HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Symond R. V. Gottlieb

SYMOND R.V. GOTTLIEB

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
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Symond R.V. Gottlieb

CHRONOLOGY

1924	Born, Detroit, Michigan July 29
1941-1942	Wayne State University
1943-1946	U.S. Army
1947	University of Michigan, B.A.
1950	University of Michigan, LL.B.
1951-1956	Practicing attorney
1954-1955	Detroit Recorders Court, Probation Officer, Youth Division
1956-1957	Blodgett Memorial Hospital, Grand Rapids, Administrative Resident
1957	University of Michigan, M.H.A. in Hospital Administration
1957-1960	Children's Hospital, Detroit, Assistant Director
1960-1961	Michigan Department of Public Health, Hospital and Medical Facilities Division, Director
1961-1964	University of Michigan, Bureau of Hospital Administration Research Associate
1964-1971	Hospital Area Planning Committee, Milwaukee, Executive Director
1966-1971	Marquette University, Lecturer
1966-1967	Governor's Task Force on Medical Education (Wisconsin), Volunteer staff
1967-	DHEW. Bureau of Health Services Research, Consultant, (intermittent)
1967-1971	Association of Areawide Health Planning Agencies, Board of Directors (President 1970)

CHRONOLOGY (Continued)

1968-1969	American Public Health Association, Committee on Comprehensive Health Planing, Member
1968-1970	Conference on Community Health Planning, Executive Committee Member
1968-1970	Wisconsin League for Nursing, Board of Directors
1968-1971	Comprehensive Health Planning Service, Consultant
1969-1971	Comprehensive Health Planning Agency of Southeast Wisconsin, Executive Director
1969-1970	DHEW, Secretary's Task Force on Medicaid and Related Programs, Member
1969-1971	National League for Nursing, Council on Community Planning, Executive Committee, Member
1970	Association of Areawide Health Planning Agencies, President
1970-1973	American Hospital Association, Committee on Health Care for the Disadvantaged, Member
1971-1982	Greater Detroit Area Hospital Council, Executive Director
1971-	University of Michigan, Non-Resident Lecturer
1971-	Michigan Hospital Association, Legislative Committee, Member
1971-	American Red Cross, S.E. Michigan Chapter, Board of Directors, Member
1971-1974	American Public Health Association, Community Health Planning Section Council, Member

CHRONOLOGY (Continued)

1972-	American Hospital Association, Type VII, Governing Council Chairman
1974-	Wayne State University, Adjunct Assistant Professor
1975	American Hospital Association, Advisory Panel on P.L. 93-641, Chairman
1976-1978	DHEW National Advisory Committee to Comprehensive Health Statistics System, Member
1977-1980	American Hospital Association, Council on Management and Planning, Member
1978-	American Hospital Association, Governing Council, Public General Hospitals Section, Advisor
1978-	Michigan Health Data Corporation, Trustee, Treasurer
1979	American Association of Hospital Planning, Board of Directors President, 1984-1985
1982-	Greater Detroit Area Health Council, Executive Director

MEMBERSHIPS & AFFILIATIONS

American Association for Hospital Planning

American Hospital Association

American Public Health Association

Association of American Medical Colleges

Association of Areawide Health Planning Agencies

Association Executives of Metropolitan Detroit

Economic Club of Detroit

Inquiry editorial board

Michigan Bar Association

Michigan Public Health Association

National League for Nursing

Rotary International

AWARDS & HONORS

University of Michigan

Phi Kappa Phi, 1957

University of Michigan

Hospital Administration Thesis Award, 1957

University of Michigan

Hospital Administration Alumni Award, 1975

Michigan Hospital Association

Joseph R. Homminga Award, 1976

Society for Hospital Planning

Corning Award, 1983

American Association for Hospital Planning

Haney Award, 1985

BOOKS

Hospital and Medical Economics. Coauthor. Chicago: Hospital Research and Educational Trust, two volumes, 1962

The Nature of Hospital Costs: An Analysis of Trends and Relationships, with Grover C. Wirick and Thomas B. Fitzpatrick. Ann Arbor: University Microfilms, 1964

WEEKS:

Usually in these interviews, Sy, I ask some question about how the person interviewed got started in the field. I know you didn't start in the health field. How did you happen to leave your law practice and decide to study for hospital administration?

GOTTLIEB:

Oh, I was lucky, I guess. All my life I wanted to be a lawyer. So I achieved that lofty goal and then I practiced for about five years and decided I didn't like that at all. But, through some civic work with the JCs, I'd gotten interested in civic activity and because of the nature of the JCs I had had some exposure to some management kind of things and a lot of management people. I found I had an interest in it, if not a talent. When I was looking to get out of the practice of law, I found it was hard to do.

You know, my first thought was corporate law, corporations in some capacity. I'd go to them and they would always tell me I was too experienced to start as a trainee which is what they normally did. But on the other hand, I didn't know anything about their business. So, I couldn't start out at a higher level. I was in that kind of in-between stage.

I heard, by accident, about the field of hospital administration from a brother-in-law of mine. He was a personnel director for the city of Philadelphia. He commented that he was looking for four people in hospital administration at the time. I asked him what that was all about and he told me.

So I did a little investigating. I went and talked with a couple of administrators in Detroit, George Cartmill and Julien Priver. George was at Harper and Priver was at Sinai. George told me that it was the greatest field

in the world and, of course, I ought to go back and get a master's degree in hospital administration. The nearest program was in Chicago. At that time I had a wife and a kid and a house. So that was kind of hard to do. I pretty much gave it up and started looking at other things.

Then, I remember it was in the early summer of '55, I was walking in downtown Detroit and I ran into a guy I knew, not too well, and we got to chatting, and we had some lunch.

He was a teacher and he was looking to get out of teaching and he was interested in hospital administration. We chatted about it and he told me that he had heard a rumor that the University of Michigan was going to start a program that year. He didn't know too much about it but he passed that information on. That was pure luck.

So I called Ann Arbor and got the run-around for a while in trying to find out where and who might know about it. As luck would have it, I stumbled on Walter McNerney who had just started. That was his first day on the job. If I had called two days earlier, I probably never would have found out anything. So we made an appointment. He was very anxious to get his first class filled. There were going to be nine of us. He was willing to take anybody for a fee. That was basically it. Luckiest thing I ever did in my life.

WEEKS:

He was about your own age, too, wasn't he?

GOTTLIEB:

Yes, a year younger.

WEEKS:

I think he told me that he was at the University of Pittsburgh and had

helped start their program there. I wonder how he got the job at Michigan?

GOTTLIEB:

Well, there are a lot of different points of view about that. But they are all rumors that have been spread around. You know, the fact that he married Jim Hamilton's daughter spread a lot of rumors. Obviously it doesn't do any harm to know somebody. You know, helpful relatives who are influential in the field. But you know the University of Michigan is not a place that goes entirely on that in making their decisions. I'm sure there are a lot of factors. I'm sure Jim helped, obviously.

WEEKS:

They would have at least consulted Jim about anybody.

GOTTLIEB:

I'm sure they probably did.

It's been a long time ago, but my recollection was we almost got a program started at Michigan in 1947. But it developed into a fight between the School of Public Health, with Nate Sinai and Sy Axelrod on one side and the University Hospital with Kerlikowske on the other. It kind of reached a stalemate in terms of the kind of political battles that go on.

WEEKS:

I never knew that before -- that as far back as 1947 they were thinking about it.

GOTTLIEB:

Yes, that was always my understanding. I don't know how accurate it is.

WEEKS:

It is quite likely.

GOTTLIEB:

I heard that many times. So then it kind of got shoved on the back burner just because you couldn't satisfy two powerful groups in the university health center setting.

WEEKS:

When I talked to Walt, he made a point of saying that when he went to Michigan he decided that he would try to get all forces on his side. That's why he was in favor of an advisory committee that had people from the different schools and the hospital there so that they would at least feel that they had some input. I don't know whether this was just good judgment on his part or whether he had been warned by this previous...

GOTTLIEB:

I am not going to second guess Walter. I was only a student in 1955 but I don't think it was a coincidence -- it was really a compromise to put it over in the School of Business. It was only there for administrative purposes.

The committee theoretically ran it and that gave the program one heck of a lot of freedom because there wasn't really any boss. That gave Walter a lot of freedom too.

WEEKS:

I think he's a shrewd man, so he probably foresaw that.

Was Ed Connors there as a teacher at the time you started?

GOTTLIEB:

He came within a month. I think it was about a month after the semester started. It was very soon.

WEEKS:

Could we go to the period following your classroom days in hospital administration at the University of Michigan? We might do that by saying that you served your residency at Blodgett Memorial Hospital in Grand Rapids, Michigan.

What did a residency in hospital administration consist of in those days?

GOTTLIEB:

Essentially it was one full year, twelve months residency. We got twelve hours credit for it. It varied according to the nature of the hospital and the preceptor. In those days, the university and the faculty tried hard not to influence the preceptors or the nature of the residency program. In some ways they were too free, allowed too much freedom.

Since I was in the first class, Walt McNerney and Ed Connors hadn't got to know a lot of people. It was sort of every man for himself. They gave some ideas about where to look, but it was up to the student -- like trying to find a job. So I looked at several places, and kind of narrowed it down to a choice between Mount Sinai of Cleveland with Sid Lewine, and Blodgett Hospital in Grand Rapids with Ron Yaw. They looked on the surface to be equally good. I remember having to consider long and carefully whether as a Jew I wanted to do my residency in a Jewish hospital or a non-Jewish. I remember Sy Axelrod giving me a lot of help thinking it through. In those days the likelihood of a Jew being able to get a job in any hospital was very limited. On the other hand, if I started in a Jewish hospital in a residency, it probably meant that I would always work in a Jewish hospital. So we weighed that. We even counted all the hospitals in the United States -- on the assumption that one day I would want to be a chief executive officer of a major hospital -- to try

to get an estimate of what my chances were, depending on where I started as a resident. I think it came out that statistically I might have an opportunity in 125 hospitals or thereabouts, if I started in a non-Jewish hospital and about 83, if I did my residency in a Jewish hospital. So I went to Grand Rapids.

There Ron Yaw had had a lot of experience with residents. I was the first from Michigan, but he had been taking residents ever since he first came to the hospital in 1939 -- originally from the University of Chicago, then from other schools as they developed. So he had a fairly well established pattern, which was to let the resident do whatever he wanted, within reason.

It was partly a rotating residency where, at least for part of the time, the resident moved from one part of the hospital to another, spending varying amounts of time -- maybe a week in admitting, a week in personnel, or whatever it was in those days, a week in purchasing, a couple of weeks with the nursing department, a couple of weeks in the operating room, and so forth. Those were basically observation kinds of activity where you sat and watched, talked to people. It was up to the resident as to how much he learned. The kind of person who asked a lot of questions and was very observant and very people-oriented could get a great deal out of it. Without making it sound like I am bragging, I was that kind of person. I got a fantastic amount out of that. Then in addition, after you had been around a bit, the preceptor assigned you projects, starting out usually with simple ones. They might be on anything. I remember one of my major projects was to develop the hospital's first disaster plan. That meant working with a lot of people, developing a comprehensive plan. I worked very hard on it. The disaster plan was a lot of fun to develop. I got into all the departments of the hospital. All kinds of

people had to have input into it. We tried to provide for everything including supplies and equipment, as well as methods of triaging patients in the event of a disaster. There were also training programs for volunteers. It was a lot of work. I worked so hard on it that I had a lot of fun as a resident. It was because the learning curve was so high. I generally worked from about 7 in the morning until 2 in the morning, usually six or seven days a week. I just had a ball. I worked so hard on the disaster plan -- it was finally published, published as a very large manual. Ron Yaw thought so much of it and what I had done that he gave me an extra month's pay, a gratuity equivalent to a month's pay. The pay was $250 a month.

Two other things were great about the residency, at least as it was practiced at Blodgett and with Ron, which was not true of the residencies of all of my colleagues. One was a fair amount of time with Ron Yaw as the preceptor -- just talking across his desk or my being allowed to be in on meetings or on conferences, and then having an opportunity to discuss them afterwards with him. So I got a lot of exposure to a really wise man. I disagreed with him philosophically, and we still do, but he was one of the wisest I knew -- was then and still is.

As long as he was there and running the hospital -- it was an old-fashioned approach to running a hospital -- it was a highly personalized kind of administration. Everything went very well. He was the one who taught me to make rounds in the hospital every day you were there, sometimes it had to be very quick. He had a little trick that he taught me. Each day he would pick one thing he was going to look for, like are the exit lights out? He would go through with a slip of paper in his hand. If he found a light out he would make a note and call maintenance. Every day he had a different item,

but his real purpose was to give himself a sound administrative excuse for going through the hospital and talking with people. He talked to everybody and he set the tone for a very warm institution because of that. There was a good lesson in that by itself.

He was a remarkable guy, but the hospital fell apart when he wasn't there, if he took two weeks off or went to meetings -- he was active in a lot of things. He was an early supporter of the American College of Hospital Administrators, an early regent of the College. If he wasn't there it took about 24 hours for the place to start falling apart. That was one of the things I disagreed with him about.

Another thing he did for me, he had a theory that interns and residents -- and there were a lot of interns in those days -- were just young doctors. They had their shingle or degree still dripping with wet paint but they wore it on their back just like any other doctor did. If you got to know how interns and residents thought and behaved and why they did, you would learn a lot about doctors. He encouraged me to spend as much time with them as I could. It took a little time to break down the reserve; physicians were one thing and administrators were something else, even more so in those days than now. Once that was broken down and I became one of the group -- there used to be an eleven o'clock round table -- I would sit with them, have coffee and be part of the gang, as it were. That usually involved student nurses as well as residents and interns. I learned an amazing amount about physicians. I learned a lot about keeping my view of them in balance — there were good ones and bad ones. Like other human beings they had mixed motivations. They were trying to achieve a lot of things at the same time. Everything else being equal, they wanted to be good doctors. So I learned some of the reasons for

their arrogance.

All of that I could always bounce off of Ron and talk to him because he really was a very wise person. He taught me an awful lot. He helped me to learn how to learn it.

My fellow students didn't all fare as well as I did. Some of them had pure rotating residencies. If they weren't the type that got a lot out of just observing, they didn't get as much out of it. Some of them had a lot less time with their preceptors than I did. It varied, some of them served strictly project-oriented residencies. They could be very rigorous. Bob Buerki at Henry Ford Hospital used to have an extremely rigorous residency. Every morning was like a new final exam for the resident. He used to have staff meetings at seven o'clock. The resident often was cross-examined about what he had learned the day before. It was quite rigorous. The quality varied among them. The faculty tended to let them go whatever way the preceptor wanted and let the student reach his own niche. Mine was one of the best learning experiences one could have.

WEEKS:

Did they have a requirement in that first class of a major essay or thesis?

GOTTLIEB:

Yes.

WEEKS:

You wrote it on your disaster plan?

GOTTLIEB:

No. When I was taking the course, during the didactic portion of the program the first year, part of the course was devoted to getting ready to do

the thesis. A how-to-do-it sort of thing. So I had done sort of a preliminary thing on the issue of how much do doctors know about hospitals. I did that on Mount Carmel Mercy Hospital in Detroit. While I was taking the program in hospital administration I had an interesting time. I lived in Redford Township which is just outside of Detroit. I commuted to Ann Arbor. I was taking about twenty-two hours a semester, then I worked on the afternoon shift in the admitting department in Mount Carmel. Ed Connors had got me the job. His aunt was Mother Superior Carmelita of the order at that time. So I worked forty hours a week on the afternoon shift and I practiced law on weekends. I had a wife and baby and I had to do this. We had quite an interesting year.

During that period I did a pilot study at Mount Carmel on how much doctors know about hospitals. During the residency I finished the one on Mount Carmel and I did it for comparative purposes at Blodgett, thus bringing two different kinds of hospitals into it. I did it all by hand, no computers in those days. I still remember, after I collected all the data, my wife and her sister sitting there helping count by hand. So I did the thesis and that was the subject. I was lucky. I got the thesis award that they started giving right away. Ron Yaw was so excited about it that he submitted it on my behalf for publication. It was published in the Bulletin of the American College of Surgeons. Later it was published in Hospitals. That was rather heady stuff for one just finishing his residency.

WEEKS:

Those were brave years.

I have talked with two or three persons who have told me about their struggles to get through medical school or some other professional college.

It is surprising what can be done when you have to do it.

GOTTLIEB:

That's true. One thing that made a difference, I have to say this, was my late wife, when I decided to leave the practice of law and try something else, and finally found my way toward hospital administration -- and found out about the new University of Michigan program. My daughter at that time was four years old. My wife had been an art teacher in the Detroit Public Schools. She quit in June of 1955, with my agreement, because she really couldn't stand teaching any more. She was burned out, didn't have any patience left, as she put it, for her own daughter. Then in July I came home and told her about the program in hospital administration. We had talked about it in general terms before. McNerney said I could be admitted.

She said, "What do you want to do?"

I said, "I think I would like to go into hospital administration."

She said, "That sounds like a good idea. Do you want me to go back to work?"

That was her immediate response. I basically said we would find another way to do it. It was that kind of support from a wonderful woman that made those kinds of things possible.

WEEKS:

It's great when your wife can understand you and why you want to make a change. You had a profession already, and yet you were making a change.

GOTTLIEB:

Understand it and support it.

WEEKS:

I have had that kind of support from my wife.

GOTTLIEB:

Not many modern wives are like that, or, in fact, modern husbands.

WEEKS:

The acid test for an HA residency, I have been told, is whether you were allowed to attend a board meeting.

GOTTLIEB:

Yeah, I went to every board meeting. That may be unusual.

WEEKS:

That's surprising. Many residents have never been to a board meeting -- were ever able to go to a board meeting during their residency.

GOTTLIEB:

That's true. That was part of Ron Yaw's training. I went to board meetings, I went to executive committee meetings, I went to all medical executive committee meetings.

WEEKS:

You were fortunate to have him as a preceptor.

GOTTLIEB:

Very much so.

WEEKS:

After your year at Blodgett you went to Children's?

GOTTLIEB:

Yeah. Children's was in a very interesting stage -- Children's of Detroit. The hospital had been administered for about twelve years by a person who was a nurse. There was a very unfortunate incident in the emergency department in 1956, in the summer I think it was. Anyway, that brought about a major change in administration. The board brought in Dr. Hugo

Hullerman to serve as the chief executive officer and to really make changes wholesale. It was in bad shape, physically, financially, personnel-wise, and in almost every other way — for a lot of reasons. So Hugo got started and I was lucky enough to have him hire me. I started there in July of 1957 with the idea that I would be what would be generally known as number two man.

Hugo was another person who was kind of broad gauged and very pleasant, and disarming because he also was pretty tough. He had done a little bit of family practice and then he had worked in maternal and child health in the state health department in Illinois. This was his first major hospital management job.

What was needed in the place was kind of wholesale reorganization. He had to reorganize the board, the medical staff, community relations, and relations with what is now Wayne State University and its medical school. They prepared proposals for whenever possible to get a new building built because the building we were currently occupying had been built in 1890. That was the set of problems. The hospital had a large philanthropically oriented board, but not a board that was very well geared to governance of an institution.

