Medicare, you have a buyer who's putting up money and wants to get a certain set of services. In industry, you get a buyer who's now putting up most of the money wanting to get a certain set of services, health services. They contract to do it through an agency, for example called Blue Cross/Blue Shield. Both are interested in containing costs. Both talk

about quality. Both talk about service. So, you get a lot of conceptual similarity. However, the differences are important. Industry keys off to a fairly great extent a collective bargaining process, something like a management-labor relationship, where the focus is getting the best deal for that particular group, and with some particularized ideas on what that means. The participants are not historically bureaucratic. The management of an enterprise is more used to doing things on contract where you agree on a certain set of conditions and then that's it. That's how you buy your steel, that's how you buy your other things. You might change your contract, change your carrier, but you don't reach through and try to tell that contractor how to manage. There are some exceptions of course. More is settled at the initial bargaining where you put it on the table. You agree to the terms and then you do your thing and you are evaluated periodically.

On the government side the scene shifts because we are now not talking about the particular interests of a certain group but about the country as a whole. There is a correspondingly much greater concern with equity and there's a much greater concern with not being embarrassed in front of the American public. You get a mentality where you want to minimize differences you can't explain, where you have to be concerned with fraud and abuse, being caught short--because Congress sits there, wants to get elected and re-elected and is looking for opportunities. That translates into, rather than a contract concept into, "All right, I'll give up part of the job but, my God, I am not going to just let them go do it. I am going to protect myself as much as possible with a myriad of rules and regulations. I am going to minimize the number of times I have to explain the differences in a procedure in Texas versus California. I'll settle for the norm even if the norm is not the best

we can do--becaue I can explain it."

The two (government and industry) are affecting one another continously. They are side by side in our economy. It's interesting to me to see industry moving toward the center: automotive asking for cost containment provisions in the contract. If Blue Cross is to get the job they have got to guarantee they are going to do A,B,C,D,E., it's moving in the direction of a more manipulative contract.

On the other side one sees some interesting articles and preliminary conjecture. Could Medicare/Medicaid be improved if they were to go to a dual choice or multichoice situation, an FEP pattern? A lot of people feel that's a pretty risky route for low income persons.

While the private sector sits there operating their way and while FEP sits more or less in the middle, as an example, you are going to continue to see a shifting of concern: Could we do it better this way or could we do it better that way?

SIGMOND:

Would you comment on the implications of these two approaches--the government intermediary, the large corporation and their tendency to do similar things. What are the implications in terms of relationships between Blue Cross/Blue Shield and the hospitals, and the physician--especially the hospitals? It is necessary that Blue Cross deal with the hospitals differently in those two intermediary relationships?

McNERNEY:

I think that the intermediary relationship under Part A and the carrier relationship under Part B for the first five or ten years of the program--1965 to 1970 or 1975--were viewed pretty congenially by all parts. HEW couldn't

start the program without the intermediary. The hospitals and doctors were relieved to have an intermediary versus dealing directly with HEW. Somewhere in the early 70s through where we are now, Blue Cross/Blue Shield were increasingly put in the position of being the messenger with bad news and got tarnished with frustration over excessive regulation, excessive this, excessive that.

The intermediary became an added strained relationship between doctors, hospitals, and HEW. In the last year the intermediary is beginning to move back to a more treasured and appreciated relationship.

On the private side, when we began to implement some of the cost containment measures initially that grew out of the pressures from the private environment, for large accounts particularly, we ran into doctors in hospitals who spoke out. "Don't challenge what is going on here. What do you mean medical necessity? That's our decision, not your decision. Appropriate care is a medical staff consideration, not a carrier decision." So forth and so on. There was strain.

In the past year or two we have seen the medical specialty societies helping Blue Cross and Blue Shield identify procedures that are of doubtful value, or redundant, or just plain should not be rendered. Bob Moser of the ACP standing at my side at the Waldorf in New York, Rollo Hanlon, head of the American College of Surgeons, in Washington, saying to the press that routine batteries of tests for all patients are not cost beneficial. Medicine and hospitals, Alex McMahon supporting, are helping.

In the 70s there was a surge of a whole host of factors. Consumerism led to a great concern about conflict of interest, ripoffs and so forth. Kennedy came along with Senate bill S1 and other bills alleging that Blue Cross and

the hospitals were conspiring against the common interest and that a bill like this was needed to protect the public not only from access problems but also form abuse itself, ripoff. Everybody in the health field got nervous. Everybody went on the defensive. There were few statesmen who were willing to step back and see what was good and needed to be preserved, and what was bad and needed to be changed. It was scurrying about and finger pointing.

