

EARL PERLOFF

In First Person: An Oral History

**Lewis E. Weeks
Editor**

**HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
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Earl Perloff

CHRONOLOGY

- 1914 Born in Russia, May 11
- 1922 Emigrated to Philadelphia, Pa., U.S.A.
- 1934 Wharton School, University of Pennsylvania, B.S., Economics
- 1937 Harvard Law School, J.D.
- 1937-1982 Perloff Bros., Inc.
- Branch Manager, 1937-1942
- Vice President, 1946-1953
- President, 1953-1979
- Chairman & CEO, 1979-1982
- 1942-1944 Office of Price Administration
- 1944-1946 U.S. Navy; Lt. J.G.
- 1958-1982 Albert Einstein Medical Center
- President, 1962-1967
- Chairman, 1967-1972
- Honorary Chairman, 1972-1982
- 1967-1982 Blue Cross of Greater Philadelphia
- Board of Directors
- Chairman, 1977-1982
- 1967-1969 Mayor's Committee on the Provision of Municipal Health Services, Chairman
- 1968-1976 Philadelphia General Hospital, Chairman of the Board
- 1969-1970 American Hospital Association, Chairman of A Special Committee on the Provision of Health Services (Perloff Committee)

CHRONOLOGY (Continued)

Date of Death: 1/17/82

MEMBERSHIPS & AFFILIATIONS

Academy of Food Marketing of St. Joseph's University

Board of Governors, Member

Albert Einstein Medical Center

Honorary Chairman of the Board of Trustees

American Hospital Association

Life Member

Blue Cross of Greater Philadelphia

Chairman

Congregation Rodeph Shalom

Honorary President

Federation of Jewish Agencies of Greater Philadelphia

Executive Committee, Member

Pennsylvania Bar Association

Member

United Fund

Board of Trustees, Member

HONORS & AWARDS

American College of Hospital Administrators

Honorary Fellow, 1970

American Hospital Association

Award of Honor, 1971

Tuberculosis & Respiratory Disease Association

Annual Service Award, 1971

Academy of Food Marketing of St. Joseph's University

Citation, 1980

PERLOFF:

Lew, you were asking me about my background. I was raised here in Philadelphia. I have never lived anywhere else for an extended period. I love Philadelphia. I am a graduate of the Wharton School of the University of Pennsylvania, which is a well-known school of industry and commerce. I am a graduate of the Harvard Law School. I am a member of the bar. I chose to go into my family's wholesale grocery business, and have never regretted it. I am now in my forty-three year with this company.

When World War II broke out--at least our portion of it--on Pearl Harbor day, I decided I wanted to do my part. Since I didn't know what I wanted to do, I went down to Washington and got me a job with what was then known as the Office of Price Administration, which was a job I thought I would have for a couple of months. It turned out to be a year and a half. It was a great experience. In 1941 I was 27; I joined them in 1942. I was dealing with important governmental people, business men from all over the country who were old enough to be my father or grandfather. I learned a great deal about what makes government work and what makes it not work. I remember so often a senator or a congressman, or a deputy or aid would call me to see if I could do something for a constituent of his. I was amazed that particularly

southern congressmen felt perfectly free to get on the phone and do anything for a constituent. For the past ten years that has been frowned on. There seems to be some conflicts of interest. You have got to know whom you are helping before you do help them.

After my stint with the Office of Price Administration, I went in the navy and was an officer on a destroyer escort for two and half or three years. Then, thank God, the war was over and I was very glad to return to civilian life. By then I had a wife and two children and was glad to go back to Perloff Brothers, our firm, and go to work again.

By then my father had been running it practically alone for some four years. He couldn't wait until I got back and pitched in, which I did.

Now, let's skip from that to my involvement with the health care industry. This happened in 1958--that would make me 44 years old, I was born in 1914--when for some reason I can no longer remember I was elected to the board of trustees of the Albert Einstein Medical Center here in Philadelphia. I knew actually nothing about hospitals and health care but I very quickly fell in love with the field and began devoting a great deal of my time and energy and thought to the subject of health care.

The Albert Einstein Medical Center is a rather interesting organization. You must recall that there also is an Einstein Medical School in New York which has no connection whatsoever with the one in Philadelphia. Theirs is a part of a university and is a far more elaborate institution than ours. Here Einstein was the outgrowth of a merger of three rather small hospitals, each of them more or less inspired by, financed by, taken care of by Jews of this community. Somebody was smart enough to realize that none of the three was worthwhile and only by joining together, merging the three, could we finish up

with one or two first rate institutions. That's exactly what was done. They were very foresighted because I am sure there would have been nothing worthwhile with the three as they were. Two very fine institutions resulted in two different parts of the city. We were very proud of it. We were very proud of Einstein.