So I was supposed to reorganize a lot of things internally and he was supposed to handle all of the other kinds of things. We had two other very fine administrative assistants, and they did a hell of a good job. So it was an exciting time.

Things were so bad in some ways at the hospital that I can remember a couple of occasions when I was proposing major changes that the medical staff leadership just hated. I proposed totally revising the admitting department and take it away from the control of residents. In the old-fashioned teaching

hospital the admitting resident determined who was going to be admitted and who was not, even when the attending physician referred the patient to the hospital for admission. The admitting resident had the authority to override him and send the patient home. The usual criterion for that: Was it a good teaching case? On the other hand, certain times of the yaer, no matter how far in advance elective surgery had been scheduled, we had a lot of upper respiratory infections that were being admitted and the whole surgical schedule could get wiped out. Sometimes they didn't get around to telling the surgeons who showed up to do the procedure that their cases had been scrubbed. It was pretty hectic. It was very difficult to have any stable kind of census.

At any rate, my job was to reform all that, reorganize it. That was just one of many. Of course, the first thing I had to do was get across the idea that, one, we were going to have a real admitting officer who was not a resident. That person was going to be in charge of admitting, and responsible to administration not to the medical staff or the medical educators. Two, we were going to do this with what today we would call a good admission scheduling system. The medical executive committee wanted to get me fired because I was interfering in their domain. I was trying to do things to take the control away from them -- it was bad for education and so on and so forth. So we had a big knock down and drag out fight.

Finally Paul Wooley who was a wonderful, wonderful guy, the chairman of the department of pediatrics, the best diagnostician in pediatrics that I ever met, a warm, wonderful guy, finally said, "Sy, none of us like this, but having somebody trying to do something instead of sitting around twiddling their thumbs is better than nothing, so if you want to try it, go ahead. If

you fail, don't worry, we will catch you."

That happened on several occasions. That kind of thing. I got about ten years of experience in three years, just because of the rate of change and the number of different things we had to get into in order to change things. Again, it was a very high learning period. It was a wonderful experience. Hugo was a fine guy to work with, very supportive. He understood what was going on. From my selfish point of view he was able to give me increasing responsibility until it was time for the next stage in my career.

WEEKS:

How did you happen to leave? This was when you went to Hill-Burton, wasn't it?

GOTTLIEB:

Right. One day Walt McNerney called me to tell me that the job to run the Michigan Hill-Burton agency was open and he would like to talk with me about it. So I trundled out to talk with him about it. He then spent about four hours at least twisting my arm and trying to convince me it was a great opportunity. I think what he really was after, I never have checked it with him since, my impression at the time was, one, that it would be a good idea for maybe the first time in the nation's history, to have a hospital administrator type running a Hill-Burton program. Two, if there was going to be one, it should be one of his boys. Therefore it had to be one other people would find acceptable. So I was the choice, his choice. I really didn't want to do it, because I had come to love hospital administration. I really enjoyed working in a hospital in an administrative capacity. That's all I wanted to do.

Walt's pitch was -- he knew me pretty well -- what could I accomplish

with ten years of hard work running a single hospital, maybe having 10,000 discharges a year, maybe I could accomplish something good for the people who came to that hospital. How would that compare with responsibility for all the nine million people in the state of Michigan and their hospital care? Not just their hospital care but rehabilitation and mental health and nursing home care. In the same ten years of effort, look how much you could accomplish. You are out there in the big world with Hill-Burton. That was the general pitch. Like an idiot, I fell for it. So I finally agreed that I would go up and be interviewed by the state health commissioner, a fellow by the name of Al Heustis. Then I was offered the job.

It was kind of an interesting time for the Hill-Burton program in Michigan. It had been started in 1948 as an independent office, the Office of Hospital Survey and Construction. "Soapy" Williams, the governor, had a theory of government -- not unique with him -- that when you started a new function in the state government, you start it in a separate identifiable organization or agency. You never start it as part of another department; it clearly is a new function. You give it all the visibility it needs, all the freedom and latitude it needs to grow and develop as it has to. Then when it stabilizes and is well accepted, or maybe falls by the wayside, at that point you decide whether you want to merge it into another department as more appropriately related to those activities.

So from 1948 to 1960 it stayed as a separate Office of Hospital Survey and Construction. It had some good people to run it. They were appointees of the governor and reported to the governor. Then in 1959, Soapy proposed to the legislature, and they agreed, that the office be merged into the state health department and become a division of the state health department. On

paper that made a lot of sense. The real problem was that for twelve years the people in Hospital Survey and Construction and the people in the state health department had become mortal enemies. They fought with each other tooth and nail on everything. Suddenly now, all these peole who had been with the Hill-Burton program were now employees and subordinate to and colleagues of the people they had been fighting with. The first casualty was the director of the program. He wasn't going to move into the health department, so he went to work in the governor's office, as a staff assistant. Jordan Popkin was his name.

So, I was the first director of the division when it had been assumed by the health department. Other division directors, the deputy commissioner, and so on, were very suspicious of me. In fact, they were suspicious of the whole program. I had them on the one side to deal with. The staff I inherited all had a history of hating the health department, of being used to being able to operate independently, now were having to operate within the bureaucratic structure of the health department.

In addition to having to learn all about what the Hill-Burton program was, and finding out that there were places in Michigan other than Detroit and Ann Arbor, and finding out that there was mental health as well as physical health, long-term care and all those other things that I didn't know very much about, and how to get along with the federal government, because this was a type of federally controlled program, I had to kind of referee this warfare that was going on between my inherited staff, who were very good, and the health department staff. It lasted for all of five and a half months.

I would like to make a pitch for the Hill-Burton program. I don't believe in the revisionist theory of history. In recent years there has been

a lot of attack on the Hill-Burton program. There were a lot of hospitals built that today we would consider being unnecessary. We built them all over the map. In some states there were a lot of political decisions made, and a lot of horse trading, states where there were payoffs and those kinds of things. Neither of those was true in Michigan; politics was minimal. Obviously there was some. We always had a very pure set of state bureaucrats both in the early days of the Hill-Burton program and certainly in the health department, so you didn't see those things.

When we came out of World War II, we had a lot of people, especially the service people, who were used to good hospital care. They found out what it was. They came back home and expected that kind of health care, with an emphasis on the hospital. They had a strong growing feeling that the hospital was the logical center for high quality care.

You look at Michigan and there were 76 hospital service areas that were developed in the state as a whole. In 1948, 39 of them didn't have a single hospital bed. By the time I came along to run the program in 1960, we had that down, I think, to three areas that didn't have a single hospital bed. That was remarkable progress that wouldn't have been possible without the Hill-Burton money. More important than that, it had a built-in, rudimentary but built-in, planning and priority function that was reasonably well developed and that in most of the states most of the time was followed. We thought that was leading to good health care. Everybody who was involved thought that.

It brought in something else. When the Hill-Burton program was started, I don't believe there was any state in the country that had a hospital licensing law. There were some that had licensed maternity beds, maternity

units, I would have to check it to be sure, but I don't think there was a single state that had a full hospital licensing law or construction standards for hospitals. Construction standards were introduced by the Hill-Burton program. It wasn't just building hospitals, it was bulding hospitals with the first externally determined quality that we built in this country. When you figure that we were doing that throughout the nation, it was an amazing contribution.

We didn't get hospital licensing in Michigan until 1968. That was our first hospital licensing law. Whatever standards we had outside of maternity came through the Hill-Burton program. Maybe, in hindsight, some mistakes were made. Maybe hospitals should not have been considered as important as most professionals in health care thought they were, and as most of our citizens did. We don't now think that the hospital should be or is as much the center of health care as we did then. I think we are correct now in our view of it.

The Hill-Burton program made a fantastic contribution. I think one of its good sides is that it was the only major federal program in the history of the federal government that was started, fulfilled its purpose, and then was killed. It no longer exists.

There was one other thing I learned. It must have been 1972 or 1973, toward the end of the Hill-Burton program, as a consultant to HEW, they put a group of us together to evaluate state Hill-Burton programs. There were some people from the private sector, people like me, some people from the state governments, some from the federal government. As a team we developed some criteria for the evaluation, then we site-visited the Hill-Burton programs in all 55 states and jurisdictions.

One of the most interesting things to me, and its going to be important

for the future -- and currently a hot issue --- the Hill-Burton program was a highly centralized program out of Washington. Very tight standards, very tight rules about how you had to do everything, about the way the priority system was determined, about the way the state plan was developed, and almost every other detail. Whatever was done at the state level, even though it was administered by the states, had to be checked and double checked by Washington bureaucrats. It was intended that the states only administer, that they do it by tight-scheduled guidelines.

What we learned in that evaluation we went through in those site visits was that even in a very tight, highly centralized federal program, every state did it its own way. The basic structure on the way things got done in each state determined how that program was run. Southern states where usually the state government is more important than local government and where the state is viewed as kind of a benevolent despot -- always good to people and so on -- there was complete trust between the state folks and the local folks. The priority system was put on paper the way the feds wanted it but was really developed by a handshake like, "Hey, Joe, I am sorry we can't give you any money for your hospital this year, and I don't think we can next year, but two years from now we will give you some money. How's that?"

Joe said, "Fine, Bob. It's a deal."

They shook hands on it and two years later they got their money. The priority system might say something else, but that was the way they did it.

When you went to Illinois, everyone in Springfield absolutely had zero trust in what happened in Chicago and Cook County. It was almost an armed camp between the Hill-Burton program and the Chicago folks. Everything was in writing and tested down to the last degree. Every state that we went into you

could see the variations that were introduced because they knew how they had to operate. Federal bureaucrats never even knew it was going on. The interesting thing is that we emphasized that in the evaluation report as one of the good things about the federal-state partnership. HEW killed the report; as far as I know it was never published.

WEEKS:

There is no question that it was of great benefit to many areas of the country. It was tipped toward rural areas more than it was toward urban areas. Maybe there were hospitals where today we would say it was not necessary, but I think we have to look at it historically, as you suggested, according to what was needed then, not on how we would look on it today.

GOTTLIEB:

I think that is true. I remember the fight I had with -- at that time a friendly fight -- Al Heustis, the health commissioner. After I had been on the job about three months, I prepared a set of guiding principles, how we were going to try to run the Hill-Burton program. It was a draft. I sent it to him and said that he and I should discuss it and then discuss it with the other division directors. This was my thinking about how we should think about the planning side of the Hill-Burton program. He and I had a long discussion on it. Our discussion focused on one point. He agreed with everything else I had in there. One point was that I said in one of the principles that the hospital should be the center of community health affairs, with all the implications of that. Al believed, equally strongly, that the local health department should be the center of all community health affairs. We went around and around the horn on it.

Finally he laughed -- fortunately because he was the boss -- and said,

"Sy, would you agree that in almost every community we know of in Michigan that there is now no organization that is a real center for community health affairs?"

I said, "I agree with that."

He asked, "Would you then agree to a statement that some organization in the community should be the center for community health affairs?"

That is what we compromised on. It indicated the state of mind.

WEEKS:

I am glad you related your experiences with Hill-Burton. Possibly you could talk more about the Michigan Hill-Burton.

GOTTLIEB:

In Michigan the Hill-Burton was very much a planning program, and very much an apolitical program.

Two things made it that way. One, Governor Williams had strong beliefs on management -- that those things that were in a sense technocratic and required a high level of expertise and so on should not be subjected to politics. So he undertook and accepted the job of keeping politics out of it. It wasn't always true, he wasn't always successful.

So one thing that he really didn't allow, that he shielded the agency from, was being politically involved. It varied a little bit with who the director was. Some of the earlier directors were very politically oriented.

The other thing was that a guy by the name of Joe Homminga went to work for the agancy when it first started in 1948 and stayed with it, usually as number two man, until after I left when he became the executive, the director of the agency. He stayed with it until he died in 1972. Joe was a terribly hard worker, he infused the concept of planning. It was a question of going

out and meeting with groups in a community and trying to help them think it through to decide what they wanted to do. It was a very activist kind of role he played. It wasn't just waiting until people came to him because they happened to meet the criteria or priorities.

If there were two groups within a town and they wanted to build a hospital, he was likely to go in and bring them together and try to work things out, to do it in a cooperative way. He kind of set that pattern and it was followed, it varied from year to year, but that was the way it was when I came and my own instincts were in those directions. While I didn't last very long, that was the general approach.

We had financial people on the staff to look at the financing and check on that. We had architects and engineers on the staff in terms of the design. They followed the construction very carefully, in fact, there was pretty tight control in that area, but it was handled very much in a planning kind of framework. Of course, in those days you didn't get all involved in consumerism, you know, having a lot of people looking over your shoulder. It was pre-development so it was easier to do it that way.

I remember the first week that I was on the job. We had a request, you talk about your horizon, suddenly I hardly knew anything. I didn't know much about state government. I knew a little bit about running a hospital, and a children's hospital at that. And I had a theoretical knowledge of other things. But I'd been on the job a week and one of the people on the staff said, "We've got this problem in Grand Rapids -- we have two organizations that want to build a psychiatric hospital. We've got money for one but we've got to do something. They are putting the heat on and we've got to give them some answers."

I said, "Well, what would your suggest?"

She said, "Why don't we have a meeting and bring them all together. We'll set up a meeting up there."

I said, "Hey, that's a good idea, why don't we get everybody in Grand Rapids together who is involved in mental health and sit down and chat and see whether something can be worked out."

Of course, I didn't know anything about mental health and I didn't know anything about Grand Rapids -- other than I had lived there for a year when I was doing my residency. So that was some help.

We invited the people from the general hospitals that were interested and there was a public hospital and there was a private psychiatric hospital, a child guidance clinic, and an adult outpatient center, and a couple of other people.

I knew I couldn't go wrong when we got there. Betty had set up this whole meeting, she had contacted everybody. We got there and everybody showed up. Then I had to start by introducing them all to each other. They all worked in the same town, in mental health. There weren't too many people in Grand Rapids in those days in mental health and I was from out of town (Lansing), and I didn't know anybody. But I had to introduce them to each other. They were no further ahead. That finally got worked out -- but it was that kind of an approach.

Soapy Williams helped in many ways on the political front by protecting the group, the agency. I remember, we had a big problem down in Monroe. There was a Catholic hospital and a Lutheran hospital. It was a very high priority area. I think it had been first in priority for a long time for giving Hill-Burton money and in 1957, I think it was, the then director of the

Hill-Burton program had applications from both of them and he took what most people would say for the time and place, the gutty approach of saying "no to both of you." You either get together to build a single hospital -- we'll be glad to help with that or we aren't going to help either of you.

That started a fight that lasted until those two hospitals finally merged in 1972. One of the longest standing battles in history. Talk about how long it takes for a merger. So it had been going on for about three years when I got into it. It was pretty heated. The town was split and the legislature was up tight. But my predecessors had stood their ground. Every thime the Monroe group tried to go to Washington for help, in those days people in Washington would say, "Nope, we don't deal with that kind of problem -- that's local, that's a state matter."

So in my tenure we had a lot of interesting experiences with it. One day I got a letter from -- I guess I'd been on the job for about six weeks -- I got a letter from the governor asking what was the current situation with the problem in Monroe -- that he had had an inquiry from Senator So-and-so. And here...I didn't know anything about the background. And I thought, okay, here's where the political stuff comes in. I'm going to get my first political lesson now. So I asked Joe Homminga, "What do I do now?"

He said, "Well, let me write a letter of reply and you sign it, and then watch and see what happens."

I said, "What's going to happen?"

He said, "Well, you just watch and see what happens."

That was kind of typical of his approach to training me as his boss. So, he wrote the letter and it was basically an update, very factual, on what had been going on since the last time he had written a letter. I read it and I

said, "Do we really want to send that? There's some things in here that aren't very nice about some of the people that we've been dealing with down there."

He said, "These are the facts. The governor asked for the update and I suggest you send it without changing it."

I said, "Well, I don't know enough to change it, so okay."

So I signed it and sent it off to the governor. About a week later I got a copy of the letter that the governor had written to this senator in which he merely said I have been aware of your concern about the hospital situation in Monroe and the activities of our -- whatever the title of it was -- state Hill-Burton agency. I have discussed it with the people in the agency. They are extremely competent. They do an honest and thorough job. I am satisfied that they are continuing to do this and I suggest you forget it.

WEEKS:

Wasn't that a wonderful back-up!

GOTTLIEB:

With that kind of backing. That was just fantastic and that helped make the Michigan agency really a very good one.

WEEKS:

When you were originally talking about Joe Homminga, I, of course, remembered the times he came to McPherson Health Center when Jim Sullivan was there and they were building an addition. I admired him very much and, by the way, he came at 10 o'clock at night many times too. I was wondering, did you mean to say that you had sort of an outreach if you saw an area that needed development that you would go to them and ask, "Would you like to do something?"

GOTTLIEB:

Yes, of course. Or if we saw an area of need we would try to find people who were interested in doing something and bring them together. Try to get them started and help them for a while in terms of thinking it through and facts and data and so on.

WEEKS:

This was really a very fine thing. I mean there aren't many federal laws passed that are carried out in that manner. You don't usually think of that kind of law that provides money for construction that would also have the feature of going out and finding people that need that service.

GOTTLIEB:

Well, it wasn't really clear in the law, in the federal law or regulations. The thing that was unique about the federal law -- and for its time it really was -- was that it was a grant program. But in passing such a law for a grant program, the money must be distributed according to the plan. Just the mere facts, you know, in this country the word "plan" in 1946 was a pretty radical idea.

So it tied the grant program to planning, at least in the sense that you develop a plan and then you have to pass the money out, if you will, in accordance with priorities and a good plan and so on. Also, I don't think that there was an earlier law that had the degree of federal/state relationship that the Hill-Burton law did. That was both a forerunner and made it unique at the time.

Then how you did it, that's what I was getting at earlier, depended on the state and how they did things, and, obviously, people. There really were not many states that went as far as Michigan in providing that level of

assistance, and being positive and helpful. But that's the way we did it. And I don't take any credit for it, I was there only six months. I was just carrying it forward the way it was already going. But in that sense it was a very positive program. It really helped me, although I was only there a short time, it helped mold my own concepts of what community planning ought to be like and so forth. So it was a fascinating experience.

WEEKS:

In the very beginning when they were setting up the state agencies there must have been some leeway for the states. As you suggested, each state is a little different in the way it goes through its political process.

Dick Stull, as you know, had something to do with setting up California and Bob Sigmond did in Pennsylvania. From what they've told me it sounded as though there was no scheme outlined, definitively at least. They had some general outlines, but they had to make a survey and set up an agency and estimate their needs. It was pretty much left to the states to suggest a plan which could be approved or not approved, as I understood it. Does that seem like a reasonable way of looking at it?

GOTTLIEB:

No, I don't think so. That probably was the way it was the first two or three years although a lot of work had been done on how you determine need and all of that. That was all done in Michigan, by the way. The Kellogg Foundation funded that and that was done as part of the Commission on Hospital Care in 1944.