Let me make this basic point: A variety of peripheral forces--Proposition 13, the surge of conservatism, and so forth--have ruled the Kennedy approval out. We are in a more negotiating frame of mind as a nation. We have watched HEW and others perform. There are no immediate answers or quick fixes to fraud, abuse, or anything else. So, there is a more relaxed atmosphere with a little less self-righteousness and scorn and finger pointing. Also Blue Cross/Blue Shield and the doctors and the hospitals have established better communication. This is a critical point because while that is happening the procompetitive forces are gaining ascendancy.

Here is what is critical in that mix. The procompetitive forces have an underlying supposition, in some people's minds, that not only should you have a multichoice at the place of employment, but also that it's best to involve the individual in the transaction through a deductible and a copayment. That would be the ultimate. Not only do you get to choose your scheme but, when you are ill, you get to use your financial leverage to "discipline the system." Blue Cross/Blue Shield on the other hand built on a service contract based on the assumption that the carriers should provide much of the discipline. Doctors and the hospitals and Blue Cross/Blue Shield are talking more knowingly again and beginning to demonstrate through medical necessity and other negotiations that voluntarily putting financing and delivery

together in a service contract has got a tremendous potential. This is significant because one can't rely on a sick person at the most vulnerable time of his life (when a patient) to be a strong economic force in disciplining the system.

We are at a very important point as to the service contract. In Blue Cross and Blue Shield it is particularly important because, outside the HMO, we are it. I find myself in a very interesting position here. Philosophically I have taken the point of view that I don't think the world needs a service contract for everybody. I don't really trust any one way of financing health services. On the other hand, I feel strongly that the American public should not be deprived of a strong service contract everywhere in the country as a choice. If you were to do away with that, you would take the heart out of private effort.

Practically what I am seeing among the Plans, as they move into the second and the third generation of Plan presidents, as they reflect some of the country's forces, as the demands on internal management increase with automation and with greater competition--what I see it an ambivalence in some parts as to whether the prime job as president is to be sure that the claims are accurate, unit cost of massaging them is low, or whether his prime job is to finance health services and worry about the bottom line more in terms of morbidity, mortality, and effectiveness.

I am viewed by a certain percentage of the plans now as being much more interested in society than I am in the economy, much more interested in the delivery system than in the efficiency of the financing system. That's simply another way of saying that the plans are not as of one. I don't have to, I think, say to many of my friends that I like to win and I am a pretty good

street fighter. The issue is not winning, but how to win.

I feel the greater hazard for us is that we might walk away from the service contract. Therefore I am putting a fair amount of emphasis that participating doctors with Blue Shield hold harmless ideas, contracts with hospitals involve differentials to recognize the social job BC is doing, cash flow advantages, etc., and a willingness to give in rapid return payment, good service, etc. It's a very interesting time. My gut tells me that although there is going to be a lot of travail, the major force behind the service contract is society itself, the users. Therefore, I am not as worried as I otherwise might be. I don't think this (the service contract) is something that is being perpetrated on the buyer. I think it is selected when there is an honest choice more often than it is not selected.

SIGMOND:

The extent that you are feeling a kind of special pressure in terms of that dichotomy you just now outlined, do you think it's a reflection of the shakedown period in terms of the merger of staffs at Blue Cross/Blue Shield, a function of the times independent of that, or a mixture?

McNERNEY:

I think the coming together of Cross and Shield into one corporation or into two corporations with one management has been a factor but not a major factor.

The way I see it operating is like this: For example, a fair number of the doctors behind Blue Shield do believe in a service contract. The Chairman of the Blue Shield Association board, Jack Clayton, believes in it fervently and is alarmed that not everybody does . Where the rub comes is that putting together of Cross and Shield, not only at the Plan level but here at the

Association, does take a fair amount of administrative energy. It becomes another factor added to a more competitive environment, commerical insurance companies doing a better job, HMOs growing, software houses coming on stage, etc. It's added to the technological revolution that has put the computer in our ranks and introduced all sorts of complications. So, the person who is either the head of the Associations or head of a plan has to do more to keep it all together. Faced with all of this does the head person have energy left over to negotiate with doctors and negotiate with hospitals, a far more demanding challenge than writing indemnity coverage?