It was about seven years after this merger, after the creation of the Einstein Medical Center, that I was elected to its board and began my health care career. After four years as a trustee--I must have learned fast and well, or my interest was greater than my fellow trustees--I was elected to the office of president of the board of trustees, which today is known as chairman of the board. In those days the top administrative officer had the title "Executive Vice President," today he is known as the "President." I think this prevails throughout the country. It's a very good idea, a very good move. It gives an appearance, as it should, of corporate existence. The board of trustees sets the policy and the president and his staff, the professional management, implements the policy. The problem arises if the board of trustees or the professional manager, the president, does not recognize their true role, mainly that of policymaking on the part of the board of trustees--this means not getting involved in the management. Those boards who don't realize that and still attempt to manage the institutions create chaos. On the other hand where the professional manager, the president, doesn't realize that it is not his role to be the policymaker but instead tries to take over the role of the policymaker, there are all kinds of trouble because then a very important part of the place of a health care institution is eliminated. I am talking about not-for-profit, the usual church-sponsored, or sponsored by other not-for-profit organizations. In that

kind of situation it is terribly important that at least two things happen: one, that there be a group of people who tell the community what the hospital is all about, act as sort of liaison between the hospital and the community, help raise the capital funds that are required, and so on; second, even more important that there be a group to whom the hospital is accountable. I love that word accountable, because the hospitals are not owned by the boards of trustees, they are owned by the community. The community should have some way to find out what is going on, why it is going on, why can't it be better than it is, and what must be done to make it better. No hospital or medical center, or component of the health care system is perfect. The best of them require a great deal of assistance, management, money. This, I think, works very well where the board of trustees and the professional management understand their role and play out their role as they should.

You asked me, Lew, the question of my background and I suddenly swung over into some of my thoughts about the place of a hospital trustee and our system.

WEEKS:

One of the things I might ask you: In some of the meetings I sat in, they talked about trustees and what is the best way for a board to work. There have been all sorts of discussions about what size should the board be, how should the board work. Should it work by committees, or should it work as a committee of the whole, and what should the relationship be between the board and its employee, the administrator?

PERLOFF:

Lew, I would be glad to discuss these matters but I think they are details. I would suggest that we had better stick to the larger picture because when we get into such matters as numbers, every hospital is different,

every community is different, every sponsorship is different. While I was president of the Einstein Medical Center we had a board of sixty. When I became chairman, at the same time, of the Philadelphia General Hospital, which was Philadelphia's municipal hospital--it's no longer in existence, I'll get to it later--we had seven on the board. They both worked quite well. The board of sixty was appropriate for the kind of institution Einstein was, seven was appropriate for the kind of institution the municipal hospital was. The board of Einstein was self-perpetuating, elected its own successors. The board of PGH, Philadelphia General Hospital, was appointed by the mayor, which was completely proper in my opinion. We talked about other types of institutions, particularly we talked about the for-profit hospitals, used to be known as proprietary hospitals. I don't know that the generic name is anymore, they have become so prominent, the big corporate ones. You have a still different situation, and yet they are a terribly important part of our health care system. Then you have got governmental hospitals, many of them being in the mental health field, but terribly important. They are also part of our overall system. So, it's very hard to begin answering questions about such things as size of the board and how often should they meet and should they act through committees or some other way. All of them have reasons to act differently. This is a very diverse country, it's very huge and has many kinds of constituencies and therefore many kinds of needs that we must be always very careful not to shut out any of them because a particular institution, or a particular group of institutions, doesn't fit the mold or doesn't fit our perception of the manner in which they should operate. So, one thing I would say is, let's keep our system diverse and plural. It's good, it's good for the country.

In my mind I am back at the point where I was elected president, I'll call it chairman of the board, because that's what it is known as at Einstein. That was in 1962, getting very close to twenty years ago. We all then, as now, worked very hard to improve the quality of patient care, which is what it is all about. In doing that, we attempt to improve the academic atmosphere, the teaching that we do with so many different groups: interns, residents, nurses, technicians, and what not. We try to improve the quality of research that is going on. All of that, in my mind, should be only because we are trying to improve the quality of patient care, improve the accessibility of patient care, and all of the other nice things that contribute to making a person's contact with the health care system something palatable, something that doesn't ruin them either financially or as human beings. In the Perloff Committee we used one word over and over again, and in our report we used it many times--that's the word "dignity."

We think that something that is missing in some parts of our system and should never be forgotten is the treatment of the people with whom we come in contact, the "patients"--it should really be more than just patients--with dignity and leave them dignity so they don't feel demeaned by the process. There is so much of that.

A big change came in our health care system with Medicare and Medicaid in 1965, and went into effect in 1966, which changed so much about our system, particularly the financing. Elderly people--I don't think of them as elderly anymore now that I am 66--people over 65 or the first time knew that they would have their health care needs taken care of without becoming poverty-stricken. That is a terrible fear that older people always have had, and even today have, because unfortunately even with Medicare less than half

the costs of maintaining one's health is paid for through Medicare. The rest has to come out of each person's pocket. If they get into a situation where there is chronic illness and they have to use a lot of prescription medicine, or, God forbid, have to go into a nursing home, it's a terrible tragedy for our older people. We have not learned the best methods of treating their health problems.

I brought myself and you up to the moment where Medicare went into effect because it was such a dramatic change and improvement in our system. When I say "improvement" I don't mean that it is perfect by any means, but it is so much better than we had before Medicare.