WEEKS:

I was going to ask you, I ran across that somewhere. The title I came up with was "Hospital Resource and Needs" and this was a part of the Commission

on Hospital Care.

GOTTLIEB:

Yes, and that was based on studies that were done in Michigan financed by the Kellogg Foundation. I think it was 1944, getting ready for the end of the war and so on. It was jointly sponsored by the American Hospital Association and the Public Health Service.

WEEKS:

This is the first time I have run across the title of it but quite often you see the Commission referred to as being a possible forerunner in gathering information that was used in writing the law.

GOTTLIEB:

Yes, I think it was the forerunner of the law and the formulas that were used in determining bed needs and so on were developed by that commission or in that report and then they later became part of the law. The 4.5 beds per thousand in base areas, 4 beds per thousand in general hospital areas and 2.5 beds per thousand in rural areas, I think I remember.

WEEKS:

Yes, that sounds like what I remember reading.

GOTTLIEB:

But I disagree with both Dick Stull and Bob Sigmond. That may have been true in the first two or three years but as the regulations got developed, they got tighter and tighter and they were very strict.

WEEKS:

Of course, they were talking about the very first day after the law, day one after the law was signed. So it may have been that way.

GOTTLIEB:

Oh, I'm sure that's true.

WEEKS:

There's one question I wanted to ask you and one little tale I wanted to tell you.

Did you run into situations where neighboring towns, where only one hospital was needed but neighboring towns would not be able to agree on where that hospital should be placed?

GOTTLIEB:

Oh, sure.

WEEKS:

I'm thinking of Hudson and Morenci. Wasn't that the classic? But I guess the man from Tecumseh -- Herrick -- had enough money to build two, didn't he?

GOTTLIEB:

Well, yeah, and he put a lot of pressure on Blue Cross, too. As you know, they built two twenty-five bed hospitals eight miles apart. He basically, it was reported to us, told Blue Cross that if Blue Cross didn't like that and wasn't willing to pay for it that he would just take his group and go some place else and get health insurance. He had the largest single group in the county. I remember being very critical of that in the Michigan study, Hospital and Medical Economics.

WEEKS:

There is a fierce loyalty there. I guess John Griffith ran into that in Vicksburg, a little town south of Kalamazoo where he made a study one time and was nearly run out of town on a rail when he told them that they didn't need a

hospital.

GOTTLIEB:

That is true, every community wanted some hospital, of course. Especially when you get into some of the smaller, more rural areas. You know, you have a high school basketball team and that's very competitive with the one down the road. If you are going to compete in basketball, you compete in everything. And that's very important.

WEEKS:

It's perfectly natural.

GOTTLIEB:

But in this state, by and large, the Hill-Burton program was more forthright in viewing that than many. There were a lot of mistakes made because of that.

WEEKS:

You couldn't avoid it entirely. I keep thinking of things I want to ask you.

One, did regionalization come about in Michigan, you know, through Hill-Burton? Did this have any influence? Back to the time when Regionalization and Rural Health Care -- Riedel and McNerney's book. How was that in relation to your tenure in that office?

GOTTLIEB:

Well, that was based on the experience up in Traverse City, Petoskey, Kalkaska and St. Ignace, I think it was. It had gotten started before I took over the Hill-Burton program. It was going on, if you will, while I was in the job. They used Hill-Burton money and they got a lot of help in planning and thinking it through from the state agency. But I didn't get involved in

that, not directly. I did some evaluating while I was there. I wasn't really active over the agency long enough to really do anything. But that's the closest we ever came to regionalization until the current move, which has different kinds of thrusts.

WEEKS:

Strangely enough, there was a revival of interest about six or seven years ago. At the Press, we had quite a few copies of that Riedel and McNerney book left and we advertised at one time and sold a lot of copies, relatively speaking -- to what we had been selling -- because of a revival of interest in regionalization. The book was a tale of failure but maybe that was important too. Sometimes the failures are as important as the successes.

GOTTLIEB:

We should have learned by now, after all these years of trying -- since 1930 -- on regionalization that it won't work.

WEEKS:

No, it has to be a two-way street referral and it will never be.

GOTTLIEB:

It just runs up against too many habit patterns, too much of the mores and customs of society as well as professional restraints and constraints, a whole set of factors. I'd always hoped for, and I still do kind of hope for it. You know that it could be effective. It's now coming about more, in the current environment, more because of the growth of the multi-institutional system. That, of course, is occurring for an entirely different set of reasons.

Most of the systems haven't gotten far enough yet in really pushing the idea of consolidation of services, and how to distribute services throughout

their systems differently. As they do, it'll be that motivation and the forces that are behind the development of the multi-institutional system that develop regionalization rather than the kinds of things we thought were important back in the 1950s.

WEEKS:

I'm sure that as you say it will come about in a different way. It probably was a good lesson to attempt it earlier so that today we know what the human failings are and that primary hospitals don't want to give up cases to the tertiary hospital, and the tertiary hospital doesn't want to refer anybody back to the primary hospital. I don't know whether it's pride, or greed, or what it is -- but it's there.

GOTTLIEB:

It's probably a combination of a lot of motivations. I hope that we learned something from it. One of my favorite sayings since I've gotten older so that I can pontificate from public platforms is, "You know, we've had thirty years of experience now with planning in this country in health. The question is, for those who have been involved in it, have they had one year of experience thirty times or have they really had thirty years of experience? Did we really learn anything from it all?" Sometimes I wonder.

WEEKS:

I think that's a good way of expressing it. I hope we can talk about planning a little later on here.

I want to tell you about a little tidbit. I buy a lot of biographies and one day I bought one written by Sidney Fine -- I don't know if you had any courses with him down here in Michigan or not -- on Frank Murphy. I discovered something I didn't know, maybe you knew it, but I didn't know.

In 1936, or whenever Murphy was governor, he went to Washington and he approached Roosevelt and Ickes and Hopkins and all these people. He was asking for money to build rural hospitals in Michigan. This would have been possible in those days under PWA or one of those agencies, but he was turned down.

GOTTLIEB:

To build them under the Lanham Act.

WEEKS:

Was that what it was? But he was turned down because he couldn't guarantee that he could furnish medical staff -- doctors for all those hospitals. The money was there and you might be able to show the need but he couldn't show that he could supply doctors for those hospitals. In talking with Ig Falk about this, his name came into it somewhere, and I said, "Do you remember this?"

You know Ig was just as sharp as a tack. He told me the whole deal. He was the one who, regretfully, had to bring up this question because he was saying it's fine to build a hospital but who is going to take care of the patients? So we might have had rural hospitals long before Hill-Burton.

GOTTLIEB:

If Ig had stayed with that part of the business longer, he would have found out what we found out in the Hill-Burton program and have ever since in planning. Everybody believes that if you build a modern, a new hospital automatically the doctors will come. That's why you do it is to attract doctors.

WEEKS:

They are still waiting in Howell, to a certain degree.

GOTTLIEB:

It's interesting that you mention Frank Murphy. My dad was a professional politician, mostly, as I was growing up in the Detroit area. He was really responsible for starting Frank Murphy out on his successful political career. My dad had talked him into running for mayor of the city of Detroit in 1930 and helped him get it and that was what got him going. Then we had good reason for not thinking of Mr. Murphy in a fond way after several other things occurred.

WEEKS:

He was a fascinating man. I saw him only once in my life, close up -- within six or eight feet of him. He had a certain attractiveness about him that people were drawn to him. I don't know anything about his politics. The only good thing I remember about him is while he was governor he at least didn't let the troops come in and use force during the sit-down strikes at the auto plants. Aside from that, I don't know. I never thought that he was a great attorney general. I don't know how he did in the Philippines but I guess I wasn't looking at those things closely in those days.

GOTTLIEB:

I remember...I obviously can't go into detail on it. I'd heard a lot of stories about Frank Murphy at the dinner table and a lot of cussing. There were a lot of good reasons for it which I won't go into.

I remember when he was governor, we went to a Democratic party rally at Cass Technical High School. I got dragged, I was a kid thirteen or fourteen years old at the time, and I got dragged to all these damned political things which I hated.

Murphy was going to be the principal speaker, as governor. He came out

on the stage in the usual way that people like that do and the audience rose and applauded, including my mother and dad. The only person in the whole audience that didn't even stand up or applaud, was me. Because I knew what he had done to my dad. I knew what we thought of him. I thought my dad was a hypocrite for standing up there and applauding. All of a sudden, I felt a tug on my ear and my dad had dragged me to my feet by my ear, literally, and hissed at me, "Applaud, damn it, I'll explain later."

On the way home, he just gave me the lecture of my life about what democracy was all about and about respect for the office. A most unusual experience.

WEEKS:

As I say, I saw him once. I saw him in a tux so maybe he looked better than he acted in society.

I was going to ask you about Jordan Popkin.

GOTTLIEB:

He was my predecessor as director of the Hill-Burton program. He was the director of it when it had been the separate office of Hospital Survey and Construction.

WEEKS:

Then he's the man you were talking about?

GOTTLIEB:

He was director from about 1955, I think it was, until 1960. And then, of course, he couldn't move over to the Health Department and he went to work for the governor in the governor's office as an executive assistant. So that is where he was when I came on board.

WEEKS:

Well, the name just popped into my mind and it seemed as though I connected it with Hill-Burton. There was some woman who was quite prominent there too.

GOTTLIEB:

Betty Tableman was there. She was an analyst -- put together the state plan. She was my right arm.

WEEKS:

I think most of the questions I have already asked you except -- Was it Jack Haldeman who was in charge of Hill-Burton in Washington when you were there?

GOTTLIEB:

Yes.

WEEKS:

I met him with Jim Sullivan and John Griffith one time when we started out on the McPherson study. He seemed to be a nice enough guy.

Now we get to the point where you come back to Michigan for the Michigan study. Did Walter again say come on, I need you?

GOTTLIEB:

No, that time, well he did in a way, but I really said, "Walter, I need you."

I got fired in the Hill-Burton job -- rather unceremoniously dumped I guess is the right word. I was there five months and two weeks and it was the last day that they could fire me before my probationary period expired. The state health officer called me into his office and told me that his deputy had filed a poor report on me and therefore I was terminated as of 4 o'clock that

afternoon -- which was a bit of a shock.

I proceeded to fight back with the help of a heck of a lot of people and a month later -- I was the first probationary employee and the only probationary employee in the history of the Michigan State Civil Service who was ever granted a hearing. I was ordered reinstated. That was three or four months later. So in that sense I won and was vindicated and all that sort of thing. I had a lot of help from the hospital field in Michigan to make that possible.

But at any rate, when I got fired...Jim Hamilton used to say, "You haven't really arrived until you've been fired twice from jobs." But that was my first experience with it and it was tough. What do I do now? We had just moved to Lansing, just a month before, and I had two kids and no prospects. All those other personal things and then the other things — the shock of it and all.

While I was getting my bearings I called four people that I knew pretty well to tell them what had happened. Included were Ron Yaw and Walt McNerney and a couple of other people. Jim Sullivan, in fact, was one. He had been a classmate of mine, as you know. That was very nice. Because out of the four people I called I got three offers of temporary tide-over jobs, and one offer of a permanent job if I wanted it. That one came from McNerney. He put it on the grounds that he needed me -- that the Michigan study was in trouble in terms of finishing and he really needed my help, and that he had this other big grant from George Bugbee's outfit that he hadn't even started yet. So he was nice enough to put it on the grounds that he really needed me. So that, needless to say, took a big load off my shoulders on the personal side.

So I went back to Ann Arbor because that was the one that was the real

job and that's how I got into the Michigan Study of Hospital and Medical Economics. While I always felt that Walt was really doing me a big favor, you know I also recognized that he needed help and I don't have any doubt that even he would acknowledge that it got to a point where I kind of earned my keep. He didn't make a mistake. I think even he would acknowledge that.

WEEKS:

I looked at the study here and looked at the part that you and your co-author Spaulding were responsible for; it was a good portion of one of the volumes, wasn't it? It was almost a book in itself. You must have done something to earn your keep.

GOTTLIEB:

Walt really hired me. I forget the name of the outfit George Bugbee was running then. It was in New York.

WEEKS:

Health Information Foundation?

GOTTLIEB:

Yes, Health Information Foundation. He had given a grant to the Bureau to do a study of hospital costs. And Walt really hired me to do that -- get it started. I think probably to prove to George that something was happening. He had had the grant for months but all the staff were busy on finishing up the big study, so called.

Then I came in and Whit Spaulding had just left. His two-year leave of absence at the Hartford Hospital was over and he had gone back to Hartford promising to write it up in the evenings. You know how that works. The Bureau was under the gun because the Commission was waiting for the report. It was already late, naturally. Walt had used up all the money already --

that he had gotten from Kellogg. Yet the report wasn't done.

So, needless to say, I got drafted really to take all Whit's notes and whatever data he had and so on and try to fashion that into the control section of the report. That was kind of an interesting experience. Everybody else had been there for two or three years and they were all either totally finished or just about finished and here I was just starting on it with this terrible deadline, and this huge task. It was in one sense — in terms of the practical reasons for which the Bowles Commission had asked the Bureau to do this -- it was the most important section. It was the control section. What are your recommendations? In that arena. That's where I learned a big lesson -- you probably learned it -- about writing. I didn't know it at the time. Here I was under this terrible pressure to finish. I had this huge thing to do. I would sit down with all these notes and I would write an outline about how I wanted to approach a chapter. I think there were about thirteen or fourteen chapters in that part of the book. I would outline it and then I would start to write. And I couldn't write. I would write that first paragraph about thirty times -- papers strewn all over the floor. I would get up and walk around and go in and have a cup of coffee. I would go in and talk to some students in the lounge. Or I would go in and bother some of the other faculty and I would come back and try to write — and I couldn't. That would go on for about three days. I'll never forget that feeling. It still happens to me, by the way, but now I understand it.

You feel totally useless. Like you don't have a brain, you don't know anything. I was feeling like everybody's eyes were on me. What's he doing wandering around when we've got this study to finish?

Then I'd go back — if I started the outline on Monday — I'd go back and

start Thursday and all of a sudden it would start to flow, and I could write for 48 hours straight. Sometimes I did that, literally -- hardly even changing a line, and it would get done. That chapter would get done and I'd think, now I've got it licked. I'd start the next chapter and go through exactly the same thing. I was just going nuts. I was afraid to admit it to anybody or even talk about it to anybody, because there were all these pros around. I was new to academia and all that sort of thing.

It wasn't until I finally finished and I was talking to the late Grover Wirick about it one day -- a couple of months later. I finally admitted to him -- he had become a good friend -- I finally admitted to him how scared I'd been that I was really holding everything up and I was doing such a poor job. He said, "Yep, you're right, we were watching you." He said, "We were amazed at the speed with which you wrote." He said, "You must have been turning out 20 pages a week. I don't think I ever turned out more than 4 pages a week in my whole life. We couldn't believe that you were writing that fast."

A couple of other times when I've had major things to write, and really almost any time I write a paper, I find -- I don't know whether it's unique with me or unusual -- but I find that the only way I can do it if it's an important thing, is to kind of write a more refined outline and then just kind of let it percolate in the back of my head. If I try to approach it in less than another week I'm not going to get any place. Once it has percolated back there without consciously thinking about it, then it kind of flows.

WEEKS:

Can we go back a minute? I've never really had the background of this Michigan study explained to me fully other than that it was a request by the governor for a study of the conditions in Michigan coming as an outgrowth of a

request for a raise in rate by Blue Cross. Is this so?

GOTTLIEB:

Yes. I don't remember all of it, everything that was happening in 1957-1958, but in 1958 we had a big recession and the Blues ran out of money. Blue Cross asked under their then contract with the hospitals to forego some percentage of their normal payment, reimbursement. Ten percent, I think it was. The Blues needed that just to get by and it was a pretty rough recession -- the '58 recession.

There were some groups of hospitals that didn't want to do that and fought it and it created quite a stir. It is my recollection -- it may have started before that -- was that then the governor appointed a commission. Judge Bowles, who was a Circuit Court judge in Detroit at the time, chaired it. It was through the commission that they basically contracted for the study. That was in the time when McNerney was really pressing to get into things like that.

WEEKS:

Did the state ask Kellogg to fund it?

GOTTLIEB:

I just don't know that. I suspect that, as usually happens in those things, a kind of cooperative approach. Let's go together.

WEEKS:

It's one of the few pure -- maybe that isn't the proper adjective to use -- research projects that Kellogg has supported, and apparently it was a fair amount of money.

GOTTLIEB:

Oh, yes, for those days it was a large grant.

WEEKS:

Half a million or something like that -- or more?

GOTTLIEB:

Yes, I think it was more than that. I don't remember the exact figures but I think it was up around $600,000. But, you know, it was also a huge thing. There were thirteen principal investigators. It took three years to do. Of course that wasn't what the proposal said. But you always take longer.

I wasn't there in the genesis, while it was being developed. I was still working at Children's Hospital while all of that was going on so I wasn't totally aware of it.

WEEKS:

What was the end result of this after the report had been made?

GOTTLIEB:

A lot of things happened as a result of it. We went around and did a lot of explaining and talking to people about it and giving speeches and all that kind of stuff. But the Bowles Commission didn't do too much with it other than sort of adopt it, and they did adopt a lot of the recommendations.

Another governor's commission was appointed after that to basically succeed the Bowles Commission. They did try to put a lot of those things into legislative proposals. If you look at the set of recommendations in that study, I forget how many there are -- four hundred some odd -- specific recommendations for action, almost two-thirds of them are now in practice. All the work that was done in the effectiveness section was all the precursor of PSROs, and the whole utilization review approach is based on standards and

Bev Payne, who was one of the principal investigators in that, made a career practically out of carrying those ideas forward.

We were the first ones to recommend -- we called it franchising in those days -- but it was really certificate of need. We recommended hospital licensure which we didn't have then. We recommended some changes in the Blue Cross board structure which ultimately came to pass. I hardly remember all of them there were so many recomendations.

But it is amazing when you look at them how many of them in this state became practice. They were carried through by a lot of different organizations.

Parenthetically, one of the fascinating things or sidelights, you might say, or ironies is that in my section on controls within the hospital system, among other things I discussed the Greater Detroit Area Hospital Council and its voluntary approach to planning in some depth — its relationship with Blue Cross -- Blue Cross being the enforcer. I used that as an example of why voluntary planning would never work, why you had to have franchising. So it's kind of ironic -- two things are ironic -- I later came to be one of the last surviving opponents of certicate of need laws and franchising and on top of that I ended up running Greater Detroit Area Hospital Council as a voluntary planning organization.

Life is strange.

WEEKS:

I was amused when you were talking about all the dash there was in getting that report done and ready to go. I can remember hearing the story of Fitzpatrick going all the way to the Philippines to pick up a manuscript. It must have been frantic.

GOTTLIEB:

Oh, yeah, it really was.

WEEKS:

There were a lot of people that had a part in it. Let's see...John Griffith came to the university about the time you did too, didn't he?

GOTTLIEB:

He came a year after I did. He and Larry Hill both came a year after I did, or later that year I think it was.

WEEKS:

Tom had been there before — Tom Fitzpatrick.