In a sense putting Cross and Shield together is putting two cultures together. This simply adds to the administrative demands. One is in a more institutional orientation; the other a more professional doctor orientation. The Houe of Delegates idea vis-a-vis the Board of Directors idea. The discussion of contracts with hospitals versus the development of a reasonable rapport with a group of independent entrepreneurs. Going back to the question: joining the associations is only one factor in the total picture.

I am hoping that we work through the efficiency kick we are on and get back to the effectiveness kick. It is clear where our preoccupation with efficiency began. Blue Cross/Blue Shield went from x numbers of people in 1965 to ten million more the next day, at a time when many plans were converting from manual to data processing. When you contemplate in the history of management of enterprise the enormous size of either one of these tasks, let alone both of them together, you can understand that it took a lot of digestion, which we are still getting over. I think there are some signs that we are gettting over it. One of my major jobs will be to be sure that we end up with an efficiency quotient able to match anybody in the market but not losing

sight of what we are in the market for.

SIGMOND:

Just pursuing that, maybe some questions about Blue Cross/Blue Shield organization as such. Assume at some point two years or so in the future the travail of the jointure is over. You really have your house in order and have made tremendous progress but there is more to be done. It never finishes, but you are essentially now cranked up with an efficient organization that brings these two forces together. What do you see as the challenges for the decade ahead once you have gotten there?

McNERNEY:

Personally or for Blue Cross/Blue Shield?

SIGMOND:

Blue Cross/Blue Shield. Or take it either way.

McNERNEY:

First of all, I see Blue Cross and Blue Shield arriving, as a financer of health services in a sophisticated sense, in a ten year period not a two year period. If it can be done in a ten year period it will be faster than anyone else can do it. But this is presuming that the relations with the hospitals, with the doctors, the hospices, the home care programs and so forth are in a negotiating vein with the public interest in mind and a focus on effective services.

I would like to see Blue Cross and Blue Shield diversify in the health field further rather than diversify a lot outside. What is done outside health should be subordinate to our basic health lines of business in terms of relative benefits, volume, and dedication of the capital produced. One of the temptations an American corporation has when it has done something pretty well

is to say, "O.K., now we will take on something else." It could be life insurance. It could be disability. It could be department stores for aged people. It could be anything. I would like to see Blue Cross/Blue Shield get into transportation for aged people, into educational programs for the chronically ill and aged, into housing arrangements, etc., with a larger concept.

SIGMOND:

Human services?

MCNERNEY:

Human services, that's terribly exciting because I do not see any evidence that the Congress or the White House will face up to the problems in long-term care or of the aging in a meaningful community way. That's a strong statement. The evidence I can see doesn't give me much optimism in terms of what's coming. We (BC/BS) would be in a more fluid position to break ground, to demonstrate and all the rest of it. The financing of these types of things would be very difficult. Maybe before 1990 there would be a way where industry, the individual, the government could collectively through us finance some of these things. That's a possibility.

None of this reduces the need for more sophisticated management, new marketing strategies, new governance structures. All will be needed. Support mechanisms must be strengthened. Our determination to keep the subscriber primary must be heightened. Our management must reflect new challenges and a significantly charged environment. But our destiny is not to imitate the product of our competitors, it is to differentiate our product. Personally, after twenty years as CEO I should seek another career and make way for new blood--for my own sake and for the corporation's.

SIGMOND:

I want to go back and ask one general set of questions--going back to Blue Cross/Blue Shield. Let me throw out three related questions and you can kind of put them together any way you want. How do you characterize the dynamics of the relationships between Plans and the national associations? How would you characterize the role of the Plan CEOs in maintaining the vitality of the Blue Cross/Blue Shield concepts? Would you want to comment on which ones have been most helpful to you? Or would it be best to say once you start commenting on that you are bound to leave somebody out? There is a general set of questions.

McNERNEY:

The essential question is not whether Blue Cross should have started as a series of Plans with a very small central team. That's not a pertinent question. Clearly they should have. Blue Cross was a community impulse that taught the nation about prepayment. The nation did not teach the community. We were fortunate to have Rufus Rorem who saw early that it was terribly important to have a few minimal basic ideas around which people rallied and ultimately against which they were held accountable. These were the right ideas. I have no second thoughts about whether the nation would have been better served in terms of how it started and how it coalesced into a Blue Cross/Blue Shield confederation.