In 1967, which is almost immediately after the period we are talking about, I was asked by the mayor of Philadelphia, Mayor Tate, to chair the board of the Philadelphia General Hospital. I agreed to do that and assumed that office of February 1, 1968 with one proviso that I be named as a chairman of a committee to study the municipal health system of Philadelphia to see just how our citizens are being cared for and what, if anything, should be done to improve their situation. That committee was named later that year in 1968 and I was appointed chairman. We brought out a terribly lengthy report which suggested that we did need a health care system which would be paid for, at least in part, by the city. You will recall that by then there was a great deal of Medicare and Medicaid money available, so that the city's contribution didn't need to be nearly as large. The Mayor's Committee on Municipal Health Services--the work of this committee was done at the same time as I was working with the so-called Perloff Committee of the American Hospital Association. I am just looking at the dates. I see that we completed our report and handed it in to the mayor in February 1970. So we had started the

work of the Perloff Committee (Special Committee on the Provision of Health Services) in the fall of 1969, so, you see, for six months I was involved with both of these; one on the national scale, one on a local scale. It was terribly important to me as a citizen of Philadelphia, and I was anxious to see how this all worked out at the level of an individual institution and its satellite services.

Mayor's Committee Report, as I said, recommended... Let me read you from the covering letter which tells in a few moments what we said. I am only referring to it because I think what happened in the case of Philadelphia's municipal hospital system is germane to the municipal or county hospital systems of many other areas of our country.

I said to the mayor:

I have the honor of transmitting to you the report of this committee which was charged by you with determining the city's future role in the delivery of personal health care to the citizens of Philadelphia. The main thrust of our report is a recommendation that the city place its primary emphasis on ambulatory care as opposed to inpatient hospital care. Such a change will result in such an improvement in health maintenance through prevention, early detection, and health education. This will be accomplished by a plan of comprehensive health care in contradistinction to one of crisis medicine.

(Just to break in, Lew, you remember this was done a little over a decade ago but we were using many of the same terms that have become so popular today, particularly in reference to health maintenance organizations.)

Coming back to my letter to the mayor:

Furthermore, we recommend that the city's health department be assigned the responsibility of planning, evaluating, and coordinating the personal health services of all Philadelphians. This necessarily includes supervision of administration of the Philadelphia General Hospital.

We further recommend that the city increase its organizational and financial support of education and training of manpower.

Finally, we suggest that at both the planning and operational levels there be important participation by the community.

So at that point we talked about the community and its importance. I won't read the rest of the letter, but we suggested the necessity for the creation of a new hospital, 600 to 800 beds, where a decade before there had been 1,500 beds, and a decade before that there had been 2,000 beds. So, it had been going down as more and more emphasis was placed on ambulatory care. The infectious diseases were being conquered. There wasn't the need for all these acute care beds, particularly in the municipal institutions.

The recommendations of this report were never really implemented. Finally in 1976, which was almost eight years to the day after I had been named chairman of the board, the mayor then, Mayor Rizzo, a very famous gentleman, one weekend decided we shouldn't have a hospital. He called in the press and announced that we were going to close the hospital. He hadn't talked to the board of the institution; he hadn't talked to the health commissioner; he hadn't talked to the people from the medical schools who were staffing the hospital--there were three of those very famous institutions. It was a

personal feeling reached by apparently a very small number of his top officials. We were aghast, being the board. A couple of days later, just as soon as I could, I resigned from the board of PGH, and I resigned as chairman, of course. The hospital actually went out of existence about a year or a year and a half later. The remains of it is now a skilled nursing home, holding about 500 patients. This is a tremendous need so I have very little quarrel with what eventually happened to the PGH.

What we were terribly concerned about was that other communities, and other counties--cities and counties--would take a leaf from our book and close down their institutions. Can you imagine what would happen in many of these cities if such a thing came about? I am thinking particularly of New York with its very large number of hospitals--sixteen, seventeen, or eighteen. It would be a great tragedy unless we restructured our entire health care system so that there were no longer the many groups who require the services of such an institution: poor people who are not adequately covered by Medicaid, Medicare, who are not adequately covered by private insurance, who don't know how to get into the system--they don't speak the language. We have illegal aliens--thinking of New York City, although that's spreading to Florida and California. I don't see how we could do without this small but terribly important portion of our health care system, mainly the governmental part, the part that's run by cities and counties.

WEEKS:

If I may interrupt you. I had an interesting conversation with Haynes Rice who runs the Howard University Hospital in Washington. He told me something that I didn't think was possible anymore. I have always been under the impression that tuberculosis had been pretty well wiped out but he said that

among the poor people, particularly the black people, in Washington TB is still a very dangerous disease and it is spread from generation to generation. The middle class people, the suburban people, don't have much trouble with TB but there always is a chance that if you don't take care of these people that some of these diseases that are rampant in the poorer sections of the city may spread to the more affluent sections. I hadn't realized that TB was still a threat. So, I can see your point that the people who were taken care of by the city hospitals before--there had to be some provision made for them or they wouldn't get care.