McNerney left before the book was published, didn't he? Because the book didn't come out until 1962. Undoubtedly this was a stepping-stone for him to get that job.

GOTTLIEB:

Well, I suppose if you look at the objective evidence, it has that appearance. Whether that was planned or part of a strategy, a career strategy, I don't know.

WEEKS:

The way McNerney tells the story, it was a complete surprise, it came out of the blue. He apparently was at a meeting in Hawaii when he was called to the telephone. It could have been Jeb Stuart who called him and asked him if he would like to run BCA. The voice said, "Do you hear me?"

McNerney said, "Yes, I hear you. I said yes."

So according to McNerney it was a complete surprise. I'm sure Jim Hamilton would say that he got him the job.

GOTTLIEB:

Did you ever interview Jim?

WEEKS:

Yes. Jim placed a lot of people.

GOTTLIEB:

Well, I never really knew and I don't think very many people did. Certainly for those of us who were working at the program at the time it came as a big shock. There was a fair amount of anger on the part of some of the staff. You know, like he was selling out.

WEEKS:

Well, I know when I came there I heard stories about the staff being a little bit upset, maybe a lot, I shouldn't say a little, very upset about publication credits and things of this kind.

GOTTLIEB:

Oh, golly. Well, you know, I remember, I guess I had been there about three months or maybe even less than that when I was summoned into a meeting by the other faculty members and it was going to be a showdown meeting with McNerney over the question of authorship. I couldn't understand why that was important. I hadn't come out of academia and I didn't understand all those little academic, political games. So I went to the meeting because I was told everybody had to be there and we were going to have a solid front and we were going to settle this once and for all.

We had this meeting and, of course, McNerney said it was all settled, it was going to be the McNerney report. Everybody was going to be listed in the acknowledgements. Now that I understand things better, that wasn't bad going into negotiating by saying that. Of course, about half the faculty couldn't

see why McNerney's name ought to be on it at all except in the acknowledgement because he didn't do any research or write anything, but he had really put a lot of himself into it.

So we had this knockdown, drag-out fight and there were threats of lawsuits and so on and it went on for two or three hours. All I wanted to do was get back and write because I was still writing then. I couldn't understand it, and I thought it was the funniest thing I ever saw. I remember going home and telling my late wife all about it and we were laughing like mad because I would give her chapter and verse and all that. Suddenly I stopped laughing and I said, "You know, if we ever get to a point where we can't laugh about things like this, it will be time for us to leave academia."

It finally all got settled, you know, and as you would expect, it has been known as the McNerney report ever since, except in formal citation and references.

WEEKS:

Yes, McNerney et al. You wonder who Al is.

You were on some other kind of study. Was this the HIF study?

GOTTLIEB:

Yes, it was a study of hospital costs, trends and relationships. That was one that ended up with me -- I was the lead guy -- working with Fitzpatrick and Wirick.

WEEKS:

The book manuscript was the result of that study.

GOTTLIEB:

That's the one that I always considered sort of two years of wasted life in the sense that you work for two years on a study of that magnitude and you

don't even get a book published out of it.

WEEKS:

As I remember, it was at University Microfilms.

GOTTLIEB:

It is on University Microfilms. I know I have one copy of the manuscript and I think Tom has one. I don't think Grover even bothered to keep one. But we were all pretty upset and angry about its not getting published. There wasn't any money left for it and it was going to be too expensive to publish straight and pay its way and we couldn't get anybody to support it. We were all pretty upset about it. It was really a pretty good study and may have been a pretty good book.

WEEKS:

Tom Fitzpatrick sort of stepped into a bad spot there too, didn't he? As I remember when I came there he was having trouble trying to raise money to support the research staff. I mean trying to find more research projects to get funded.

GOTTLIEB:

Well, he had that and he was acting director with the problem of not knowing for sure whether he was going to be director, and with all the ususal university politics that were going on over that issue. Far from unanimous support from his own faculty. So he really had his hands full.

WEEKS:

I've always been very fond of him. Maybe because he hired me, I don't know. But it isn't that. I like him very much and I still enjoy seeing him and talking with him.

GOTTLIEB:

I suppose I'm biased. The outcome is one of the reasons I left but he was by far the best man of the whole deal. In terms of an all around man, compassionate, extremely well read, and an extremely good intellect. He had good depth. He seemed to do, in those days, really well with the students. He had good political sense. I thin k he was, by far, the best all around person in the group. I'm sure that not getting that job ruined a really fine person.

WEEKS:

Yes, and I think to make it even worse, when he went to Pittsburgh, he stepped into a bad situation there.

GOTTLIEB:

Yes, but I think that by the time he got to the Pitt program it was, for him personally, it was too late. That's one of the sad events of my life.

WEEKS:

Because he really is a fine person.

After you had finished writing your part of Hospital and Medical Economics and also the HIF report, you began to look for a new job. I remember the days when you were trying to decide on what kind of job you wanted and you chose a Milwaukee, Wisconsin job -- it was a new agency, the Hospital Area Planning Committee, as I remember. Did I get the impression in looking at your C.V. that there were a couple of years spent in planning what the agency was going to be before you established it. I confuse it some way.

GOTTLIEB:

No, it was a new agency. All the planning had already gone into developing it. It was organized. I was just the first executive director to

come aboard. As a matter of fact, they had already hired a consulting firm to do a study of bed needs when I got there. But then it took some time for them to finish the study and for me to improve it enough so we could use it. It was a brand new agency but it was already in existance.

WEEKS:

Was it for several counties around Milwaukee?

GOTTLIEB:

At that time it was four counties, later expanded.

WEEKS:

Was this funded by the community?

GOTTLIEB:

Initially it was funded by the community in the sense of contributions from business corporations. Then shortly after I arrived the Hill-Burton program and the Hill-Harris amendment in 1964 provided for some federal money, grants to areawide health facilities planning agencies. We started getting some federal matching money. Those were the days when you got federal money you could do planning without strings. By the end of the first year it was 50-50, local and federal money.

WEEKS:

You worked with an advisory board?

GOTTLIEB:

We had a board, initially seven business men, later expanded to about fifteen. Through the first three or four years the board was all business men, gradually we added some advisory committees of physicians and hospital people. We did some other things to expand it. It was a project of the business community.

WEEKS:

You made recommendations to the board?

GOTTLIEB:

I did but we had committees.

WEEKS:

Did your group act as an advisory body to the four or five counties? What was your function?

GOTTLIEB:

It was purely advisory. We had no power other than having the big business community behind it. Unlike in Michigan there was no financial power behind it. In Michigan Blue Cross had the qualification program for participating status which included a planning criterion, namely that in order to get a participating contract a hospital had to be built or expanded in response to demonstrated community needs. The Greater Detroit Area Hospital Council then reviewed the project and made recommendations to Blue Cross. The Blues had the powers to exercise if they wanted to. We didn't have anything like that in Milwaukee.

WEEKS:

This sounds more like the old Pittsburgh program back in Bob Sigmond's day and Rufus Rorem's day when they had a bunch of heads of corporations get together and act as a board as to what to do. After all it was their money, probably, that built it.

GOTTLIEB:

Hospitals were looking for philanthropy in terms of capital contributions. We could have a certain amount of influece over that in a voluntary sort of way. But other sources of financing, other power we didn't

have. It was strictly trying to get things done through cooperative action. That was the approach so we learned a lot of lessons about planning, the relationship to power, and really, in a sense, how you had to go about it.

It really didn't do any good to have a direct confrontation with a hospital, by reviewing a proposal and saying yes or no. That was essentially a useless exercise. If you did that, you might win a few, you would lose more than you would win. It was too late at that point to sit down and talk about how something could be improved, to be of any positive kind of help, and to get any cooperative sort of support. By the time a hospital came in with a proposal to you that they wanted an endorsement of there was a big financial investment, a big psychological investment, a whole lot of things involved there. It could only be a confrontation. Most of the time you would lose because you didn't have the power. You didn't have enough control over the purse strings.

So you learned that if you wanted to do womething you had to get in a lot earlier. You had to be out there counseling with them, helping them think it through early before it all got cast into concrete. Then you might influence the outcome. That was when you could get in and say, "Have you talked to somebody else? How about a cooperative approach? Let's plan and talk about it." So that became the more common approach. Not that we didn't review projects, we did. Many times we said no, many times we had a fight. We even won one or two cases.

WEEKS:

But they could go ahead if they wanted to?

GOTTLIEB:

Sure.

WEEKS:

If they could raise the money?

GOTTLIEB:

Sure.

WEEKS:

But when you advised against it, this might have some effect on their contributions.

GOTTLIEB:

From some quarters. Business had gotten together because of the capital contributions. That was the reason most of those agencies got going was because business was concerned about the number of requests they got for capital contributions. The question was: How can we be sure this is really needed? That was the first question. The second was: If it is, can we space it out over time, balance it out, and so on? They didn't care much about health care costs. In fact, they didn't care about them at all. They were pretty shortsighted on that.

WEEKS:

It wasn't quite as much of a problem in those days. Costs were rising but I don't think they were quite as much in proportion, were they?

GOTTLIEB:

They were rising pretty fast. People were talking about health care costs from about 1928-1932. A lot of people talked about it from the point of view of...guys like me, you know the far-outers, the theoreticians, the cloud niners were saying that this is a world of finite resources; that there is a limit to what we are going to be able to allocate to health. Everybody would say, "Yeah, Sy!"

WEEKS:

You were there during the years that Medicare and Medicaid were coming in. This, as we both know, was a watershed. We probably didn't realize fully what was happening. We didn't realize how it was going to affect the financial situation. I think most of us would agree that it was good that some people were getting service who didn't before. You probably would agree with me that we need some means of controlling the machine that's running. When we find we have no brakes, it's frightening. The figures they have been quoting recently about Medicare: in 1966-67, the first year it was about four billion dollars, now it is a billion a day or more.

There was no federal participation at all in this planning process, was there?

GOTTLIEB:

In 1964 to 1967 you could get a federal grant, a Hill-Burton grant. They reviewed it and made a site visit and so on, but there were only two men in Washington to work on it, covering the whole country. By 1967 there were seventy such agencies around the country. So, it was very light-handed and they gave you the money. The site visits were to see if they could help you improve. You all learned from each other on the site visits. So you got federal money but there was no federal program. That didn't come along until the Comprehensive Health Planning Act (P.L. 89-749) was passed in 1966.

WEEKS:

There were no state agencies outside of Hill-Burton, were there?

GOTTLIEB:

No.

WEEKS:

Did you have any interactions with the Regional Medical Programs?

GOTTLIEB:

Yes, that came along in 1965. That went on along side of anything we were doing.

We would work together on some things, but mostly we went our own ways. Very little coordination.

I went to Milwaukee in 1964. We were about the tenth or twelfth to come into being. The first one was started in New York in 1938; Columbus, Ohio came along in 1945. Detroit and Rochester, New York came along at about the same time in 1956; Pittsburgh in 1959. Even when I got into it in 1964 it was still brand new.

I remember the very first meeting that George Bugbee put on at the University of Chicago. It was an institute for executives of areawide planning agencies. There were twenty-three people there and they represented all the health planners in the United States. There may have been two or three missing. It was literally that. George held that institute for the following seven or eight years. You could see it grow; you could see it grow in sophistication. It was all trial and error on how to do these things. They did them differently because it was a product of the community you were in. It was at the very beginning of trying to come to grips of how a community could, in some fashion or other, could provide greater direction in how resources allocated to health were used.

I look at things today -- planning or any other aspect of the field -- very complicated, very difficult. In retrospect it looked pretty simple, maybe it was compared to today -- the competing forces dealing with the health

issues. When you stop to think of those guys, whether it was Jacque Cousin in Detroit, Rufus in Pittsburgh, Hi Sibley in Chicago, or Martin Paley out in San Francisco, me in Milwaukee, or what have you, they were really pathfinders. They were trying to develop what amounts to, what we think is today a discipline, a solution of problems. That was kind of exciting to be in on the beginning of it and try to help shape it. That's an important part of it. We played a major role in helping people think it through. It was a unique style.

WEEKS:

The more I know George Bugbee, the more I respect his ability. At the first acquaintance you don't thin k of George as being that kind of man. He has a great ability to organize. As he said to me one time -- I think he was talking about his V.A. Forum and something was said about organizing one of his meetings -- "My goodness, I certainly should know how to run a meeting by now."

GOTTLIEB:

That's for sure.

WEEKS:

I was thinking of some of these persons. You were talking of Hi Sibley, for example. Before him I think it was Karl Klicka. Also I think of the early days in Pittsburgh. I think there is a change from the planning agencies built around the philanthropists, or the big executives and gradually a change to a more community-wide involvement. Then finally, of course, the federal government came in with their different approaches.

GOTTLIEB:

That's true, but some of us would say they are not all changes for the

better. As a matter of fact, I think when we look at the next mutation, the one that's starting now, some people seem to have come full circle; the development of the business coalition, the health care coalitions, and their kind of active planning or semiplanning role is really, in part at least, going to be a successor to the health system agency.

WEEKS:

In other words, you are saying the purchaser is going to come in and help beyond the planning stage?

GOTTLIEB:

Yes. He is going to be able to play a much more active role. The purchasers, the payers, and the providers. The consumers will probably play a lesser role. Whether it is good or bad depends on what you are trying to accomplish. I believe that the planning under the health systems agencies under the current government program and its predecessor have been failures in the sense of what did they do to change the health care delivery system or save money or do any of the things that were theoretical objectives. They didn't accomplish very much at all.

The responses I get from the consumer-oriented people are that they accomplished a lot. The consumers, the general public, got into the act. They had a voice. They knew what was going on. They had a chance to express themselves. They made decisions. The problem is that they made a lot of decisions, they expressed themselves on a lot of things, but they didn't get anything done. It was because the people who had the purse strings, the people, as I put it, who had authority to allocate and use resources were still making those decisions on the allocation and use of resources entirely apart from anything that went on in that process. So that, in my judgment,

didn't work.

If you were a consumer advocate, you believed that if you give it enough time eventually that consumer kind of movement will become effective. It was successful, at least, in giving them a voice, getting things out of the backroom, and giving them a voice. They would say it was a very successful program.

Now a lot more people are looking for harder results in terms of cost containment, or in terms of changing the system or whatever. They are not going to sit still for that and wait for the consumers' movement.

WEEKS:

The last time I looked at figures there were over 200 HSAs. I was wondering if there were 200 executives who knew enough about planning to run those.

GOTTLIEB:

That's a matter of some dispute.

WEEKS:

Getting back to chronology: You succeeded Jacque Cousin at Greater Detroit Area Hospital Council?

GOTTLIEB:

No. Gene Sibery. Then Bill McNary ran it for a couple of years as interim director. Sibery left to go to the Blue Cross Association in Chicago, and Bill McNary had just retired from Michigan Blue Cross and Blue Shield. Bill took it over as an interim thing -- he lasted for two years.

WEEKS:

You were offered the job and, I suppose, were happy to get home to Michigan again.

GOTTLIEB:

In some ways.

WEEKS:

I don't know enough about your Greater Detroit Area Hospital Council. My impression is that it is sort of a two-pronged outfit. One, it's a hospital association, and in another way a planning agency.

GOTTLIEB:

It's vastly misunderstood as to what it is because it's pretty hard to define it under the current circumstances or the current world. It originally was a hospital organization, going back to 1944 when it was formed as a small trade association. In 1956, business leadership, labor leadership, and the hospital leadership got together and basically reorganized it in its current form. What they did was take an agency that was, technically and legally a hospital organization -- we have hospital members, organizational members. You read the articles of incorporation and it looks like a hospital organization. We have a voting membership and about two-thirds of them are designated by the hospital members. in terms of ultimate control it is the hospital organizations.

Then they did the thing that makes it so unusual. They layered on top of that the characteristics of a community organization -- in these days you might call it a coalition. The board of directors, the executive committee, the planning committee. Then as the years went by -- policy, philosophy, practices -- they were basically centered around the concept of a community service agency. That's the best way I can describe it. For example, although two-thirds of our voting membership are designated by hospitals, the bylaws provide that only one-third of the board of directors and one-third of the

executive committee may be hospital executives. The other two-thirds must be public members. At that level, business pretty well dominates the policy making, the active decision-making power. That carries through the organization. That makes it very much a hybrid that's very hard for people to understand. Then add to that -- the name makes it sound like a hospital trade association.

Then we have some services we provide to our member hospitals -- education, some services to members that again are two of the three major functions of a trade association. But we don't represent hospitals, which is the other major function of a trade association. So, we don't serve as their advocate. We don't represent them in the legislature or by lobbying or anything like that. There is just enough of that so that again it gives the feeling to people that because we provide those services to members that we are a "hospital association."

On the other hand, there is all this planning activity, which was the original reason we were reorganized in 1956. It's the dominant thrust of the organization. In planning we call them straight on, we call them as we see them. We are very independent of member hospitals. We take very strong positions on issues they may or may not agree with. Everyone knows that.

That's the best way I can describe the complexity of it. It even carries through on financing. Hospitals pay dues. The dues revenues are restricted. They can only be used for services to member hospitals. On the other hand, the United Foundation, Blue Cross and private foundations contribute funds for planning. Those are restricted and cannot be used for membership services.

It's interesting. That kind of organization functions well for a long time, and could be pretty independent and objective, so I had a lot of

strength. In the last five years of that format it becomes harder and harder for an organization like that to really function well. The amount of polarization is too great to bridge the gap. There is too much of: if you are not totally for us you must be against us -- that kind of thinking.

We are currently going through some major changes just because we know we have to clarify the image of a community organization that has a different relationship with hospitals than a hospital organization. You can't have it both ways any more.

WEEKS:

How does the federal government impinge on you in HSAs and so on?

GOTTLIEB:

Again we are very unusual, but it's not unique. We organized the Comprehensive Health Planning Council of Southeastern Michigan back before I arrived, in 1969-1970, and since spun it off. It became eventually the Health Systems Agency with our support. The first five years, 1971 through 1975, we had a contract with them when they were the so-called B agency under which we did the health facilities planning. Basically we did it as we always had except we had to submit recommendations to their board for approval. That, generally speaking, at least from our point of view, worked out, from the point of view of our constituents, not from their's necessarily. We had that kind of a role and we were in a sense a part of what they did. While we had a lot of day-to-day sayings, it essentially worked out. The reason we had that contract was that when they were organized back under the old Comprehensive Planning Act they needed fifty percent local matching money. The United Foundation and Blue Cross said to them we will give you the local matching money under the condition that you enter into a contract with the hospital

council to do the health facilities planning.

Their reasoning was very simple. We were a known entity, had a good track record. They didn't want to lose the advantages they already had to this new organization with which nobody knew what was going to happen, or if it would accomplish anything. I am sure there were political reasons as well, but that was the essential reason. So we had that relationship, and when 93-641 was passed and provided for full federal financing for the Health Systems Agencies they didn't need the local matching money and they could tell us where to go, and they did it very promptly.

We decided by then not to fight it, we didn't want to get tied into the mess of 93-641. Since then we have kind of just operated along side of them.