Johnny Mannix, of course, frustrated with the tempo of his peers, extremely bright, overcome by the unwillingness of people to do the right thing, threw down the idea of American Blue Cross. Time magazine captured it and there it was. That was what? In the forties, fifties? My guess is the fifties. I don't think that was right and then I don't think it is right now.

I could go on an ego trip and think how nice tht would be, but one has got to get things in the right order. Once one accepts the service contract and combining finances and delivery services through it, then one must acknowledge the importance of communities, neighborhoods, and states, because only at these levels can they be effectively combined. This is a long way around the barn but what I am saying is that, because of the nature of our product, we must build around local institutions that are known, accepted and trusted by those who must commit to service.

It's terribly important to have strong Blue Cross/Blue Shield Plans around the country led by strong individuals. From my point of view the stronger those individuals are the better.

In the general formulation we face two major challenges that will never go away. The first is the type of leadership and strength. I would like to see it of a philosophical orientation, such as I described, not just preoccupation with efficiency, it has to do with the larger community welfare. In other words, our strength should come from persons pointed in the same direction within a unifying idea as opposed to being a set of bright, scintillating but separately and differently oriented people. Given the confederated framework, getting that group, with a reasonable consensus on what it is all about and where we are going, is a major challenge. It's not the skeleton I am talking about, it's the goal.

The other major challenge is to what degree is the basic idea of service enhanced by centralizing certain activities as opposed to doing them separately in Plans. The associations have an important role to play in today's markets vis-a-vis Plans to help capitalize on economy of scale,

avoiding inventing the wheel twice, production of uniformity where it is demanded by the account on a service contract, etc.

Now, I'll just make this comment with regard to people who have been helpful over the years. When I came aboard, which was with Blue Cross only, people like Bill McNary, Doug Colman, Dick Brockway, Tom Tierney, etc., were good examples of people who were strong at home and plan-oriented but they also had a unified idea of what Blue Cross/Blue Shield is all about. Today, interestingly enough, five to six plan presidents with that type of zeal and conviction are still of critical importance. Some days I think I am down to three.

So dedicated plan presidents or at least a cohesive minority are critical in the whole scheme of things. A small group of them understand what it's all about. That sounds awfully elitist, but it just happens to be the case at the moment. At this moment as we sit here our critical mass is small. One of my major challenges is to get the most talented small group more solid on where we are going and what further cooperative effort is to take place.

SIGMOND:

Let me ask you to comment on what I think is one of the very few McNerney failures. I am thinking about the effort--it's not unrelated to what we are talking about--I am thinking about your effort to get some public representation on Blue Cross boards. I guess you have some public representation on Blue Shield boards now so you actually have some experience. Is that an issue that has to be reopened? Has it made any difference? Would you want to comment on it?

McNERNEY:

I don't think failure is the right word. Omission might be the right

word. That is a battle I decided not to take on. Never have. I remember when it first came up, which was in the more contained environment of Blue Cross. We had some preliminary conversations. Doug Colman and others were around, and we discussed it. There was a genuine feeling on the part of some pretty good people that they represented the public, honestly and well, that the problems being faced were how to put publicly oriented things together, which was essentially a managerial challenge. There was sincere feelings, I mean that--among some people that I respected a great deal, that moving the public in at that point wouldn't result in a better job being done.

In addition there is not an administrator in this world who doesn't understand that public membership as opposed to operating experts leads to more administrative freedom. Perhaps what these older heads (among the plan presidents) were doing by resisting this--at a subliminal level--was keeping a reasonal balance between where I was going, of which they were not always certain, and the ability to get there.

I looked that public representation question over and I concluded that it wasn't one of the important battles. I understand the cosmetic nature of it. Interestingly enough we never took a lot of flak on that. So, maybe a sin of omission, but not a failure in the sense of having tried and not succeeded. On the Blue Shield side, having observed the role of the public member, so far it hasn't been a very real one. I tried an intermediary route. You probably remember. I got the Blue Cross board to approve of a public advisory committee. Archie McCardle was chairman of it. We had Marietta Tree, Andy Pattullo, we had black representatives, labor representatives, management representatives, and so forth. I would routinely meet with them and expose them to the major issues that Blue Cross that Blue Cross/Blue Shield faced.

They became very interested. They dug in. Finally they came to some conclusions and made some recommendations. All recommendations were not accepted by the board.

Archie McCardel then said very properly, "Look, we are not going to just sit here and react for you. If we are going to play a meaningful role, fine. Otherwise, we shouldn't exist."