PERLOFF:

I am certain that still exists, it shouldn't. We should make it possible in both our organizational and financial arrangements to have all citizens to be able to go to their nearest hospital, or at least to the hospital of their choice without regard to ability to pay. Unfortunately it doesn't quite work out that way. There are also special groups, undesirable citizens that nobody wants around. At Philadelphia General Hospital we used to take care of prisoners, for instance. We used to get all the rape cases in the city. So, unfortunately, there are groups of our citizenry whom nobody wants. It is only in institutions run by city or county where they are taken care of, and taken care of in such a manner that they are not left with the feeling that they are undesired. Somebody, somewhere, is willing to help them. Unfortunately, they are not treated that way by many of our other institutions.

I have just rambled all over the place. I don't know whether I have covered the question of the role of the voluntary hospital trustee adequately for your purposes.

WEEKS:

You might be able to tell me something about what you did to learn as much as you could about the hospital business. If there was any definite way that you learned except experiencing the different situations.

PERLOFF:

Of course, today the American Hospital Association and the state hospital associations are extremely helpful in providing pamphlets and video cassettes, and all other tricks of your trade, communications, to help trustees learn what trusteeship is all about. I never went through that kind of regimen and I don't know how good, or not good, these are. I am sure they are very good. I learned by spending time at the hospital and talking to people, talking to the administrative staff, and mostly talking to the physicians and to nurses, and attending every single meeting I was ever asked to attend. Taking an interest. The average trustee is a very bright fellow, or today, a very bright lady.

WEEKS:

Usually a community leader of some kind.

PERLOFF:

A community leader. They have no problem. They have a desire to find out what it is all about. They become very knowledgeable very fast. I have observed it now almost twenty years at Einstein. I am constantly amazed at how fast some, if they only have the interest, become great trustees, and some, only because they don't have the interest, just never amount to a hill of beans.

WEEKS:

Did Einstein do anything to orient you? Did they do anything to help you?

PERLOFF:

Yes. Yes. I think that Einstein really had a secret weapon. Our executive vice president, whom I adored, whose name was Pat Lucchesi, was very well known in the community, quite a leader. He believed completely in the role models that I discussed: that is, the board set the policy and that he, Dr. Lucchesi--he was a physician, by the way--implements the policy. He thought that one of his responsibilities was to make each trustee as capable as he could. He took great interest in each of the new trustees and just talked to him and showed him around and attempted to maintain his interest in any way that was possible. I use the male gender so much because we had no women on the board then. We didn't get our first woman until maybe ten years later. I hope today there are no hospital boards of trustees that don't have women, but in those days we had no women on our board. So the education came quite completely from Dr. Lucchesi and members of his staff. In my case I think it came a great deal from physicians who were interested in the total health care system, not only in their own practices. They would sit and gab with me and exchange opinions. They told me what they thought would help improve the system, then I would try to find out from other sources. I found it very easy, because I just loved the result of what I was doing. It was a tiny, little contribution, really, that I guess I was making but it was worthwhile.

WEEKS:

You touched on a point, the relationship between the board and the medical staff. Quite often, of course, there is a joint committee of some kind that works, but quite often there is a lot of standoffishness there, too. Did your board try to involve the physicians in giving information or even in decision making in some cases?

PERLOFF:

When I became president in 1962, we did have one of those joint committees--I can't even think of the name of it--joint conference committee. We at Einstein had just begun putting a physician or two on each of our committees. It was during my period as president and then chairman, which was over a lengthy period of time, we increased the involvement of physicians so that there were certain of them included in every important decision that was being made. Their input was very worthwhile. We eventually broke down the barriers and started electing physicians to the board of trustees, the policy-making body. Then we had them on the board of trustees but not on the executive committee. We then started getting them on the executive committee. I would say that by the time I was through as chairman of the board in 1972, ten years later, we had learned to involve physicians in just about everything we did.

In the Perloff Committee report we made a big todo, as we should have, about the involvement of physicians in what we called the management of institutions. We couldn't see, and I feel the same way today, how you ask physicians to help you improve the institution--I am not talking about improving the care they give their own patients, that they do a great job with--but improve what goes on in the institution without involving them in the management. So, in the model we created, which we called the Health Care Corporation, we had placed great emphasis on the role of the physician in the management. That's a very important thing. They are there not merely as physicians, but they are helping run the place. We also placed a great deal of emphasis on the place of the consumer, for whom this whole thing was being run. Up until then it looked like we were dogooders who put it on our own shoulders to do something for the consumers. No such thing! It was their

hospital. They were the ones who were treated well or treated badly and they should have a great deal to say about it. This is a concept that is not accepted universally in our country, but I think should be.

WEEKS:

One difficulty is knowing who represents the consumer. We are all consumers, yet we all have special interests.

PERLOFF:

I didn't say this was easy, Lew. I said we should try to do it. It is not easy at all.

WEEKS:

I agree with you. One point that interested me since reading some of the suits that have been filed against hospitals and physicians for malpractice. One case I am thinking of, I can't think of the name of the case, where a man who proved himself incapable of doing the work he said he could do was still admitted to a staff. In your experience when the credentials committee submitted recommendations to the board, did the board investigate those very much? Did you have a credentials committee that was quite investigative?