What we've tended to emphasize -- it's been especially true the last five years -- is what I'd call constructive planning, trying to bring about change, to be an active agent, if you will. We work with hospitals, other health care organizations, and so on to change the structure of the delivery system. We work on mergers. We work on vertical integration — that's the current term -- we used to call them Comprehensive Community Health Centers. It's the same idea. We work on bringing about cooperation. And the health systems agency's primary task has been project reviews, providing advice to the Michigan State Health Department on yes or no decisions on certificate of need.

We've some pride in the things we have helped on like the capacity reduction program, where we did a lot of the thinking. Some things we'll fight them on -- the political world. But not necessarily from the point of view pertaining to the hospitals but because our perspective on the problem might be different. When I took the job in February of 1971, I didn't know at the time whether we would last a year. It has now been eleven.

Then after our contract with CHPC ended, we did a lot of soul searching and decided to try to continue in planning and everybody said well, we'll try, and watch it for a year -- now that we have a health systems agency. If there is still a place for the Hospital Council in planning. But you got to cool it. It apparently has proven that it has some value, after those eleven years.

WEEKS:

Is the future of HSAs rather bleak?

GOTTLIEB:

It appears to be. The current administration is, of course, anxious to pull out all support -- all federal support -- for that whole structure, HSAs, state planning agencies and so on. The law is up for extension this year. If it is not reauthorized by September 30, it will go out of existence. So there is currently a lot of political jockeying.

WEEKS:

Aside from the politics of it, has it really been successful? Does it deserve to continue, leaving politics out of it?

GOTTLLIEB:

Well, you get a lot of different opinions on that. My own personal opinion is no. It has been largely unsuccessful. It has been poorly done for a lot of reasons. A lot of the problems were inherent in the law itself and are so basic that they could not be cured.

Most of the providers, as they are now called, think it has been a failure. The business and the insurance industry and the Blues don't think it has been working very well but they've been a little reluctant to give it up just because they are afraid of losing all control. Their definition of

planning is really certificate of need regulation.

WEEKS:

I was wondering what would happen if HSAs went out, the state agencies would probably go also, wouldn't they?

GOTTLIEB:

They might unless the state chose to continue them for some reason. Those are still open issues, very hard issues.

WEEKS:

It's the state agencies that certificate of need goes through, isn't it?

GOTTLIEB:

Yes, the HSA plays only an advisory role.

WEEKS:

What about the connection with Blue Cross as to the qualifications for a hospital?

GOTTLIEB:

In Michigan, that went by the board. That program was operated from 1960 to 1972. Basically what happened, that program was based on the fact that the original Blue Cross enabling legislation in 1939, the law provided that Blue Cross may contract with any licensed non-profit hospital -- that was discretionary. So the qualifications program basically was built on that discretionary authority.

Then all the program did from a legislative standpoint for the Blues was to gradually build up enemies. They didn't really get tough with the program too often, not enough, but every time they did they just created enemies. You don't make any friends out of a program like that.

So in 1971 and 1972, there was an all-out attack to change the enabling

legislation to require Blue Cross to contract with every licensed hospital. They just took the word "non-profit" out of it. When it became apparent that the Blues were going to lose, then a lot of people began to say let's not destroy that without having something at least as good in its place and that's when they began to advocate a certificate of need law.

So a certificate of need law was passed in 1972 and tied to it was the change in the Blue Cross enabling law. So now Blue Cross doesn't have that discretion anymore. They must contract with every licensed hospital.

WEEKS:

Was that the time licensing went in?

GOTTLIEB:

No, hospital licensing was passed in 1968. Public Act 17, 1968.

WEEKS:

Your future depends a great deal on what happens to HSAs, I mean it could have an effect. You might have a greater role in planning, let us say, if HSA or some other agency is not here.

GOTTLIEB:

That's what I have always felt, Lew. Our future depends on our willingness to decide what we want to do and going ahead and doing it. I'm a strong believer in that, probably too strong.

We're looking, currently, and we're in the final stages, I hope -- we're looking at what does it take to have a strong organization that does planning in a broad sense and that really tries to do something to (1) change the structure of the delivery system where it needs it and (2) that somehow relates the decision-making processes involved in purchasing decisions with the decision-making processes involved in the supply and organization of the

delivery system. What can you do about that through a voluntary non-profit organization?

If the HSA lives or dies, as far as I'm concerned, really doesn't make any difference. It hasn't been a particularly effective instrument anyway. If it continues, it's just a continued waste of money and time for a lot of people. If it doesn't continue and there are things that they've been doing that the power in the community wants us to do then we'll probably have to do some of it.

WEEKS:

In other words, it seems as though you feel that your role is to be of service to the community in the health field and, if you can't be of service in one manner, there must be another way you can be.

GOTTLIEB:

Yes, that's it. It also means that you have to change with the times, and you have to be able to deal with the issues of the times. In this current environment of increased awareness of the scarcity of dollars, increased pressure in terms of dollars, the increased polarization of major interest groups, of policy confrontation on the part of all the major organized groups, of cut-throat competition, very expensive competition between hospitals, hospitals and physicians, and physicians and physicians, and all kinds of things, Blue Cross against commercial insurance — against health maintenance organizations. It's a world in which I happen to believe that there is a crying need to do an impossible job. That is to have somebody bringing these groups together around the same table to find the areas where they can cooperate and work together to solve the problems of health care and financing these organizations.

It's getting tougher and tougher to do. But I happen to feel that if we don't bring groups together -- now I'm not talking just about us, I would say the same thing for other major metropolitan areas -- if somebody doesn't do that then everybody will soon lose sight of why we operate this kind of health care system.

WEEKS:

You have had some seminars and other types of meetings trying to bring people together to discuss these problems, haven't you?

GOTTLIEB:

Oh, yes.

WEEKS:

You have focused on that a great deal. How do you relate to the Michigan Hospital Association? Do you find yourself complementing each other?

GOTTLIEB:

Not too often. In practice, yes, but not by design. I think we help them more than they help us and it's really not anything in a conscious sense. In a sense that we are a lightening rod for a lot of issues that would be very divisive among hospitals and the state hospital association would have a lot of difficulty dealing with if they had to do it directly. We take the heat and the brickbats and all that. So in that sense our existence is useful to them. We have no formal relationships. Most of the time we disagree on these issues. Organizationally, we have a lot of members in common, of course. The hospitals don't care about these things. Whoever can help them with their problem, they are going to go to for help. But it has not been a particularly good working relationship. And they have become a very effective organization from what I call the point of view of the narrow, immediately perceived self-

interest of a hospital, we tend to be more concerned with what I call the enlightened self-interest of hospitals and other participants in the health care scene.

WEEKS:

Here again, you are also quite different from the souuthwestern Michigan group, too, aren't you?

GOTTLIEB:

Which southwestern Michigan group?

WEEKS:

Isn't there a hospital group out in southwestern Michigan?

GOTTLIEB:

Yes, that's purely a trade association. There isn't anybody like us. That makes it an interesting and lonely place to be sometimes.

WEEKS:

Even the Cleveland Council isn't like it used to be, is it? Didn't they have a strong hospital council at one time?

GOTTLIEB:

Well, they still have a strong hospital council but they never did planning. There was a separate organization that did planning. Back in the old planning days. That has long since gone.

WEEKS:

Yes, I was quite surprised at how much planning was being done through John Mannix in his connection with Blue Cross there. They've done quite a lot of planning, not planning in the sense of planning hospitals as much as studying health needs for use in planning.

GOTTLIEB:

Yes, John has always been a strong advocate of that. Very active and forceful, and he still is, God bless him.

WEEKS:

Yes, he is a remarkable man. You take John Mannix and Rufus Rorem and Ig Falk and a few of those people, at their age and all they are doing, and it makes you feel lazy.

GOTTLIEB:

Well, I go a step farther. You talk about the use of your whole project. Maybe that's what happens when you get older. I look at some of those guys, whether it's John or Rufus, Jim Hamilton, Bob Buerki, Ron Yaw, and could name a few more, George Bugbee -- those guys were really giants in their time. They probably wouldn't be very effective now in the current environment. Styles have changed so much. They were really giants and they really contributed. They each made massive contributions, each in his own way and in his own part of the field. I don't necessarily agree with all of them, obviously, but I have tremendous respect for all they contributed.

My concern is that I don't see those kinds of people on the current scene. I just don't see any people who are making major contributions, I talk about giants in the sense of the stature of a Bob Buerki that was a figure all to himself. But the current scene doesn't seem to be able to stimulate the same kind of individual leadership capacity. People, who because they are there, really make a difference.

WEEKS:

Maybe the field is getting too big for an individual to stand out.

GOTTLIEB:

That may be part of it.

WEEKS:

I've talked with all those people.

GOTTLIEB:

You are lucky.

WEEKS:

Really, I think I benefit from this more than anyone else. I've learned so much from you tonight that I didn't know. I thought I knew something about things.

One of Rufus' ideas, of course, and I don't think it was original, I think other people had the same idea, and that's pool depreciation. Do you think that's ever going to come about? Legally I don't know whether it would be possible or not for corporations and communities to pool depreciation.

GOTTLIEB:

I remember arguing about that when we were doing the McNerney report. It's in there, it's one of the recommendations. I don't know whether we were original with that or whether Ray Brown and Rufus had talked about it before. We always thought we were original. We argued about that heatedly at that time. We ended up recommending it. I was on the losing side of that fight. Just because I felt that it was probably illegal.

WEEKS:

It might be unworkable, too. On paper it sounds fine. I don't know anything about law, but the reason I raised that question to you, as an attorney, is that it might possibly be illegal.

GOTTLIEB:

If all the participants, in the sense of the hospitals, all signed contracts agreeing with that -- you can agree to anything. But to force it on them from outside sources, their argument would be that you are taking away their property, especially if you are talking about depreciation since the technical definition of depreciation is an allocated return for a historical cost which you have already incurred. So it's just a repayment for a cost that you incurred some time in the past, in a sense. So they would argue, I think, heatedly and probably successfully that that's a taking of their property. So you have that. But then take that a step further on a pool depreciation thing -- we are currently very concerned about what's happening with the unemployed, what's happening with the poor, the chronically unemployed as well as structurally unemployed and inability to finance care, and how to get access to health services.

Well, you get access in two ways. Either you get it free, or somebody pays for it. If you get it free, then the providers eventually can't afford it. The more free services you have to give it gets to where there is only so much they can load on other people. Then on top of that, the other people are beginning to complain about the load and the loading factor. So the question then comes up, well, who is going to take care of the poor? -- or the unemployed?

Well, you can either do it by providing more money from some source, which in the current environment you can't do -- you can't reasonably expect. Or you redistribute the money you already have. So that the providers, for example, who are taking a large share of the responsibility, don't put themselves at such a financial risk because they are taking care of all the

people who can't pay. What's that? That says, let's take some money out of everybody's pocket in order to have it put into a pool so that, say, a hospital that has a large load of unemployed people on uncompensated care can draw on that pool -- to make it possible to provide medical care.

Do you know how far that argument goes in the current environment? After they get through calling me a communist... What you are really saying is, you are asking some to give up something for the benefit of all.

WEEKS:

You are trying to level the thing off, in other words.

GOTTLIEB:

Forgetting the social and political questions that are involved in it, it is really asking a lot. Especially when everybody is also under pressure.

WEEKS:

But it is a reasonable theory. It mathematically is reasonable. Humanly, it's reasonable.

GOTTLIEB:

And if we really still believed that the whole purpose of this health system of ours was to take care of people -- and give everybody an equal chance at a healthy life, then it would be reasonable too. But that's the problem, I'm not sure everybody still believes that.

WEEKS:

Somewhat similar to this, but not quite the same, is what Lowell Bellin told me about the city hospitals in New York. He said since Medicare and Medicaid have come in, those people who formerly might have had to go to city hospitals are beginning to go to better hospitals where they can be admitted because there is a payer. I think he believes that in time -- things

continuing the way that they are -- that the city hospitals are going to lose all those people and there won't be the need for city hospitals. They have closed some, I believe, in the past few years. But that doesn't take care of the unemployed or the people who cannot pay -- who do not have a source of payment — the people you are referring to.

GOTTLIEB:

Yes, John Knowles, when he was at Mass. General — I remember him telling me once -- at the time I was in Milwaukee and we were trying to decide what the future of Milwaukee County General Hospital should be, we were trying to, if not close it at least get it out from under county control -- and Knowles said, "Don't do it. Don't ever do that. It makes sense, it's logical, it would be much more cost-efficient, and so on but you are assuming then that if you do that the private sector and all the haves will always feel an adequate responsibility to take care of the have-nots. That is just not human nature. You have got to have that public hospital as a buffer against the depravity of the well-to-do."

I've tossed and turned on that issue for a long time. We helped move Detroit General Hospital, as you know, to the Detroit Medical Center and it is now owned and operated by the Detroit Medical Center Corporation -- not by the city of Detroit. A heck of a job to get that done but it is no longer a public hospital. The Detroit Medical Center made all kinds of commitments in terms of taking care of everybody regardless of ability to pay.

But the pressures of doing that are now fantastic in terms of having the dollars to do it with. One of these days they are going to renege on their commitment -- just because they can't afford to keep on. They are going to have to make a choice between whether they are going to take care of the well-

to-do and those who can pay for their care or are they going to take care of those who can't. They can do that one of two ways. They can either stop taking care of (or ration) those who can't, or they can start providing cheaper second class care.

About two years ago, we did a very thorough study of Wayne County General Hospital, another public hospital. That one is really badly managed from an accounting perspective. They are really throwing a lot of money away and it is really terrible. So we at that time recommended -- we were doing the study for the Wayne County Board of Commissioners -- we recommended that they lease the hospital to a non-profit corporation, or give it to a non-profit corporation to operate. We had a heck of a political fight and we lost.

That was just about the beginning of this recession. A few weeks ago somebody was saying we've got to re-open that question -- one of my liberal friends -- and I said, "No, I am not going to re-open it." I said, "I think I'm glad we lost, because I detect, among the private sector -- by well-meaning people -- but I detect a shift away from a willingness to accept the responsibility.

There are other factors, too. I remember when Medicare and Medicaid were passed, there were all these dire predictions about how private physicians' offices would be inundated with these public patients and public hospitals would close -- everyone considered that good -- teaching hospitals were wondering what they were going to do for teaching material and all that kind of jazz. I was one of the few that said -- my chief decent quality has been that I have very good predictive capacity -- I was one of the few who said wait, it's not just a financial question, it's a social question too.

We had occasion, it must have been about '68 or '69, we were looking at

the statistics for the outpatient clinics at Milwaukee County General Hospital for some study or purpose or project we were on, and it followed just about the course you would expect. In the first year after Medicaid and Medicare came into being, the volume of outpatient visits at the county hospitals started to go down in almost a 45 degree decline — the first year or year and one-half -- as people who had now had freedom of choice were flocking to private physicians and private hospitals.

Then gradually, after about eighteen months of the program, it leveled off and began to creep back up. By 1969, I guess it was when we had finished this, the volume of outpatient visits at the county hospital was higher than it had been in 1964.

WEEKS:

What do you think caused this?

GOTTLIEB:

It was basically social. Social in a lot of ways. They went to physicians' offices, they were rushed through, they didn't feel comfortable. The physicians, many of them didn't really want them, especially at the bottom end of the ladder, all kinds of social/cultural problems that didn't fit well in the private sector. There was an interesting phenomenon that we found in going out -- some of my staff did, I never got a chance to -- going out and talking with people who are sitting in the waiting areas. The county hospital -- there were no appointments -- typical old fashioned county hospital approach -- they didn't have appointments so they would come at eight o'clock and they would bring their sack lunches. They didn't know whether they'd get seen that day even. But the waiting room was a social place. They didn't mind that at all. They would talk to each other, they had a lot of

friends there that they had made because they were all out there quite often and they had missed that in the private sector. Especially for the older folks who didn't have anything else to do anyway really.

They would go out there and they didn't mind that if at four o'clock somebody would come out and say, "We aren't going to take any more patients today, come back tomorrow."

There are all kinds of social and cultural patterns that have as much influence on what people do as the dollars. The fact of the matter is, I'm really concerned about the current environment, this current "I'm going to take mine while I can get it" mood of the American people. Sure, everybody's got problems. You always have to fight like hell to take anything from the middle-class and give it to the poor and the less fortunate.

WEEKS:

Including Social Security. I know I'm getting more Social Security than I would have earned on an actuarial basis if I had put it in insurance. I would much rather receive what I should according to an actuarial account. Then if somebody needs more than they are getting... I still believe in the means test if there can be found a decent way to do it. If people need it, they should get it but people who don't need it, shouldn't especially get it.

GOTTLIEB:

Yes, but you are a student of history now and you have to put Social Security in the context of the times in which it was passed. The idea that it was a social insurance, principally, that was available to everybody on an equal basis. That took us at the time of that depression and, in a sense, no matter what happens to you and who you are this is not the means test, this isn't degrading -- you have paid for it and you are all going to be treated

equally. You down there in the construction trade, which was pretty low down in those days, are going to be treated the same as Mr. Got-Rocks. It was a product of its times. Can we afford to give it up now?

WEEKS:

No, I don't mean give it up. What I would like to see is a person like myself who is getting more than he deserves according to the insurance principle — I'd like to be paid on the insurance principle. Have everybody paid that way and then if people need more, I would rather give them the bucks that I don't need.

GOTTLIEB:

Have you included Wilbur Cohen in your interviews?

WEEKS:

Wilbur is a fine person and I like him very much but he has a simple answer. He looks at the benefit side and when I said, "Well, how can that be paid for?" He said, "Take it out of the general fund." That's his answer. I don't think it's that simple. We know it isn't.

GOTTLIEB:

Of course not. He knows that too.

WEEKS:

I think he is a fine human being and I like him very much but maybe I'm too hard-nosed about the fact that someday we've got to pay the piper.

GOTTLIEB:

I think that's a very complicated problem. We've gotten soft. I don't know how you solve it in the political world.

WEEKS:

No. It's going to be a very unhappy situation. Maybe somebody like

Reagan -- I said somebody like him as far as age and willingness to serve on term -- would be willing to take that risk if he thought he could accomplish something good. I don't want to see Social Security taken away from people who need it.

GOTTLIEB:

No, I understand that's what you are saying. I was only reacting -- I'm a bit of a student of history, not as much as I used to be -- I am a great believer that you have to put things in a historical perspective. You can't talk about changing anything unless you really understand what it is now, what it is that you are trying to change.

I find that in planning all the time. I drum that into my young staff all the time. You learn it in law school. That's interesting. One of the things you learn in law school, certainly in litigation -- several points along the way -- the really good lawyer always starts to prepare his own client's case by thoroughly understanding the other side's case. First you understand the other side then you can prepare your case. If you don't thoroughly understand the other guy's case and what all his facts are and what their probable interpretations and background and so on, then you can't do a good job for your own client.

The same thing is true, or in way of an analogy, the same thing is true when you are talking about changing a social structure. Improving the health system, or financing or so on. You had better darn well start by being sure you understand what you've got now. And in order to do that, I am a strong believer, you got to understand the history of how it developed.