So everybody cheerfully said OK. We more or less demonstrated that an advisory committee under these particularly circumstances does not work.

SIGMOND:

Does or does not?

McNERNEY:

Does not. If you have an advisory committee or board, you want the best people on it. If you get the best people on it they just don't want to be sitting around in a sort of sinecure position. At Blue Cross/Blue Shield we'll probably within the next two years, go to one board nationally, and, during the course of that, obviously have to face up to this issue because presently the public is on one board and not the other. My guess is that the next steps will be very modest in this area.

SIGMOND:

One of the unique characteristics of that McCardle thing, as I observed it from a distance, was that you arranged for outside staffing. Do you think, if you had staffed it yourself, it would have been any different? That they might have adapted more to the realities of the organization?

McNERNEY:

What do you mean, staffing?

SIGMOND:

My recollection is that you hired a group in New York.

McNERNEY:

No.

SIGMOND:

Then I am wrong on that.

McNERNEY:

Yes. Barney and I would go. I was always there.

SIGMOND:

There was a guy named Wineberger or something in New York...

McNERNEY:

Vic Winegarten. He was a consultant who helped put the group together. I don't think staffing was the flaw.

WEEKS:

A statement I read recently said that one of the first things you did when you came to Blue Cross in 1961 was to set up a committee to study the problems of the aged as to health care, finances, and so forth. Previously in a way in these interviews we are taping you did allude to it. Was it a study? Were reports published? Did AHA or anyone else enter into this study with you?

McNERNEY:

OK. This was an interesting experience for me. When the aging issue began to heat up, Kerr-Mills was leading toward Medicare--the early '60s--there was a lot of tension, a lot of politicking, and the rest of it. I convinced Ed Crosby that the AHA and BCA should do a study of the aging and that its initial focus should be on what the problem was. That is: number of aged, age distribution, sex distribution, the amount they spend on health, and

length of stay versus the same for the under-65 population. We were trying to get a grasp of what the problem was. My thought at the time--I am not going to speak for Ed, I hesitate to do it for another individual--my thought at the time was that if we were to define the problem better--there was a lot of speculation about it--we would service a good public debate purpose. It would also make it clear we were not afraid of the problem. In other words, we did not intend to lobby in Washington against every move that was going to be made. Let's start with a more common definition of the problem. Then we got into the prescriptive steps; what were the alternative courses of action?

No matter how noble those purposes were, as the debate intensified, I learned my lesson. That is to say, one was either for or against, none of this in between stuff, or let's not get bogged down by factual considerations. Although relatively skillful, I got hemmed in by the press and by members of Congress, and with side shots from the AMA. This sort of highlighted the fact that outside the normal processes of studies there are a lot of eddies and currents and political processes.

That's what it was about. When it came down to the short strokes, whatever happened between 1961 and 1965, fortunately I found myself in very good continuing conversation with Wilbur Mills--saw a lot of him--Wilbur Cohen was involved during a fair number of these conversations. It came out well.

SIGMOND:

I suspect you did more than you realize about increasing the sensitivity on the hospital and doctor's side.

McNERNEY:

Maybe. That's a good point, Bob. Yes, it stopped forever the discussion of whether there was a problem. That the studies did. They said there is a

problem. These people over 65 are spending three times those under 65. They have a disproportionate number of poor persons not covered at all. Something had to be done, I guess that shifted the debate over to what to do. Perhaps it was helpful in that regard, I hope so.

SIGMOND:

That's my view. I think it's your major accomplishment in that period.

McNERNEY:

I am certainly very delighted to know it because I felt very strongly about it. Being a lot younger at the time, I was so distracted by the lack of appreciation in Washington for what I was doing that I didn't even look around to see whether it was appreciated within the field.

WEEKS:

As I remember the sequence, you launched a campaign to enroll more government people that fall of 1962.

McNERNEY:

Let me tell you about that. There is another example of either the type of leadership you need, or naivete, and I am still not sure which. Having established the problem something has to be done about it. OK? When it became apparent that the government wasn't going to pass anything, I then turned to the plans and said, "We have got to do something."