PERLOFF:

It's a very complicated and emotional procedure, Lew. Certainly it's clear that the law says and the practice says that boards of trustees have the power to appoint and reappoint and promote the medical staff. As a practical matter they must lean upon the advice of the present medical staff to do the leg work and send up the judgment of the organized medical staff concerning the applicants for appointment and reappointment and for promotions. This has to be done without giving the physicians a feeling that a) the board is merely rubber stamping or b) that the board has taken it upon itself to be the sole

judge of the qualities of the applicants. You see how thin a line you are treading there. The total relationship between the board and the medical staff eventually determines how well they work together in this most important area. When you get a physician on your staff, and he should not be on there, you have made an almost fatal error. It is very hard, as a practical matter, to get a physician out of the hospital once he has been put on the staff. You almost have to bring a lawsuit to do so.

WEEKS:

Eventually he may bring one against the hospital.

PERLOFF:

Right. I think this process was helped a great deal then the Joint Commission for the Accreditation of Hospitals--this must be seven or eight years ago--started insisting--they have a great deal of power, the Joint Commission--that the "privileges" which are accorded to each physician be determined in advance by the chairman of the department in which that physician works and then approved, as everything has to be approved, by the board of trustees. I think this brought to the attention of both the members of the board of trustees as well as that of the organized medical staff the importance of this whole entire area and that we had better be careful who we named to our staff, because we are not going to be able to do very much later. If we give him the privilege to do something for which he has not been trained sufficiently or for which he doesn't have a special knack, you have a monster on your hands. You have got a very bad situation, and he can do a great deal of harm. I think the case in which you mentioned--there have been many famous cases...

WEEKS:

You were through with your term at Einstein when PSROs came along weren't you?

PERLOFF:

Oh, no. I was never really through. I was president for five years at Einstein, then chairman of the board for five years, then chairman of the executive committee for five years, and since then I am in my fourth five year period, as chairman of the nominating committee. I work very hard at it. I love it very much. I give it almost as much attention today as I did in my very first days.

WEEKS:

That's wonderful.

PERLOFF:

My involvement hasn't been reduced whatsoever. I was trying to say to you, Lew... We were talking about this question of appointments, reappointments, promotions and the importance of the board of trustees acting in concert with the physicians, the organized medical staff, and I said this process was helped a great deal by the emergence of the requirement of the Joint Commission that every physician on the staff have his privileges delineated by the chairman of the department. This gave the chairman a lot of power, which he should have. I find it's a better process today than it was fifteen or twenty years ago.

WEEKS:

It also gave him the responsibility.

PERLOFF:

It also more clearly defined where the responsibility lies although really it always laid with the board of trustees. It is one thing to have the legal

power. It's another thing to know how to carry out that power, or to whom to delegate the authority, which the board of trustees always has to do. They don't know everything medically, and they can't just order physicians to do things. This is a very interesting relationship for that reason.

WEEKS:

You may want to say something about the Perloff Committee and how it came into being.

PERLOFF:

The origin of the Perloff Committee: The American Hospital Association by 1969 realized the financial problems that plagued the industry. They thought they knew some of the answers, but really weren't sure they had all the answers. As is usual, they appointed a committee. The committee strangely was chaired by Earl Perloff, a hospital trustee, which had never happened before because the American Hospital Association, then, and I suppose now, was basically an organization for hospital administrators, hospital managers. I will never understand why they picked me to chair it. I was delighted to accept. I had a lot of ideas. There were fourteen other people named to the committee. By the time I got to know them well I thought they were the greatest group of men I had ever met in my life. It was a very diverse group. We had, I believe, three physicians, two hospital trustees, there was a gentleman who came out of the proprietary field, there was a great--I am talking about the Monsignor Tim O'Brien who was from San Francisco, truly one of the kindest and most wonderful human beings I had ever met. He was a member of the committee that constantly reminded us how important it was to think of the meaning of the term "dignity." Steve Morris, who was on that committee, became the next chairman of the American Hospital Association. We

like to think it was because he was on the committee. Quite a number of the others went on to achieve great things in the hospital or health care field.

I believe I did say that the origin of it was an attempt by the American Hospital Association to find out why our institutions and services were not being financed properly. When our committee got going we found that it was not the financing that was the big problem in our national health care arrangement, but it was the organization of our system that needed improving very much.

Maybe I can do a little bit of the same thing... I had given so much thought to this letter of transmittal which I addressed to the board of trustees of the American Hospital Association. Parts of it were written succinctly--all of it I hope is written succinctly. It summarized in many ways what we were trying to do. I said that we confirmed the fact--and I am going to skip all over this thing to give you the flavor of it. I said:

We confirmed the fact that it was not merely the lack of finances that keeps the Americans from getting the best health care possible, but far more importantly the shortcomings in the organization of our delivery system. We found that health care is not readily available, that there are shortages, maldistribution and ineffectual employment of health manpower, that the delivery of health care is more fragmented and disorganized than it should be or needs to be, that the patient is too frequently regarded without respect or uniqueness as an individual and too often only treated for his symptoms, which I guess we call "crisis medicine." So we recommend a substantial restructuring of our delivery system to make it an organized cohesive system designed to make health

care more accessible, more comprehensive, more responsive, and more relevant. These sound almost like code words, but each of them represents a terribly important goal that we should be heading towards.