Not so long ago, Herb Klarman asked me if I would give him some ideas on what a curriculum in health planning ought to be like. So I told him I would

have to think about that and I would write him a letter. And I did. I gave him what I thought the elements of a curriculum in health planning ought to be. I told him at the end of the letter that I was sure that he and anyone else who saw it would laugh like mad because it was way far out -- crazy. But I really believed everything I had said. I think I listed ten elements and what they all are is not important. But the first was history -- the history of medicine, the history of hospitals, the history of health care financing, the history of health planning and all in the context of social and political history. That was the very first ingredient as far as I was concerned.

Second was ethics. The understanding of formal ethics, theories of social justice, comparative cultures and all the things that are in that. I went down the list and way down at the bottom was the one everybody else always lists first. If you still have time, you can teach them something about quantitative data.

WEEKS:

Did you get a reply?

GOTTLIEB:

I think it got a lot of interest. It got a lot of interest here too, from John Griffith and Howard Zuckerman, and the people over in MCO. It has gone around to quite a few universities. I don't know whether anybody's doing anything with it but it got a lot of attention.

WEEKS:

Along that line, Columbia is, I guess, trying some joint degrees. A masters in Public Health plus a masters in Urban Planning -- a joint degree. I don't know whether they get into hospital planning.

GOTTLIEB:

I don't know. I haven't heard the thing's going.

WEEKS:

One thing I was going to ask you about your year with Ron Yaw. Was that at the time they were setting up the Council of Teaching Hospitals? I've heard somewhere that he had something to do with the origin of that.

GOTTLIEB:

It must have been after that because I don't remember it. I was there in 1956.

WEEKS:

I've never really looked up the year that that was founded.

I read that paper that you sent me that was your annual report of 1980 in which you were looking at the future and making some recommendations for the future. I was wondering if you have any feeling as of today about what's down the road for the rest of the decade?

GOTTLIEB:

I don't know. Most of the things that I said in that still apply. In fact, some of them are already turning out to be true. The thing that is on the horizon that is not particularly covered in that approach is the impact of the overemphasis on economics, the viewing of the health care provider organization in terms of an economic model. That is implied in terms of competition, in terms of profit centers, of making decisions based on their revenue-producing characteristics rather than their expense-reducing characteristics, of creaming, and of dual class health care. I think that is the most dangerous thing on the horizon. I think that we are moving very rapidly in those directions fed by the pressures from the purchasers.

WEEKS:

Jim Hamilton used the expression "rising expectations" implying that people today are expecting too much -- in many cases -- they are expecting too much in health care. I don't know whether anybody has looked into that side of the question or not. Are we expecting too much? Because we have Medicare, do we go to the doctor more frequently than we need to? Or are doctors telling us to come back more often than we need to? Or, as we know in defensive medicine, are they ordering too many tests? Are they using the high technology apparatus more than they need to? Are they doing it because it's a new toy or because it's the thing to do?

Yesterday when they reported that Hinkley's brain had been under x-ray and it was smaller than usual, the implication was that because it was smaller he might be abnormal. Yet, I remember reading sometime that one of the largest brains ever recorded in history was that of an idiot. So the size of the brain necessarily does not mean -- cannot be correlated with intelligence.

GOTTLIEB:

We know for sure that size doesn't correlate with intelligence but there is some evidence that size of brain, among other things, has meaning for those who are becoming more and more convinced that schizophrenia basically is organically caused. That is where the evidence points. This big fancy new PET that we're getting here in Ann Arbor, heaven help us, is probably going to give us a lot of clues in that arena.

I don't have any doubt that there is too much utilization of a lot of things. But then we go at it with a meat cleaver and you remember in the Michigan study of hospital economics our conclusion in the effectiveness of the study basically was, yes, there is an overutilization and there is some

under-utilization. In those days people worried about that. Nobody worries about under-utilization very much these days.

We know that if you reduce people's access to care by deductibles, co-insurance, not making financing available, that they will use less care. That may solve the overutilization problem. What we said at that time, what we didn't know is, if you put barriers in the way of people getting care, whether that meant they were not going to get care they didn't need or that they weren't getting care that they did need.

WEEKS:

This is a ponderable question and I think that we are also saying that we don't know whether it would be good to have somebody who could say this has to be done or this can't be done or whether we try to do it on a sort of consensus basis by getting together and trying to make our decisions in a humane way rather than having a big government agency saying you've got to do this or you've got to do that.

So what we are trying to do, I guess, is solve our problems without bringing the government in.

GOTTLIEB:

Well, I don't think that's the real key. I don't think government's done a much better job than anybody else has, in fact worse in many ways. The real question is not whether it's government or private, at least not to me, the real question is whether you bring some degree of rationality into the process by which you look at the issue. We tend to leap to conclusions that "this will work" and therefore we do it. And it is usually single issue oriented or single solution oriented. The current solution, everybody says, is cost sharing. If you put deductibles and co-insurance in so that people are aware

of what they are buying that they'll use less in the way of health services. They'll only use them when they need to.

Even assuming from a labor/management negotiation point of view that that would be successful, it's looking only at a tiny part of the problem. It really comes out to be cost-shifting more than cost-sharing, and it doesn't really look at how you focus that. For some groups in society that may be a worthwhile thing. For older populations, it may be a terrible thing, and yet, you've got to do it to everybody. It's a question of whether you can get people to look at these issues in a reasonably balanced way.

A friend of mine who happens to be an officer in Blue Cross/Blue Shield in Michigan went to the hospital yesterday for what we loosely call open-heart surgery, coronary by-pass surgery. This is a guy who attacks hospital costs every day in his working life -- really after them, especially the high cost hospitals. He's very good and I have a lot of respect for him but he works in that environment and believes it strongly and he is really out after them.

Now, first of all there is a lot of evidence that coronary by-pass surgery ain't worth a pot to piss in, forgive the expression, and he ought to know that. Second, I happen to know he didn't bother to get a second opinion for the surgery. Even though they mention that like hell in the organization. Third, he went to Henry Ford Hospital, one of the three highest cost hospitals in the state of Michigan. Because, where his health was concerned, he ran out of logic.

In a very tiny microcosm that's what we're involved in. You've got Ford Motor Company saying, "Our health care costs are too high, we've got to do something to control them." Putting a lot of pressure on. How many Ford employees, from the lowest level to the president of the company really

believes that they want something less in health services, or that there is anything fundamentally wrong with what they are getting now? Very tiny proportion.

I am theoretically a pro, so I think there is a lot of overutilization and unnecessary admissions and a lot of things that could be done. But that's my elitist point of view, and even that is tempered, because I'm an elitist by saying -- but I know all the complications of doing it, and how these things are interrelated. You look at all that together and nobody really wants to do that. It's too difficult, too slow, they think. Their methods would make it even slower -- won't work. I'm not saying that mine would but at least I'm saying, okay, I've got to look at the product that we have in terms of cost, which is what everybody wants to talk about. But I also want to look at the product in terms of health care and health. It is the product of the interdependent behavior of consumers, providers, payers, purchasers. They all operate on each other. It is an interdependent kind of behavior. To assume that you can attack one point and leave the others constant and have anything happen is ridiculous. What does happen when you attack one point is that it bursts out someplace else.

To say we're going to control utilization by controlling the providers doesn't make any sense. It won't work. Nobody else will stand still for it. To say we're going to do it by imposing cost-sharing on the consumer means it isn't going to work either because it's going to burst out someplace else.

WEEKS:

They'll get insurance to cover it.

GOTTLIEB:

Of course.

WEEKS:

Do you have any particular reason, any possibility, any hope for health education to be effective? Can anybody convince us that we shouldn't smoke cigarettes? That we shouldn't drink too much? That we should take more exercise?

GOTTLIEB:

I suppose. In a very long-term sense we've seen some signs of it, not in cigarettes, but we certainly see a lot of people jogging out there. But I'd rather take the money that we are currently spending for "health education" or health promotion and hold off on using it for that and just turn it in to research on how to motivate people in the health arena and the life-style arena and so on. I don't think we know enough about how to do it.

WEEKS:

We probably have to do that before we can do any good promotion, I agree with that.

GOTTLIEB:

I'm one who would much rather zero in on the things -- in terms of prevention or health promotion -- zero in on the few things, with the limited resources, the few things we know we can do something about. We can do something about hypertension. So we should. We can do something about diabetes, so we should. We probably can do something about alcoholism, so we should. Pick the four or five or six things that are specific where we know that something can be accomplished and it is going to have a specific result. Rather than worry about obesity in general or smoking in general because I don't think we know enough about those things.

That means we have a lot of emphasis in those areas. We just finished a

study of end-stage renal disease programs that will go out next week, I think, if it's approved. Clearly, it now costs about $1,200,000,000 a year for end-stage renal dialysis. Almost half of that has been for patients who have developed the renal disease out of hypertension. So if you really did something about hypertnesion, you not only save the kidneys and people's lives and a whole lot of other things, but there's a nice specific kind of end result. We know enough about how to detect and control and even help educate people to control themselves in hypertension. We could make some headway.

But I'm not sure everybody wants to spend too much energy on hypertension because the incidence is about ten to one among blacks as whites.

WEEKS:

Talking of blacks and health. I should have known better, too, but I didn't. I hadn't thought of it. Haynes Rice was telling me that TB is a big problem in the inner-city in Washington.

GOTTLIEB:

I hadn't heard that in a long time.

WEEKS:

TB and venereal disease are the two big things, you know. Like all the rest of us, I had assumed that TB was almost gone. And he says, those people don't stay all by themselves, they mix with the white community too.

GOTTLIEB:

Yes, that's what the white community forgets.

WEEKS:

So a health problem, even if we are not directly affected, may indirectly affect us through other people who have it.

Anybody that you have been associated with, worked with or known that you

want to say a good word or a bad word for?

GOTTLIEB:

I don't know of anybody I'd say a bad word for.

WEEKS:

I didn't expect you would.

GOTTLIEB:

I don't feel that way about it. Like everybody else, I've had my hard knocks and rough times and fights and battles. In all my years, to be perfectly honest about it, there are only two people that I've ever had that kind of battle with that I ever have felt I'd like to get even with and I still feel that way. Yet, interestingly enough, once a few years ago I had a golden opportunity to get even with one of them and I couldn't bring myself to do it. And I really had the chance.

The others, even with the hard knocks, generally speaking end up friends afterwards. Or at least you get along with them. I don't have those kinds of feelings about people.

I've had so many good people, though, that have been a positive influence and I've enjoyed knowing. I mentioned a lot of them, though not all of them.

McNerney and Yaw and Connors and Mannix, Bugbee, Rufus, Steve Severts, who is in New York now. I couldn't begin to list them all. Many of them had very strong, positive influences on my life and really did things. They were risk takers. They were willing to stand up and be counted. And they made a difference.

WEEKS:

You can't help but be better for it for having known them and worked with them.

GOTTLIEB:

Hell, that's what it's all about.

A funny, kind of reciprocal thing. A couple of weeks ago I got the Corning Award. When they first told me I had won an award, it was really kind of hard to sound enthusiastic. It was nice and I freely admit that but it would be difficult to get up and say "whoppee." I tried to say the right things and so on. I really sort of took a cavalier attitude, and then the letters of congratulations started coming in from all over the country and some other parts of the world -- two or three hundred of them. Some of them were very perfunctory but some of them showed so much warmth -- who cares why they wrote them, the feeling was there, and gradually you just got caught up in that...there's a lot of warmth.

Then you go to the award ceremony and somebody talks for fifteen minutes about what a great person you are and five hundred people out there staring at you and you are trying to look nonchalant and modest and all that. Then you get up to give an acceptance speech and five hundred people stand up and applaud you. You'd have to be pretty inhuman not to begin to be affected by it. An interesting experience. It isn't the first award I've had but it's the first time I've felt that way.

WEEKS:

There are a lot of people out there that think a great deal of you, there's no question about that.

GOTTLIEB:

My acceptance speech was to mention basically about ten people who made a contribution to me -- so that's why I raised it.

WEEKS:

That's wonderful.

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WEEKS:

I wish to make a note of hiatus. The original interview took place in Ann Arbor on June 3, 1982. Due to some difficulties with transcriptions and taping the oral history was not completed at that time. However, finally on July 17, 1986 the oral history was completed. In addition to discussion of earlier events the present manuscript contains material on the hiatus period (in the pages which follow) particularly about the recent reorganization of the Greater Detroit Area Health Council (as it is presently known).

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WEEKS:

Sy, it has been four years since our first oral history taping. I would like to ask you about your special activities. I would like to have you talk about those developments in those four years. Finally, possibly you would like to look ahead for a decade or so and tell us what you see down the road. However, I won't hold you to that.

Some of the activities I have noted. Earlier you served on the Wisconsin Governor's Task Force on Medical Education, didn't you? Did that have some impact?

GOTTLIEB:

It had a lot of impact. At the time I was the volunteer staff. I was drafted. At the time I was running the Hospital Area Planning Committee in

Milwaukee. Three of us were drafted. Bob Coye, who was then Associate Dean of the University of Wisconsin Medical School. There was a third one whom I forget now. We were drafted to be the staff for the governor's task force. The problem that had led to it was that Marquette University School of Medicine was in serious financial trouble. The university was at a point where they thought they could no longer afford to maintain it unless they could get some help from outside. They were then in somewhat of a conflict with the University of Wisconsin in Madison because they were looking for state money. Wisconsin also had a strong constitutional limitation against church-state relations. Marquette was a Catholic university. The University of Wisconsin in Milwaukee branch also wanted to start a medical school. So part of the strategy of trying to resolve all these things was that the governor appointed the task force and we staffed it. The whole idea was for them to come up with some rationale as to how many medical student places were needed, how many schools were needed, and, hopefully, how this all could be financed. So each of us did some major background papers. I did one on how many doctors do we need. I think my answer was that the number was infinite depending on what you did with them. I did another one on the organization of medical practice. Bob did some, and so forth. Then we generally staffed the task force. It was a series of activities that finally got good results. Other things were involved, and a lot of other people were involved, especially the Milwaukee business power structure.

WEEKS:

Did you get any help from the AAMC?

GOTTLIEB:

A little. A very little.

What finally happened was that it was agreed in order to provide state money for the Marquette School of Medicine that the school would have to be separated from the university and become a separate school of medicine, an independent college. The university finally and reluctantly agreed to the proviso that the independent wasn't to be taken over by the University of Wisconsin. There was agreement on the number of students that each school should have. The brewery industry in Wisconsin made the major sacrifice. They agreed to the doubling of the tax on beer in Wisconsin that was significant. They allowed a one cent a barrel tax on beer in 1934 after repeal, and the beer tax had never been raised. This was 1967. They had managed to keep that from happening. They agreed to let it be raised to two cents providing the increase was dedicated totally to medical education. This is what the legislature did. At that time they raised about $35 million. It saved the school of medicine in Milwaukee. The task force was a very useful part of that total mechanism. I really enjoyed that.

WEEKS:

I also have a note here of your work with the HEW Bureau of Health Services Research.

GOTTLIEB:

That was kind of intermittent. I did a lot of consulting, the one and two day variety -- come in and help this committee, and so on. Back in 1969, I think it was, a conference was held to talk about data needs in the health field, a very extensive conference. I was asked to contribute a paper on the data requirements of an areawide health planner, which I did. That, in a sense, made me one of the key participants, along with about a dozen others who submitted papers. I didn't realize until it was almost over that there

was an agenda and it was very political. I didn't know data was so political. That was what led to the concept of developing the uniform hospital discharge data abstract. So several of us continued to work on various committees of HEW at that time for what seemed like years to gain an agreement on a uniform hospital discharge data abstract. I think it took ultimately about 14 years to get that. I served on one committee or another, and developed one text or another for at least 11 of those 14 years.

WEEKS:

Your work with the Association of Areawide Health Planning Agencies. I don't know anything about the goals of the agencies. Were they looking for representation? What was their reason to be?

GOTTLIEB:

That was another interesting thing. Maybe Sigmond talked about it. I think I talked a little about this in the original interview. Back in 1963 George Bugbee held a conference meeting at the University of Chicago for the executives of areawide health facilities planning agencies. That was the first general forum of local planners that we had in this country. It started in New York City in 1938. That was the first one, then Columbus, Ohio had one in 1945. There is some dispute whether Rochester, NY or Detroit came next. One after another they came along. By 1963, and, of course, George had always since his days with the Commission on Hospital Care had an interest in that subject. So he held this seminar in 1963. All the planners in the United States were there -- all 23 of us. That was just about all of them. Bob Sigmond, and Hi Sibley, Gene Sibery, Jack Haldeman from New York, Joe Peters, and a few others. So George held that every year until about 1970, which I think was the last one. Prior to 1964 all those agencies had developed

locally, entirely with local money, and each had taken off in its own way for its own purposes. Then in 1964 the Hill-Harris amendment to the Hill-Burton Act was passed. That provided some money under section 318 to provide some financing, federal financing, for areawide health facilities planning agencies. It was very nonspecific in the way the program was run. Very loosely, they gave you the money and you did what you wanted to. It was kind of nice. So they were called areawide health facilities planning agencies, sometimes 318 agencies, a common terminology. Naturally then, as the number grew, there was a move to have an association.

I think in about 1965 or 1966 Jack Haldeman and Bob Sigmond and a couple of the others decided to form an association of areawide health facilities planning agencies. Then at the end of 1966 the Comprehensive Health Planning Act was passed. Nobody knew what it was or what it was going to do, but everybody knew they had better be a part of it. In local communities all over the country, in the big cities especially, where there was a 318 agency there usually was a fight going between the 318 agency and other forces in the community over who was going to organize and control this new thing, whatever it would be, a comprehensive health planning agency. The fight was different in different communities. There was always a fight, keeping in mind that this was the height of the 196Øs period so you had a lot of activist groups that had not been in power before and were seeking power. The areawide health facilities agencies basically represented the establishment. That was the way they were originally organized. In the effort to try to bring those things together we reorganized the Areawide Health Facilities Planning Association. That would have been roughly at the beginning of 1969 that we did that. Some of the same leadership were still there, some were moving into other things.

Some of the leaders were transforming into areawide health planners which would reflect the Comprehensive Health Planning: Martin Paley, Ed Lentz, Jerry Ransehoff from Cincinnati, John Donaher from Dayton, Steve Sieverts from Pittsburgh who was in the process of getting ready to take Bob Sigmond's place -- and I was in on it. In 1970 I was president of the association. At that time we had, considering the small size and relative lack of power, we had a fair amount of influence on amendments to the legislation, getting adequate funding on it from Congress.

I have got to tell you this one. I still remember. It was in 1969. Nixon was inaugurated in 1969. In the spring of 1969, Martin Paley was president of the association. We sat around one day, you know as you do, with your feet up -- Ed Lentz, Martin and I, I think -- we were talking about how we could make an impact. Someone suggested -- I don't know which one -- "At the local level with our comprehensive health planning we are trying to bring together all the major interest groups into a single organization and get them to work together. Why don't we try that at the national level? Nobody has ever done it. Why don't we try to get all the major national organizations together to talk about how we can work together on a national basis on comprehensive health planning?