I talked the Blue Cross Executive Committee into exhorting all plans to go on open enrollment for the aged. Having made statement one about the problems of the aging, it is unconscionable that nothing be done. I thought we should go do something. So the executive committee acted. Word went out to all the plans. Two things happened. One, not all plans responded with alacrity. It wasn't all that bad, but, more importantly, the political figures and the

press accused me right then and there of trying to forestall any action of legislation by trying to solve it <u>without</u> any chance of solving it through Blue Cross. That was just a further lesson. The shot from the press in Washington was much less searing than the realization that not all the plans could crank up and get out there as fast as they should have.

WEEKS:

I think there was some criticism based on the fact that someone of the press called two or three plans and they...

McNERNEY:

Yes. That was within a week. No institution can respond in a week, and I said so. But, when the person who answered the phone at one plan said, "What are you talking about?" That became an article.

You know, Lew, that makes a very interesting point. I didn't get permanently wounded. It makes a very basic point: It is better to have tried than to sit there and conjure all the things that can happen. A lot of things can happen, you know. When you look back historically, the ability to rationalize inaction is so tempting that maybe that type of vignette isn't all that bad.

WEEKS:

One further point. Could you generalize enough to say that the deals offered by the various plans to the elderly...were the rates charged sufficient to cover the costs, or was there really a subsidy there?

McNERNEY:

It varied by the plan, but by the large in the early 1960s the aging could get a better deal through us than anyone else. The degree of subsidy varies all over the lot. I can't recall exactly what, in those days, the distri-

bution would be like. I suspect some plans very little to none, some of them in the middle ground, and some still pretty heavy. The noncancelable part of it was a tremendous asset. The transfer aspect of it was a tremendous asset. I suppose you recall--I certainly do--when Medicare came in we had a job in some sections of the country to convince people to give up their Blue Cross care. We had to call them and reassure them. If our competitors had done reasonably the job we had done on the aged, Medicare would have come at a different time and in a different shape. We were largely it in the market except for some...I remember my mother and father had a policy they paid unconscionably on that paid $7.50 a day when they went to the hospital.

SIGMOND:

There was an outfit in Philadelphia that made a lot of money on the aged.

WEEKS:

Seventy-five years ago that wouldn't have been a bad deal.

McNERNEY:

That wasn't 75 years ago. Although, you know, Jim Bryant who worked as a Blue Shield consultant at one point, sent me his hospital bill. He had his appendix out in the 1930 and I think the bill was 30 some odd dollars.

SIGMOND:

Hospital bill?

McNERNEY:

Yes, the hospital bill. He got a copy of it. Unbelievable! There were just a few things noted, you know, bed, a few things like that.

WEEKS:

I have been reading some things trying to get ready to talk with John Mannix. I read about how he was trying to get an inclusive rate so he upped

charges 50¢ a day to cover all laboratory fees, and was making money.

McNERNEY:

When I first met John Mannix, it was in class. He was a visiting lecturer at the University of Minnesota. He really caught my fancy. I was sort of coasting along, and then this dynamic person appeared one day. He started to make some sense. My interest in prepayment was piqued.

WEEKS:

I am looking forward to talking with him.

McNERNEY:

Oh, yes God, I just wish he hadn't taken that byway with that insurance company. He had to do it, but he lost time in getting it out--while he was out and getting back. Just too much time was wasted and his skills were needed within.

WEEKS:

I talked with him on the phone the other day. He had a consulting job in North Carolina. I have forgotten the exact figures but it seems to me he's made 14 trips from Cleveland down to North Carolina in the last three or four months.

SIGMOND:

For Tom Rose.

McNERNEY:

I think that's excellent. For personal as well as for other reasons, I hope I am as sharp as he is when I get...What is he, 79, 80?

WEEKS:

He is 78, I think.

McNERNEY:

We done?

WEEKS:

If you are.

Interviews in Chicago

January 21, 1979

March 22, 1979

July 11, 1979

July 10, 1980

INDEX

Aged 30-31,105,121-122,123-125

Alaska 9

Alternate delivery system 29

American Blue Cross 116

American College of Hospital Administrators (ACHA) 3,61-62,94

American College of Physicians (ACP) 109

American College of Surgeons (ACS) 109

American Hospital Association (AHA) 3,27,30-31,62,70,71,72,
75,83,85,88,93,121

American Medical Association (AMA) 27,46,72,85

Commission on the Cost of Health Care 67

House of Delegates 46,67

Anderson, Odin 12,19

Ann Arbor, MI 25,27,41

Association of University Programs in Health Administration (AUPHA) 11,57-61

Axelrod, S.J. 19

Bachmeyer, Arthur C. 11,83,87

Ball, Robert 37-39,86

Barnett, E. Dwight 58

Baylor University

U.S. Army Program in Hospital Administration 60

Baxter-Travenol Co. 8

Beiter, Jerry 3

Biostatistics 8

Blue Cross 26,29,37,38,40,43,48,49,63,64,69,70,72,73,77,
89,98,106,108,109-110,112