We did recommend a financing system:

...to utilize all existing sources of funds: based on each citizen's ability to pay...

Of course this is where the problem of the aged and poor comes in. I would say the part of the report that deals with financing, because of the lack of time, was not as well thought out, or as useful as that portion of the report that dealt with the reorganization of our health care system, mainly the creation of our Health Care Corporation. That's the part of the report that we were most proud of, and the part that we wanted to see enacted into law if any part of our report was used for that purpose. You may or may not know that for three, four, or five years Congressman Ullman, who was then the number two man on the House Ways and Means Committee and later became its chairman, did introduce a bill each of those years which carried out the basic intent of our Perloff Committee report. Nothing ever came of it. I think the HMO or Health Maintenance Organization concept is an outcome of the work we did. I like to take a little credit because I think the HMO is a very fine concept, although it's had a very slow start, and I think it will grow and grow and will achieve many of the aims that we had in our minds.

Since I have said the Health Care Corporation was our pride and joy why don't I tell you about it in as few words as I can--and it's not easy because

it's a complicated organism. What I said about the Health Care Corporation, we again used a few words, each of which have a lot of meaning. This was not intended to be read as a novel or even as a paper in some medical journal. Each word had a great deal of meaning to it. We said about the Health Care Corporation that it was an organization

...having the resources necessary to provide truly comprehensive health care to a defined population...

That is, the population was a very exact group, not an amorphous, city citizenry, people that would walk in off the streets--there is nothing wrong with taking care of those too, under all circumstance that would be done. But the basic idea was that there would be a definite population that could be pointed out, usually in a geographic area, part of a state, or a whole state in the less populous ones. That would be the defined population.

The Health Care Corporation would have the following characteristics. In order not to burden you with too much language let's see if I can pick out some of the more important phrases and clauses. We said, "Each Health Care Corporation would synthesize management, personnel, and facilities..." (Facilities meaning bricks, mortar, and equipment) "...to deliver the five components of comprehensive health care..." (Here I am giving you our definition of comprehensive health care. There can be variations.) We said the five components were: "...health maintenance..." (I guess we were the first to use health maintenance in this manner, meaning literally maintaining the health of the people, not taking care of them when they had gotten ill, but keeping them healthy. We called that health maintenance. We put an awful

lot of emphasis on that.)

WEEKS:

That's number one.

PERLOFF:

That's number one. Then we said, "...primary care..." (That's the first contact between a person and some member of the health care team. Usually a physician, could be a nurse, could be a technician of some kind, a nurse practitioner, or what not, but a primary contact.) That's number two, the third would be "...specialty care..." that's the care we know best. That's the care given by hospitals. Acute care I think it is better known as. We, I say we, we are not the only ones, we call that specialty care, or as "restorative care."

A tremendous number of people in the population are injured either as a result of illness or accident, old age or whatever, and need restoration. They have got to continue living. God hasn't seen fit to end their woes, so they have got to live and we have got to see that their health is restored to the point where they can lead useful lives.

Five, "health-related custodial care." We recognize that in our imperfect world that people do get old and that in many cases, unfortunately, live very long, live to the point where they need custodial care. Our health care system cannot be asked to take care or to finance custodial care but we thought that the portion of it that was health-related we should take care of.

So, the five components of comprehensive health care are: health maintenance (keep them healthy to start with); primary care; specialty care; restorative care; and health-related custodial care.

What we said was that in order to be a Health Care Corporation you must

have the resources, the personnel, and facilities--I believe is the word we used--to render these five components. You as a Health Care Corporation didn't have to own all this. You could make arrangements with other institutions to carry out portions of this. You could make arrangements with the physicians to render the health care, and you could make arrangements with nurses.

When the tape ran out, Lew, I was making the point that it wouldn't be expected that the Health Care Corporation would itself own or control all these resources and personnel but could make arrangements with others to carry out portions of the responsibilities that I have enumerated that fall to the Health Care Corporation.

That's one of the characteristics described in the report:

Each Health Care Corporation could synthesize management, personnel, and facilities into a corporate structure with the capacity and responsibility to deliver the five components of comprehensive health care to the community...

Number two, we said, "Health Care Corporations would cover the comprehensive health needs of every geographic area and all of the population..." This would be for the entire nation, all fifty states which would be divided up in some fashion in geographic areas in each of which there would be one or more Health Care Corporations. No region of the United States would be without at least one Health Care Corporation.

Number three, we said that the Corporation:

...would assure optimum service to the community by physicians. Every practicing physician would have the opportunity to be affiliated with a Health Care Corporation, and physicians would have the opportunity and could accept the responsibility of participating in the management of Health Care Corporations.