We laughed and then we said, why not try it? So we made a list of them. That, of course, included the American Hospital Association, the American Medical Association, the Blue Cross Association, the Health Insurance Association of America, the United Ways of America, the American Public Health Association, and three or four others. We divided the task up and decided we were going to have a meeting on a given day. Through McNerney we got the Blue Cross office in Washington for a meeting room. We invited all these

organizations to send representatives to our meeting. That needless to say caused a lot of talk. What were these guys up to? Should we go? Just about everybody was afraid not to send someone. They didn't send high level people necessarily, but they sent somebody. Before we knew it we had a meeting. Then we started worrying about an agenda and all the usual things.

As luck would have it, as we were talking on the phone one day, Martin and I, Martin said, "As long as we are going to be in Washington, would you like to go see the new Under Secretary for Health?" This was very early in the term, March or April.

I said, "Sure, why not? It would be a good idea, but how do we get to see him?"

Martin said, "I know him. He's from California. I think I have contacts to him. Maybe I can get us an appointment." He worked it out and arranged an appointment.

We were going to have our meeting on a Monday -- I vividly recall it -- he set the appointment up with the Under Secretary for Monday afternoon, at four o'clock. We went to our meeting. It happened that the meeting was held the same day as Eisenhower's funeral. The meeting started. Martin talked, I talked, Ed talked, everybody else kept quiet. It was like pulling teeth to get anybody to say anything. The tension in the room was extreme. They couldn't really understand what they were doing there, and whom they could trust and so on. Who were these guys anyway? About eleven o'clock, a secretary came to the door to talk to Martin. So I took the chair while he went over and talked to her.

Martin is a very bright guy. He said, "I am sorry to interrupt you, Sy. The Under Secretary is on the phone. He has to cancel our meeting for this

afternoon because he has to go to the funeral. Could we stay over until Wednesday morning? He would still like to see us. He would give us an appointment Wednesday morning."

I said, "Sure, why not?"

All of a sudden you could feel the bustle in the room. We had really lucked into it. What we didn't know was that for the first three months he was on the job -- and we were in the third month -- he had refused to see anyone from the health establishment. We were the very first ones. Other people had been trying to get in and couldn't. Our stock went up 1000% From then on the meeting was cool. Then to make matters better we said that as long as we had two days we would make some appointments with lower level HEW people. The word had gotten out that we had organized this meeting. We were coming to the meeting representing the 12 most powerful organizations in the business and we got the royal welcome. Talk about lucking out, that was a fun time. It carried us in good stead for a couple of years.

WEEKS:

Who was the Under Secretary?

GOTTLIEB:

I can't remember his name now. A nice guy.

WEEKS:

Fame is fleeting. You learned your way around Washington then.

GOTTLIEB:

Yes, we learned our way around Washington.

WEEKS:

How about the League for Nursing? I have you down for both the Wisconsin League and the National.

GOTTLIEB:

I was active in that for a while both in Wisconsin, where I was on the board, and on the executive committee for planning of the National League for Nursing. I didn't really do too much in that. I was part of a group that was brought in to, in a sense, have the National League be more responsive to the interests of people other than nurses, and also have other people contributing to what they were trying to do for nursing. It was an important movement for a while. I made a little contribution.

WEEKS:

This might be a good time to talk about the nurse's role. I have talked with nurses all the way from Faye Abdellah down. I have had some interesting responses as to what they believe the educational requirements should be, whether there should be two kinds of registered nurses, or whether they should build up the licensed practical nurse so that she could become a second level RN. I also have run into the question about the nurse's duties. Can she have some independent judgment in taking care of a patient? She might know how better to take care of a certain kind of a patient than the physician would order her to do. All of that kind of thing seems to make the nurses kind of restless and unsure of themselves. Did you notice anything of that sort?

GOTTLIEB:

They have always been unsure of themselves, at least in my experience. Their role has always been unclear. I don't think those were the particular issues when I was active in administration. I was in several jobs, but I have gotten so far away from that now that I really don't have too much to add. Those were points of view that have gradually evolved. My concern for the moment is the cost of what nursing is proposing to do can be huge. It doesn't

mean that they are wrong. In a period when the whole system is cost-driven, everything we are doing is pushed by the cost issue. It doesn't seem the time to upgrade the standards and to create another nursing professional, create another fee-receiving professional. I think those things are in direct conflict with the cost containment mode we are in.

WEEKS:

In line with that, I don't know how many nurses in Michigan are in independent practice. Occasionally you see something in the local newspaper about independent practitioners among nurses. Now and then you read something about a midwife. I don't kno whether midwifery is ever going to come in. All the OB/GYN people will have to pay too much insurance and they will go out and leave their...

GOTTLIEB:

They may, except the midwives are finding it difficult to get liability insurance, getting any coverage. It's even tougher for them than for the doctors.

WEEKS:

I would think that, yes.

GOTTLIEB:

I don't know how many midwives there are in Michigan. The number is not big, you know, independent nurse practitioners. There is legislation currently pending that would require insurance carriers and Blue Cross to pay nurse practitioners on a fee-for-service basis, just as they are paying physicians. I don't know how far it is going to go because it has the ring to it of mandating that as a benefit. Business, labor, and the insurance carriers are strongly opposed to any mandated benefits. But currently it is a

hot issue in the Michigan legislature. Some states allow that or require it.

WEEKS:

A wild thought just crossed my mind. I wonder if any of the HMOs have midwives.

GOTTLIEB:

Not very many. I think some of them use midwives for some purposes. The same as with a nurse practitioner -- under supervision of a physician. They may or may not directly pay them a fee. It varies. There isn't much of it in Michigan as far as I know.

WEEKS:

I haven't heard of it either but the thought crossed my mind. You have done some teaching along the way, haven't you?

GOTTLIEB:

From time to time. I have been on several faculties. I have never taught a whole course, usually sporadic lectures or seminars. Depending on where I was, it might be one in a semester, or a half a dozen. I did that at Marquette University in Wisconsin, the University of Wisconsin in Madison, the Harvard School of Public Health, Cornell, the University of Michigan, Wayne State University. I still do some of that. It depends on how well I get along with the faculty.

WEEKS:

You served on several committees of the AHA. I have a note that you served on the AHA Committee for Health Care for the Disadvantaged.

GOTTLIEB:

That may be the most interesting one that I served on with AHA. That came along at the end of the sixties. AHA was being picketed, threatened.

Board meetings were being picketed by militant black leaders and some extremists. Ed Crosby was very concerned about it. Ed cared more about that subject than many of his members did. So he, in a hurry, got the board to agree to set up this committee. It was a committee appointed by the board, and reported to the board. It was a mixed committee, which was almost a first for AHA. At least, it was the only one I remembered.

WEEKS:

What do you mean by mixed committee?

GOTTLIEB:

It had some hospital execs, who were powers in AHA, some good ones, some hospital association head folks. It also had some blacks, some people from the NAACP Legal Defense Fund. It had a few very militant people. It had a couple of economists with different points of view. So technically it was a committee of the board of AHA, but it had that kind of mixture of people.

It was that group that developed the patient's bill of rights which for its time was considered a very explosive document. We worked for months -- I can't tell you how many meetings, I can't remember how many but I can remember periods when we were meeting twice a month and were going over it word by word trying to come up with something that would satisfy the minority community, the consumer community and at the same time that you could get by the conservative hospital establishment. It was a hell of a fight. It went up to the board, they referred it down to the councils and back up to the board. It got kicked around for a while. Lawyers looked at it and they got scared. Ultimately the pressure of the times -- I don't remember exact dates, but it took a couple of years -- got the AHA to approve the statement. They encouraged hospitals to use that or a similar statement. It is called the

patient's bill of rights.

They were always afraid it would be built into legislation or regulatory devices. That didn't happen for a long, long time. In the last two or three or four years, in a few states, that has occurred. In a lot of discussion it has been said that if you have a patient's bill of rights that you also should have a patient's bill of responsibility. That would balance it out. For its time it was very enlightened and far seeing.

WEEKS:

Was this at the time the thought originated that everybody had a right to good health rather than as a privilege?

GOTTLIEB:

That goes back to President Lyndon Johnson's speech when he signed the Medicare bill which I think was on March 1, 1965. In his speech at the signing he declared that the access to high quality health care was a right. This was near the beginning of the turbulent sixties. The bill of rights came later, 1970-1973. This was more about your right to know what the treatment was, your right to know what options you have, the right to privacy within the hospital, a whole variety of things of that type that shouldn't have even been issues. But the way care was, and to some extent still is practiced in hospitals, the patient is an impediment to the hospital because they get in the way, too often.

WEEKS:

You were saying that Ron Yaw ran a hospital where there was great feeling for the patient. That then was probably outstanding, wasn't it?

GOTTLIEB:

I think that was true, yes.

WEEKS:

I don't know whether your other AHA committee assignments were as interesting. Probably not from what you said. You were on the advisory panel for PL 93-641?

GOTTLIEB:

I was on that for a long time too, chairman of it eventually. P.L. 93-641 was the National Health Planning and Resource Development Act of 1974. That advisory panel was sort of monitoring how the act was being administered, monitoring its performance, having some input into proposed regulations. Initially it was related to that, and when time came to amend it we helped take a position on what the amendment should be.

Our last "great act" was in 1980. Everyone assumed that the now newly elected Reagan administration -- or really before that, the about to be elected Reagan administration -- would abolish 93-641, have it repealed. The question that was in front of people was: What should follow it? What was the future of health planning, and of certificate of need regulation? So AHA mounted a major effort in that direction. There was a conference in November of 1980 and a lot of papers were submitted. We used the discussion at the conference as the basis for finally adopting an AHA set of principles, a position statement. I think we got through that task at the end of 1981. I chaired all that task force work and led it and pushed it. Basically it is too recent to tell how we got the statement done. Let's say that it was very similar to what my own organization had adopted just before that.

WEEKS:

You must have had a little influence.

GOTTLIEB:

A lot of people had good influence.

WEEKS:

The APHA Health Planning Section, was that...

GOTTLIEB:

I was only involved in that a little bit. That was during the Comprehensive Health Planning days.

WEEKS:

Is that just one of the sections that APHA has for assigning members to areas of their greatest interests?

GOTTLIEB:

It was the section on community health planning just as they have a medical care section. Before that they had kind of a rump group that evolved into a section on community health planning. I stayed with that in kind of a noisy but not useful role for a couple of years largely because many of the people who were involved with that were also in the Association of Areawide Health Planning Agencies or almost all the other things I was involved in. It was just wearing another hat.

WEEKS:

Were there any other AHA connections you would like to mention?

GOTTLIEB:

Until the last three or four years I was involved in a lot of things. I was greatly concerned about the future of public general hospitals. I still am. So I was involved with a lot of that. In that area, for a while, I was on the Council of Management and Planning. That was an interesting three-year experience, being in a tiny minority point of view. There was always a major

relationship even though my work was getting farther and farther away from being concerned just with hospitals. My ties are still with the hospital field. It was always a major resource for me for information and insight about what was going on.

WEEKS:

I may have mentioned that I don't know what the Michigan Health Data Corporation is.

GOTTLIEB:

That's another interesting experiment. The corporation was organized back in 1978 as an effort within Michigan to bring together the major provider and academic organizations that are interested in health data, and to try to develop a single, integrated data base that everybody could use that could be trusted because it wasn't part of a partisan or special interest group. It would avoid duplication of effort. It was to start with what in effect was the abstract set, the uniform set. It grew out of three interests kind of coming together at about the same time. My Greater Detroit Area Hospital Council had been doing a hospital patient origin and use study since 1971. I think we were the first ones in the country that had most of the elements of the discharge data set. We had been doing that on a continuing, voluntary basis with a universe of all our 80 hospitals. We were interested in expanding that statewide and also in improving some of the pieces that were not as good as they could have been.

Concurrently John Griffith and the Unversity of Michigan Bureau of Hospital Administration were beginning to do some research in what later became the Community Hospital Performance Measurement Study. They needed a total data base, preferably for the whole state. So they wanted to speed up

that process and be a major actor to ensure that the data base was a good one, and that they had access to it.

At about the same time the Michigan Hospital Association, which, as the saying goes, had never "played in the data game," was suddenly waking up to the fact that data are power, and very important in a political process, and that, somehow or other, they should try to get into the game. They also realized that they hadn't been in it so they had to get in through the back door if they could. John Griffith's effort gave them a good excuse to do that. He needed their cooperation for that research. Also they recognized that there would be some value in having that data base under independent auspices. Nobody could accuse them of using biased data.

So those interests kind of came together. We formed the Michigan Data Health Corporation which now consists of about 15 organizations who are members of it: Michigan Hospital Association, Michigan Osteopathic Hospital Association, state medical society, state osteopathic association, the state Medicaid program, the state department of public health, the state office of health and medical affairs, the University of Michigan, Michigan State University, Wayne State University, and now the professional review organization in Michigan, and us, the Health Council, and Blue Cross/Blue Shield of Michigan.

We have developed as a group, although there is more control of the whole thing by the Michigan Hospital Association, frankly more than I think is good. We have developed what we call the Michigan Inpatient Data Base which includes the original patient origin hospital study, the uniform data abstract. Now we can handle that all by DRGs. It also includes some other data: population estimates and projections and some other things that are in the data base. It

continues, it is self-supporting. The primary financing is shared by the Michigan Hospital Association, the State of Michigan, and the Greater Detroit Area Health Council. Anyone who wants to buy access to the data pays an access fee. It still has potentials. We are jealously guarding it with eyes on the future.

WEEKS:

Is your discharge abstract similar to...

GOTTLIEB:

It is essentially the uniform discharge data abstract which has about 15 bits of data on it, most of the fundamentals you need on every patient, except now we can translate back to DRGs and other useful measurements. We are currently talking about how to expand the base. It's kind of a fragile alliance. The MHA's principal reason for being interested in doing it with the group is probably to avoid having the legislature of the state mandate the collection of a separate data base. It would then be public data. With this approach we can still follow some rather clearcut rules on confidentiality, and other things that we would have more flexibility, more accurate and complete data this way, in our judgment. We avoid a state mandate.

WEEKS:

I wonder how this compares with John Mannix's efforts down in Cleveland? I think he had every hospital in northeast Ohio so he had a complete data base for that population catchment area.

GOTTLIEB:

He was into it very early. He did a hell of a good job for his time. Our data base in sourtheastern Michigan included every hospital and always has. He has some pieces of information we didn't try to get, like financial

information. You could get that through Blue Cross. We had a broader base, we didn't have to start with Blue Cross. The Blue Cross portion of the business was the same. He has done some extraordinary things in moving the information base on which everybody operates. He did a lot more than I ever did.

WEEKS:

He is an amazing man.

GOTTLIEB:

Yes, he is.

While we are on the subject of some of the outside activities. I have been very lucky in the past four years to receive two, what I consider, useful awards. They are nice things to have happen to you. The Society for Hospital Planning gave me the Corning Award. That was in 1983, the year after Bob Sigmond received it. I mentioned this in passing, earlier. That is supposed to be an award for career performance in planning. I don't know whether I deserve it, but I'll take it. It was one of the nicest things that ever happened. Joe Peters was the first award winner of the Corning Award and Bob Sigmond was second, and for me to follow those two is a great honor.

Then last year, 1985, the Haney Foundation which was organized to honor Bill Haney who was a long-time financial consultant, really a good guy in trying to help hospitals be successful in achieving their original missions. At any rate the American Association for Hospital Planning established a memorial fund in his name. It is now a foundation. The foundation decided they would use the funds to present an award annually to an outstanding person in health planning. They were nice enough to give me the very first award.

WEEKS:

You also have the Homminga Award from the Michigan Hospital Association, and you received the Phi Kappa Phi at the University of Michigan. That's when you were in the hospital administration course?

GOTTLIEB:

Oh, yes. I got the University of Michigan Alumni Award in 1975. That was a surprise.

WEEKS:

You deserved that too.

GOTTLIEB:

That was on the twentieth anniversary of the Program in Hospital Administration.

WEEKS:

I should have remembered that. I was there that night also.

GOTTLIEB:

When your colleagues and the persons you have worked with honor you, it's the best kind.

WEEKS:

You probably have done more outstanding things than any other graduate of the Program, as far as I can see.

GOTTLIEB:

Oh, no. We have some really great graduates of the Program. I could name a couple of dozen better than I am. I am very sincere about that. We have got some really outstanding graduates.

WEEKS:

Some time ago I was reading of a survey of graduate schools of health

administration and Michigan was rated tops.

GOTTLIEB:

Yeah, wasn't that great!

WEEKS:

I thought that was pretty nice.

GOTTLIEB:

The only thing I didn't like was that they rated Ohio State third. The old football rivalry with Ohio State.

WEEKS:

Of course there is a Michigan man running it.

GOTTLIEB:

I'll tell Steve Loebs that you said that.

WEEKS:

A moment ago we mentioned the fact that things have been changing at your Council in the past four years. Will you discuss those?

GOTTLIEB:

I'll go into it briefly. Back in 1979 or 1980 it became clear the Greater Detroit Area Hospital Council had really done a very good job for twenty-five years. My predecessors were extraordinary good people, Jacque Cousin, Gene Sibery, and Bill McNary. The nature of the world was changing. It was becoming more polarized among the various competing interest groups. Competition was beginning to rear its ugly head among hospitals. The business community was really beginning to get serious about cost containment. The regulatory process that we call certificate of need had ruined planning as planning. People were getting more secretive so that a voluntary organization like ours that which depended on a free flow of information had a planning

information base increasingly drying up -- quantitative information, the real information. We were in a period when people were more likely to say if you "ain't" totally for us you must be totally "agin" us.

So I took the question to a small group of our council, businessmen who sat on the council board. Basically I gave them four options: we could continue doing what we were doing probably for a long time but we were going down hill and I thought with diminishing effectiveness; we could go out of business; we could forget all about community planning and maybe even dump all the nonhospital people that sat on our board -- two-thirds of our board, become a trade association of hospitals which we had never been; or we could devise some new kind of organization that might better be able to deal with the problems of the eighties and nineties. Fortunately, because I like working and eating, they decided on the fourth course of action that we ought to reorganize totally in order to basically accomplish three things: one, we had to eliminate whatever image there was that we were a hospital organization -- the hospitals had always been upset because they didn't think they controlled enough. Everybody else, business, labor, the black community, doctors, insurance companies were all a little bit suspicious of us because they thought we were controlled by hospitals, too hospital-oriented in our thinking. One thing we had to do was to build the image of somebody in the middle clearly and not a hospital-oriented organization, or a hospital controlled organization.

Second, we had to rebuild our power base. As with any community organization, when it is started it is with top echelon people. When the Council was organized in 1956, it was the presidents and the board chairmen of the major corporations -- Leonard Woodcock from the UAW, the president of Blue

Cross, and so forth that organized the Council in its original planning role in 1956. As an organization like that matures and people feel it's doing its job then the level of participation goes down. You increasingly find vice presidents and department heads. You get more and more remote from the base of power. Since it is voluntary effort you need to have power base. People you work with must perceive you as having power or else it doesn't work at all. It's not a regulatory body and you don't control a pot of money. There is only one other source of power and that is the people involved. So through the years we have gotten more and more remote from the real seats of power. While they were still there, in some ways it was harder to use them and harder to convince people that the council had power. Some of the battles we had in the late seventies made it clear people were testing. So we had to re-establish that power base, regenerate it, as it were.