board members 50-53,118-121

Cleveland 64

coverage 38

fiscal intermediaryship 33,39-40,49,105-109

hospital relationship 49-50

Illinois 83

inner plan bank 29

Michigan 75

multihospital system 70

Blue Cross Association 1,25,26-31,33,40,46,67,87,89,121

Executive Committee 123

fiscal intermediaryship 33,40

plan relationship 40-42

Blue Cross Association/American Hospital Association study of aged
121-122

Blue Cross & Blue Shield Associations 16-17,22,25,43-48,64-65
69,73,88,89,106,108,110,112-118,119

diversification for the aged 115

human services 115

Blue Shield 27,40,41,43,48,51,72,73,89,98,109,112,117,125

board membership 50-53,118-121

carrier role 34,49,108

doctor relationship 49-50

Blue Shield Association 40,41,46,67

Bowles, George E. 17

Brockway, Richard 118

Brooks, Glidden 5,7

Brown, Ray 11,58,83-84,87

Bryant, James 125

Buerki, Robin 92

Bugbee, George 15,62

Califano, Joseph 97,101

Carey, Hugh L. 76

Carter, Jimmy 101

Catholics 3

Charleviox, MI 15

Chicago 25,27,28

University of 15

Ciocco, Anthony 9,84

Clay, Clement 10,11,88

Clayton, Jack 112

Cleveland 126

Cohen, Wilbur 17,32,71,85

Colman, J. Douglas 26-27,118

Columbia University 60

Commentary 56

Commission on the Cost of Health Care, see American Medical Association

community service 14-15

Congress 11,31,35,51,73,79,86,102,105,107,115,122

Connors, Edward J. 3,94

copayment 20

costs, hospital and health 17

Council of Economic Advisers 101

Crabtree, James 9,58,59,84

Crosby, Edwin J. 25,30,62,84,93,121

Crosby, Mrs. Edwin 84

Densen, Paul 84

Detroit 15

Diokno, Antonio W. 19

EDP 40

Enthoven, Alain 69,80

Epidemiology 8

Evans, Robert T. 28-29

Fairfax County, VA 3

Falk, I.S. 87-88

Federal Employees Health Benefit Plan (FEHBP or FEP) 70,108

Federal Hospital Council 102

Federal Trade Commission (FTC) 51

Feldstein, Martin 80

Financing 20,37

Fiscal intermediary 33,104 also see Medicare, and Blue Cross

Fitzpatrick, Thomas 19,22

Ford Foundation 26

Ford Motor Company 93,106

Foundations 64

Furstenberg, Albert C. 12,21

Gardner, John 85

General Motors 43,106

Goldwater, S.S. 92

Governor's Commission (Michigan) 17-25

Grand Rapids, MI 76

Great Britain 78

Griffith, John R. 19

Haber, William 17

Hamilton, James A. 1,3,10,11,15,18,58,84,88,89

Hanlon, Rollo 109

Hartman, Gerhard 11,58

Harvey, William 68

Hawaii 26

Health administration research 4,23

Health Care Financing Administration (HCFA) 101

Health Insurance Benefits Advisory Council (HIBAC) 102

Health Maintenance Organization (HMO) 41,51,64,66-70,88,93,94,95,97,113

Health planning council 101

Health Systems Agency (HSA) 94

Henry Ford Hospital, Detroit 93

Hess, Arthur 37-38,86,103

Hill, Lawrence 3

Hill-Burton 102

Hilo, Hawaii 26

Hospital administration programs 12-17

Hospital & Medical Economics 17,20,25

Hospital Research & Educational Trust 25

House Commerce Committee 101

House Oversight Subcommittee (Moss) 25

House Ways and Means Committee 101

Iams, Frank 3

Illinois 29

Individual Practice Association (IPA) 64

Insurance, commercial 66

Ivy League colleges 80

Johns Hopkins Hospital 84

Joint Commission on Accreditation of Hospitals (JCAH) 63

Kaiser-Permanente 42,67

Kellogg Foundation 17,18,23,59

Kelly, George 73

Kennedy, Edward 28,69,77,79,99

Kerlikowske, Albert C. 12,21

Kerr-Mills 121