This places a tremendous amount of importance on physicians. I want to point out very carefully that we said the physician who had the opportunity to do all this wouldn't be forced to do this. If he didn't like any part of it, just stay out of it. This causes all kinds of complications both for the physician and for the Health Care Corporation, but that's another subject. All through here we never say you must do something. We say you have the opportunity to do it. If it doesn't suit your lifestyle, if it doesn't suit your temperament, stay out of it. Go your own way. It's perfectly all right. That's pluralism at its best.

We are still on physicians. We say:

Various forms of medical practice, including group practice, would be permitted within the Health Care Corporation.

Group practice. We said the various forms including group practice, we wanted to make that point. We would hope that was the way most of the physicians would choose to practice. They do today, in groups, either loosely associated, or not so loosely.

Next we said:

The Health Care Corporation would be responsible for providing professional peer review and other mechanisms to evaluate the quality of all health care on a continuing basis.

This is new. We said that the HCC itself, because it is responsible for the quality of health care, has to be its own monitor. Where does it get the ability to do that? First of all it has an organized medical staff. Then you have got the Joint Commission on Accreditation of Hospitals. You have got all kinds of specialty boards and all of these other voluntary agencies that are available. Whereas today the Joint Commission sort of has the final word, we said no, the HCC has the final word. They would be very foolish if they didn't accept the advice of and professional opinion of these various voluntary and accrediting agencies. So, the HCC has a lot of power and also a lot of responsibility.

We talked about the HCC being responsible for its own manpower needs which have to do with inservice education and the recruitment of health personnel and so on.

Then we--and this is the last point I will make on the HCC and the basic concept--we said:

Each Health Care Corporation would develop a suitable mechanism by which the community could express its health needs and through which the Corporation could actively respond. All persons in the community would have a role in identifying how health services would be provided, in determining how care could be made more accessible, and how the delivery of care could best support the dignity of the individual and his family.

This, remember, was being written in 1970, almost at the peak of consumerism, but we didn't include that for this reason. We didn't realize that it would be a terribly difficult problem when we would attempt to implement it, the input of the consumer, but we thought we ought to try. The entire system is entirely for his good. He should have an important say in how to do it. You said earlier this morning, Lew: Who is the consumer you want to talk to? I can't answer that. Each Health Care Corporation would decide that for itself. In each part of the country there is more or less emphasis on who the consumer is, who speaks for the consumer, and so on. We have no magic answers. Answers to that you have to find out, but you have to keep in the back of your mind while you are creating these great institutions and services that you are not doing it to enhance the prestige of the XYZ Medical Center, you are doing it in order to be in position to render better health care--"better" in quotes, whatever that implies--to the consumers, the people out there.

In the case of the Health Care Corporation--remember we have already said that would be a defined population group so that in a city the size of Philadelphia, because I know it best, there might be six or eight or ten areas. Let's say area number eight would consist of three acute care hospitals, a rehabilitation hospital, many custodial homes and much ambulatory care and education. Keep people healthy. Why should they smoke? My Lord, you could save many more lives, if you could get everybody to stop smoking than you ever could by all the open heart surgery and bypasses in the world. Many of these environmental problems, good air and good water, a reasonable lifestyle would improve people's health far more than stepping in after the lung cancer has appeared and cutting out whatever it is they cut out. We felt

very strongly about that.

Now I don't know, Lew, if I have given you enough of a bare outline of what a Health Care Corporation is.

WEEKS:

You might answer one question if you will, please. Who would start this corporation? Would a community start it?

PERLOFF:

That is a good question, Lew. Who would start it? Anybody who wanted to. In most communities it would be started by one of the leading hospitals. If it's the kind of community like Philadelphia or Detroit, it could be a group of hospitals, or a group of physicians. It could be started by a for-profit group. We astounded many of our friends when we, this was about ten years ago, when we said why not have proprietary hospitals, or rather, for-profit groups, run these Health Care Corporations. In some areas, the government might have to do it. Anybody could do it, but subject to a lot of rules. There would be federal regulations having to do with quality of care.

Legislation would be enacted on the federal level which would deal with just four basic matters, but important matters. That federal legislation would define the scope, standards of quality, comprehensiveness, and the benefits to be provided. This would be national in scope. The federal government then steps out and all the implementation is at state level, except for the financing--they never step away from that. These regulations would be administered at the state level. The actual work, of course, would be done by the Health Care Corporation. When I say "state levels" I always mean to include parts of the state, it could be regions. Our country is so great and so large, and with so many different components. In one state it might be a

whole state, and in another it might be a fraction of a huge city.

WEEKS:

But there would be a state commission to regulate it all?

PERLOFF:

Basically it would be regulated by the state in accordance with the regulations that had been set at the federal level for scope, standards of quality, comprehensiveness, and benefits. But what four huge concepts we have used when we have talked about those! As it is today, Medicaid benefits are different in every single state of the union. That's not right. Why should somebody living perhaps in Mississippi not have access to as good care, or to equal benefits--forget the kind of care--as somebody living in Michigan does? It doesn't make much sense, if they happen to be in a poor section of the country. Under this system the benefits are expressed on a national basis.