Kimball, Justin Ford 106

Kinde, Matthew 17

Labor 78

Lansing, MI 15

Lawson, Marjorie 25

Leadership 53-57

Legislation 75

Lewis, John L. 78

Likert, Rensis 22

Long-term care 115

McBee, Walter R. 28

McCardle, Archie 119-120

MacEachern, Malcolm T. 11-12,58,60,86-87

MacLean, Basil 1,87

McMahon, John Alexander 62,109

McNary, William 26,118

McNerney, Shirley 9,11,84,88

Mannix, John 116,125-126

Masur, Jack 25

Medicaid 31-32,34,36,37,40,71,99,100,108

Medicare 30,31-40,71,72,86,99,100,106,108,121,125

carrier (Part B) 34

copayments 34,35

deductibles 34,35

fiscal intermediaries (Part A) 34

implementation period 40

payroll taxes 34

Mellon, Richard K. 4

Michigan 3,15,17,20,90

Michigan, University of 11,12,13,17,85

Michigan, University of, Program in Hospital Administration 13,15,16,24

Michigan Study 17-25

Mid-Atlantic Hospital Assembly 26

Mills, Wilbur 32,72,75,85-86,122

Minnesota 1,88

Minnesota, University of 11,126

Morris, Emory 17,18,23-24

Moser, Robert 109

Moss Oversight Subcommittee 25,51

Multihospital system 65-70

National Association of Blue Shield Plans 67

National Association of Manufacturers 75

National health insurance 40,50,72,77-80,85

Nelson, Philo 28-29

Nelson, Stanley 93

New England 3,88

New Jersey 4

New York 68,74

New York City 27

Niehuss, Marvin 12,15

North Carolina 126

Oakland, CA 28

Occupational health 8

Parish, Ned 44

Parran, Thomas 4,9,10,18,84

Parran, Mrs. Thomas 9

Pattullo, Andrew 11,17,18,23,59-60,119

Payne, Beverly 19,22

Pennsylvania 6,12

Philadelphia 125

Physician ratio to population 80

Pittsburgh 4,5,8

Pittsburgh, University of 4,5,6,8,11,58

Pratt, O.G. 1,2

Prepayment 18,20

Professional Standards Review Organization (PSRO) 22,72

Proposition 13 79

Quality of care 20

Rate, inclusive 125-126

Rating, community vs. experience 18

Retention (Blue Cross) 66

Rhode Island Hospital 1,2,3,4

Riedel, Donald 19,22

Rochester, NY 1

Roosevelt, Franklin Delano 4

Rorem, C. Rufus 26-27,89-90

Rose, Thomas 126

Safecos 64

San Francisco 28

Satellite hospitals 93

Saturday Review 56

Sayre, Wally 60

Scaife, Alan 4

Second opinion on surgery 82-83

Senate (U.S.) 109

Senate Finance Committee 22,101

Service contract 27,110-112,117

Shared services 69

Sigmond, Robert 19

Skinner, Charles G. 19

Social Security 37,86,88

Spock, Benjamin 6-7

Stephan, James 4

Stevenson, Russell A. 12

Strong Memorial Hospital, Rochester, NY 87

Stuart, Jeb 26,28

Surgeon General 4

Surgery, ambulatory 81

Tel Aviv, Israel 8

Texas 28,60,74

Tierney, Thomas 118

Time 56,116

Tree, Marietta 119

Tresnowski, Bernard 121

Truman, Harry S. 4

Two percent factor 36

U.S. Department of Health, Education and Welfare 17,23,34,36,
38,51,71,85,99,100,102,104,108-109

U.S. Department of Health and Human Services 99

U.S. Department of Interior 9

U.S. House of Representatives 79

U.S. Indian Health Service 9

U.S. Public Health Service 59

U.S. Steel Corp. 43

U.S. Supreme Court 64

Utilization review 29

van Steenwyk, E.A. 26-27

Voluntary Effort (VE) 48-50

Waldorf Hotel, NYC 109

Warden, Gail 93,94

Washington, DC 3,27,28,29,39,44,62,68,69,71,72,73,75,76,80,85,100,
109,122,123

Wesbury, Stuart 63,94

White House 71,115

Williams, G. Mennen 17

Winegarten, Vic 121

Wirick, Grover C. 19

Woodhams, Ray 93

Yale University 10,88