I am not naive enough to think that when it gets down to the state level...the state can do an awful lot. It will also be provided some money, not the basic money but some money. Whoever supplies the money has the power. Perhaps it should be that way, at least it is that way.

Some of the members of the Perloff Committee were such fantastic people and became such very dear friends. In the first place we had a staff -- the entire leadership of the American Hospital Association. There was Dr. Ed Crosby, whose title I believe was executive vice president, he certainly was the heart and soul of the American Hospital Association, who was one of the truly great statesmen in our field. He sat in on every single meeting but one and that was when he had to speak at the International Hospital Federation somewhere in Europe. Kenny Williamson and Dr. Madison Brown, who were Crosby's two top staff people, participated and sort of led our group. David

Drake who was the top economist was part of our staff. Mike Lesparre, who was their top communicator, did the minute taking and other matters of that sort. He didn't keep minutes, he kept notes, so we were very much dependent on what he wrote down.

There were intriguing people in the committee: Everett Fox, who was from one of the hospitals in New York. He was administrator of hospital affiliation contracts at New York University Medical Center. I have already mentioned there was a very great Catholic personage, Monsignor Timothy O'Brien, who came to us at that point from the Catholic Charities of the Archdiocese of San Francisco. By the way, I can remember one Sunday his conducting mass in Mrs. Perloff's and my suite. We had in that room more Protestants and more Jews than Catholics. It didn't make any difference, we were one family. We had no trouble conducting some kind of service. Maybe it wasn't a mass, perhaps I shouldn't call it a mass because I don't know exactly what a mass is. He was a fabulous person. So that group went.

Dr. Crosby became one of my dearest friends. We later, some six months after the report came out, the Crosbys and the Perloffs went off on a trip to Canada, England, and Ireland. We attended meetings of the Canadian Hospital Association in Canada, in Ireland we attended a meeting of the International Hospital Federation, and in the London, England area we met with the leading people both in the government, and in politics, and in the health care system. We visited one research institution in particular that was very outstanding. In other health care institutions we didn't spend all that much time. Towards the end of the trip Dr. Crosby became quite ill. By the strangest of coincidences Russ Nelson, Dr. Russell Nelson, who was a very, dear, dear friend of Ed Crosby's, was in London at the same time and acted as

Dr. Crosby's physician. Russ knew Crosby's health history very well and decided to send him home, which he did. I guess Ed lingered another six months. He never returned to full health. He died very young. I think he was 62 or 63. He certainly left his imprint on the entire industry. I loved him very much.

We knew we would have a very difficult time getting the attention of the health care industry of this country to the report. I suppose we were pragmatists enough to realize that nothing might ever come of it. We were hoping that individual thinkers in our field would take the trouble to read it, give it some thought, and perhaps add to it. We saw this as a beginning of a process that really began from the transmittal letter. I said:

Our goals are lofty, but we believe they are ultimately attainable. This report can provide a basis for which the entire health field including physicians, institutional providers of health care services, and the many organizations, governmental agencies, and underwriters of health care benefits can join forces and work toward an improved health care system. We consider our proposal a beginning, a starting point from which many individuals and groups can contribute to the shaping of a system to have the immediate potential of providing better health services for all our people and for future generations; a system that will provide the best that medical science can offer.

So, you see, we didn't fool ourselves into thinking that we had created a new system. We were trying to wake up the country to what needed to be done. There were many great minds out there, if they only paid attention to what our

problem was and got away from what was constantly on everybody's mind, namely financing. When we had our press conference three out of four questions were on financing, not an organization. We had spent 90% of our time on organization. We thought we had created a great new way of delivering health care, but they were interested in financing. Today, with a great new president coming in, what do I hear? Let's forget about national health insurance. We obviously are not going to have any such thing. Again emphasis on money, financing. It costs too much. It does cost too much. We say that one of the reasons it costs so much and doesn't produce what it should is because it is not organized properly. That if we would only get it organized properly, we are sure we would deliver better health care, and, perhaps, we would save some money. Hopefully we would.

WEEKS:

By stressing health maintenance?

PERLOFF:

Exactly. We are not the first to have said that preventive health care is important. People have been saying that, I guess, for the entire century. We know that it is important. When all these infectious diseases were wiped out, improving our environment by better pharmacology, if nothing else. We suddenly increased people's life span by ten years, not again because we were able to do open heart surgery. That's terrific if you are the person who needs it. The way to reduce cost and the way to improve people's health is by paying attention to prevention and health maintenance, cleaning up the environment.

WEEKS:

That's where most of the advances have been made.

PERLOFF:

I think so.

WEEKS:

That's why there is so little typhoid and other diseases that were scourges in the past. I think that you and the members of the committee should be very proud of what you did in your planning for better health care. Even though the Ameriplan did not become enacted into law, we are already seeing it's impact on present day planning and thinking. All of us in the health field are influenced by your work.

PERLOFF:

Thank you for your kind words. I consider the work I did on that committee as some of the most rewarding and gratifying of any in my life.

Interview in Philadelphia

January 15, 1981

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