The third thing we had to do was that we had always been very strong in what is loosely called planning. That is, we had always been strong in our concern and effectiveness in dealing with the supply of health facilities and services, and some in the organization of delivery systems. We had paid very little attention to the financing side, just peripherally, both operations and capital financing. We had paid almost no attention to the demand side, utilization, and benefit design, and all those kinds of things. It was clear that in the eighties that you were going to have to be concerned equally with all of those things, and anything else that bore on the issue. Certainly we needed a more balanced program. Without giving you all the gory details, it took us three years to do all this with all the actors involved. At the end of 1982 we reorganized and became the Greater Detroit Area Health Council, the name change being just a symbol of some very fundamental changes.

One thing we did was to drop all activity that was solely hospital oriented. That was about a third of our total activity. That also included dropping any committees that were structured to have only hospital type people on them. We were sufficiently successful in doing this that the hospitals immediately formed the Southeast Michigan Hospital Council to take care of their advocacy and other association needs at the local level.

The second thing we did -- we had always had hospitals as member organizations, but those were the only members we had. So we developed the idea that any kind of group could be a member organization: business corporations, labor organizations, medical societies, hospitals -- we wanted to keep them -- insurance companies, health maintenance organizations, Blue Cross-Blue Shield, governmental agencies, state Medicaid program, and a few major consumer groups. The idea behind that was that instead of having a person who happened to work for General Motors sitting on a board, General Motors became the member. Since that decision was made by Roger Smith, Roger as chairman of the board of GM, and since he designated the people who would sit, the individuals who would sit, in theory at least, would see that the message would go out to the whole corporation, to everybody, that they really supported the Health Council and also that we would have, when we needed it, all the resources of the General Motors Corporation at our disposal. That's the theoretical concept. By and large that is working pretty well with about half of the organizations. So we now have 155 member organizations of all kinds. Each of them designates two people to serve as corporate members of the Council, meaning voting members. They serve on committees, the governing body, and so on. Then in addition, because in a community like Detroit having those designees does not get you the black leadership in the community, we

elect some people at large. There is no limit on the numbers to serve as public voting members. The interest primarily is to see that we have a balanced constituency, black leadership has a voice in what goes on. We currently elect about 90 people at large in the community. So what we have then is an organization with 155 member organizations with about 450 corporate voting members, most of them designated by the member organizations, and some of the elected. That was all done primarily to re-establish a policy. And it's working.

The third thing was to broaden out the program. We wrote a mission and goal program statement that you wouldn't believe, Lew. It covers the whole world of health care. Everybody thought I was crazy, that no organization could do all of that. It covers everything the federal government used to think they were doing, and that HEW didn't do very well -- plus more. Everybody thought I was crazy in having it written and published. The real reason for doing it that way was to put everybody, in effect, on notice that there wasn't anything having to do with health care that we might not at some time be involved in. We were justified to do that because we had notified you in advance that we might. A lot of the key people understand that, everybody else thinks that it is just one of our wild statements.

Those were the major changes in the organization so that we now are the nation's largest health care coalition. That's the new in term. It is probably the most complex one since we did not allow anybody into the organization to be representative of a group. It is not the hospital association that is the member of the Council but each individual hospital that is a member. That was done to keep it from being just a political organization and to keep a main focus on the total community. They are there

because it is a community-oriented organization. So that makes it quite complex to do it that way. The United Foundation which supports about 20% of our budget still thinks of us as a community planning agency, which we are, a community service organization, which we also are. But we also try to deal with the principal issues of cost containment in the context of access and quality of care. We do three basic kinds of activities. One is what I loosely call action kinds of activities. These are projects or activities that are time-limited in their nature and have a specific targeted and measurable result. Usually they have a cost containment feature, maybe an access or a quality feature. The cost containment feature usually has overtones of access and quality.

We have some demonstration projects going. We do have a grant from the Robert Wood Johnson Foundation for a community program for affordable health care which Bob Sigmond probably talked about. With that money, and matching it with almost twice as much, we are able to carry out at the moment five demonstration projects, each of which has as part of its objective the reduction or redirection of utilization. That's a demand question and indirectly a cost containment question.

We also do planning. Most of our planning is in the area of what I called stimulating, catalytic, facilitative role to get things done. An operating organization can meet with our planning committee, talk about their problems or their long-range plans, whatever they are willing to disclose in the current competitive environment. We have a set of planning principles that we adhere to. The committee will then make recommendations on what the group ought to do and then the staff follows up and tries to help get it implemented. That may be a merger or the closure of a hospital. It may be to

get together in some joint ventures. It may be to expand your role with other health plans -- a whole variety of things. We have had all kinds of folks come in. We had a meeting this morning with a planning committee. The presenter was the state Medicaid program talking about what they were thinking about doing in the future. We will have a lot to say. We are looking at them as a finance source, the same as Blue Cross. Michigan Bell has come in as a corporation, talking about what they were thinking of doing. So it's all kinds of sponsoring organizations. All of those things are kind of action oriented.

Then we have a set of activities that I call foundation linked. We are not a lobbying organization but we are very interested in health policy so we take on policy issues. We will get all the key actors around our table and get them to slug it out and see how much agreement we can get them to reach on the direction of health policy, or a health policy statement, a set of recommendations for an action program. We are currently concerned with the health care for the poor, with financing graduate medical education, and with professional liability. Of course, everybody is. We are concerned with preferred provider development and for-profit enterprises in health care. We currently are writing an issue paper on DRGs. We are also considering certificate of need reform and all that sort of thing. All, most all of them with an eye to let's think it through, debate it, and try to come to as much consensus as we can get. Then have a position statement, a policy statement, and use that with a lot of people over time to bring about change.

The third thing, we provide a lot of services to our members. We have major data collection programs, we have reports to our member organizations that use data, to understand it, to interpret it. We have already talked

about our role in the Michigan Health Data Corporation, the originator of that data base. We are currently developing a business health care data reporting system, a claims based system that cuts across the lines of all companies and carriers. It is starting with a million and a half covered lives and should go up to double that in the next year or two. I am afraid to think of the claims total. So we provide that in the sense of service to our members. It also provides us with a base for use in the rest of our programs. Then in addition to data we provide a lot of advice and counseling for all our members and other organizations on matters within our purview. We do some education in top leadership development. You remember June Zimmerman. June is still our consultant on leadership development and puts together most of those programs.

WEEKS:

I get the impression that you are much closer to the community than you were before.

GOTTLIEB:

In some ways we are in balance. I made a mistake. I wrote a paper in 1980 on the future of health planning, in preparation for the American Hospital Association's conference. You remember I mentioned that I was chairman of the task force. I made the mistake of believing what I wrote. In reorganizing the Council, we tried to, in effect, reshape it according to the concepts of my paper. I am kidding when I say I made a mistake -- I am not sure I am kidding. It is one thing to write a paper for national publication, and it's another to do it for the local level. I did believe strongly in the concept that only the key stakeholders and decision makers in the community could really have an impact on the outcome. Those were the ones that had to

be involved in whatever you did in community planning. I don't care whether we call it a coalition or a community service, it's really all a planning effort. I don't care whether we call it marketing or planning, it is essentially the same concept.

While we are close to the community in many ways and less marked as a hospital organization, sometimes those old ideas die hard. At the same time we are much more an instrument of power to try to get things done. Sometimes that works well and sometimes it doesn't work so well. All the member organizations, of course, reserve the right and automatically assume that they will continue to do their own thing, have their own independent agendas and carry them out, have their own bilateral negotiations. They are not bound to use anything that comes out of our Council. So, it's a constant effort to keep them all together, and to get them to give up something for the sake of everybody, and recognize their own enlightened self-interest. It is a constant effort to get them to pay attention to what comes out of the Council and make use of it. That is what it is all about. Competition is going to go on, the great experiment in a free market in health care will go on, but the market doesn't solve all problems. The market place may be good, but we are talking about health care. I am not passing judgment on the market concept. It may not be positive, but it is worth the experiment. Then who speaks for the community interest group, where do the community's interests get recognized? The market place is not the way to provide service to someone who cannot pay the price. It is not the place for innovation in respect to the tough problems like what to do with the elderly. It is not going to solve the problems associated with those serving the mentally ill. I think there is room and I think it is very important to have an organization like ours in any

complex metropolitan community.

Some people are concerned about how you balance regulation and competition. That is an important issue. I am concerned with the kind of thing a coalition gets at -- how do you balance, in appropriate ways, cooperation and competition. How can you, in effect, nurture cooperation in a competitive environment? Everybody has enough things in common even as they fight with each other and compete with each other. There has got to be room for that. A lot of important interests get lost.

One of the things I learned after all my years of experience in planning -- I started out in 1960, I guess, thinking that planning involved doing things that were in the community's interest, and trying to get people to disregard their own self-interests. Unconsciously that was the way I was thinking. Somewhere along the way I learned and accepted the reality that everybody by his very nature has to behave in accordance with his own self-interest. The job of a planner, a community planning organization, whatever you call it, really is to enlighten that self-interest. you have to make sure it is a long-term self-interest and it is not directed only at immediate needs because that is not in the individual's self-interest.

An enlightened self-interest requires a meshing of the community's interest and the individual organization's interest. For a community to disregard all its individual parts and self-interests is totally insensitive. For the individual organization to disregard the community's interests is to ensure urban suicide. So I think there is room for our kind of organization. We have the best handle on how it ought to be done for the next 15 years. It is a good experiment. So far I think we have had a sufficient amount of success with it, worth trying for some years longer.

WEEKS:

I have been watching with interest the self-interest of people who are trying to get the right to operate a lithotripter. How is that going to be resolved?

GOTTLIEB:

Right now it's too late to resolve it in any voluntary way. It will just have to wend its weary way through the courts. It means we will not have any lithotriper service in this community for a couple of years, at least before it's legally permissible. That's very unfortunate. In other states and in other communities those people were a little bit smarter and they managed to get together in joint ventures. Several cities with five or six hospitals and groups of physicians got together in joint ventures and bought a single lithotripter, worked out an equity interest in it, so no one had too much money in it but had some voice in operating it. Here in Michigan we weren't quick enough to see that. On that one it's probably a lost cause; it will have to be fought out.

WEEKS:

At great cost, and loss of money.

GOTTLIEB:

As other advances in technology come along, I think a lot of them have learned their lesson. I know -- I wouldn't want to disclose for this record -- we are having other kinds of technology -- we are having some other joint types of discussions within the Health Council. The staff played a role. I think we are likely to have some success. The current problems that have to be dealt with in trying to do that are that when we started all this back many years ago antitrust was not a concept that applied in the health field.

Currently when people are not talking about malpractice they are talking about antitrust, it seems. So there are certain antitrust stresses to try to work out in a way that the self-interests of the individual hospital and physicians participating may be in the community interests as well, hopefully. Maybe it is not in the interest of the hospital that is not participating. They have the potential of crying, "foul." It's partly a question of how it is done.

WEEKS:

Did I understand you to say that your council is considering the malpractice liability insurance problem?

GOTTLIEB:

We did that. We developed a position paper on it. It went a little beyond what some of the legislative proposals are. It did suggest what I call compromise solutions. It tried to take in account the interests of not only the provider, the purchaser, but also the consumer, and the attorney, and the insurance carrier. I don't think we have had nerve enough to go far enough. That's always a problem in a coalition of our type. As I say too often, and some day it's going to get me into trouble, "We have got all the animals in the zoo in the same cage. You need all the chairs and capguns you can get to hold them in line, and to keep them from attacking the trainer." Since I am supposed to be the trainer, that sometimes gets difficult. So, you have to be careful on the issues you choose to take up.

I remember one policy statement we developed about ambulatory surgery. It went through the usual process stuff. It was a pretty good policy statement. It was attacked by one of the members of the executive committee who had a different point of view. He objected on the grounds that it sounded like something a coalition would put together. That's why he opposed it. He

wanted an all-out statement on one side. It was too much in the middle for him. He didn't realize that was why most of the executive committee voted to approve it. I turned to him and said outloud to him so everyone could hear that if he could read he could apply the criteria that were in that policy so that very easily they could come down on his own side.

WEEKS:

In other words you were analyzing a situation, telling your readers all the options there are.

GOTTLIEB:

Sometimes we do that sometimes we come down with very specific points of view and recommendations. We have proposed a whole plan for -- a very complex plan dealing with a very complex problem: how to finance health care for the uninsured. That has not been approved yet after two and a half years of development. At the last meeting of our executive committee they worried more about the wording of the motion than about the content of a task force report. They finally accepted the report and approved its use as the framework of further discussion and negotiations. That was pretty close to approval without the details of the approach. By the standards of many of our members that was a pretty radical approach. Great progress. Some day we will get through the whole statement when we have enough of the power committed to make it acutally work. That's what you have to do. It is not intended to be wishy-washy or just provide information or insight. If that's all we got out of it, nobody would continue to pay for it. You have to be fairly careful in the issues you choose. You have to be very alert to what everybody's interests are and try to deal with them in some kind of constructive way or otherwise it is the kind of organization that can't work.

WEEKS:

For a man in your job that means you have to have a lot of diplomacy, a lot of persuasive power...

GOTTLIEB:

A lot of hutzpah.

I have been lucky, Lew, luckier than any man has the right to be. A lot of people would consider me a maverick. There are a lot of people who would consider me too theoretical, not with it. Somehow or other, with the image of being a guy who takes on tough issues, tries to get things done, and often in opposition to very important interests -- I won't tell you I win them all -- somehow or other I have managed to survive, if you will. But in the sense that people accept what I do, I haven't had anybody try to get me fired in quite a while even though I have got an awful lot of people angry with me. Even in the national things I was lucky enough to get into I usually was of the minority point of view. That doesn't mean I was always right, but I usually had my own viewpoint, and expressed it.

I remember how mad McNerney was at me when I was on the Secretary's Task Force on Medicaid back in the 1970s. I think he had arranged to get me appointed to it. We were talking about how you fund a Medicaid program, cost effectiveness, and so on. One of the large issues was certificate of need planning. That was in the early days of certificate of need. Clearly McNerney and a lot of other people wanted a strong statement supporting the concept of certificate of need -- supporting federal legislation for it. I argued so heatedly and forcibly, and, frankly, articulately against it that when it finally came to a vote a substantial majority of the task force voted against the recommendation on this. I think my old friend Walter was pretty

angry with me. Somehow I get away with all that. I have not been very good, frankly, with playing the game, but somehow or other things have been very good for me.

WEEKS:

I think the reason you have been able to get around the situations without permanently disrupting relationships is that those who know you know you are honest, and -- I think I have heard you mention this before -- you are a humanist and believe in doing the right thing. When you speak, you are speaking from your heart. If they disagree with you, it's a matter of disagreement, not of motives.

GOTTLIEB:

Thank you for that.

WEEKS:

I think it is, I don't have any question in my mind.

I know you are getting tired but I do want to ask you one more question, at least. I have talked with people a great deal about HMOs, capitation, all the way from Dr. Garfield at Kaiser on down. Someone posed the question to me one day: What comes after HMOs and capitation? I think that's the best question that could lead anybody into discussing the future.

GOTTLIEB:

I don't know that I know the answer to that one, except that I know something will come after. As it is going there are two fundamental things wrong with the HMO movement, and capitation as a means of payment. One of the things that is wrong is there is no incentive to take care of the people who are not in the market. So it is basically anti-access because it is limited to those who are enrolled. The purpose for enrolling them related to the

objectives of the HMO is that you have got to be able to make money off them. I am not blaming anybody for that is a clearcut limitation.

Second, the whole purpose of the capitation approach is to provide financial incentives to control utilization of services if possible by rewarding providers if they are successful, and punishing them financially if they are not. I have concern about it. For years we have said that the whole trouble with health care costs problem was "the greed of the medical profession." I never said that, but a lot of people have. That was always the key line of the attack. I have to wonder how we solve the problem by feeding the greed of the medical profession by giving financial incentives to not provide care. I think that's a matter for serious concern.

Third, of course, inevitably is the pinch. I can't see how you can provide service under a managed care system -- as we are coming to call them -- without ultimately diminishing the quality of care eventually to a point where the consumer will not accept it. It leads to cookbook medicine, it leads to the elimination for all practical purposes of the art of medicine. It leads to shortcuts in order "to save money." How does an HMO control things? One way to control things is to spread out appointments in the outpatient and ambulatory care. If somebody wants an appointment today and you are using too much ambulatory service you can say we are all booked up, we can't see you for two weeks. It happens all the time. It is just a short cut. Ultimately you get caught in that. So I see trouble ahead.

Then you have the added current problem. Right now the HMOs -- certainly in this area, and I think to a large extent nationally, are getting less in price competitive with the traditional plans. The reason is very simple. With all the things that are happening, take Blue Cross-Blue Shield of

Michigan as an example. With the movement toward HMOs and PPOs, as more population goes in that direction, with other utilization management techniques being used -- precertification, second opinion on surgery, ambulatory surgery, and so forth, with the impact of DRGs on the length of stay — the inpatient utilization rate for Michigan Blue Cross-Blue Shield is down pretty close to most of our HMOs. The result of that is that the base price that the Blues have to charge is not too dissimilar to what the HMOs have to charge, but the HMOs have committed themselves to providing more benefits.

The HMOs have one other handicap currently in that they are still tied to charging a community rate, an average rate for all their enrollees. The Blues and the commercial carriers who started that way are on experience rate. One of the hot issues in Washington right now is to relieve the federally qualified HMOs from the requirement that they must charge the same rate for all their enrollees. That's the only way they are going to be able to compete.

When those things come together the question is whether the purchaser, either governmental or private, is going to find much advantage in it. At the same time we need some kind of managed care, we can't return to what it was. I am looking for ideas like other people. I suspect it may be something like the total budget reimbursement which you can do only if the purchaser controls more than the provider.

More important than that, it seems to me, is how long will it be before society's current selfish, self-centered attitudes change. We are in a period that has been growing since the mid-1970s -- I don't care what you call it, some people just call it conservatism, I call it basically a period of intense

personal selfishness, I want mine, and don't give any of mine to somebody else. That engenders the anti-government attitude, the anti-welfare attitude.

WEEKS:

Beat the system.

GOTTLIEB:

Yeah. And I think that is the predominant societal view right now. It's unfortunate that we have to go through periods like this. I was grateful for the sweet sixties, but the pendulum will swing back.

I don't think by nature the American people are selfish. I think by nature we are a very generous, loving kind of people. I think as more and more of the problems the current environment creates in health care surfaces that the American people are not going to sit still and watch them. You can't have 38 million Americans living below the poverty line and having inadequate access to health care, and have the rest of society watch that and accept it. We are not a society that will be content to walk by the door of a hospital and see people die on the streets because they can't get into the emergency room.

The lower middle class is the group whose health care, both the amount and the type, and the way in which it is provided, is really determined by large purchasers on their behalf. They have relatively little voice even if they are organized in unions. They are going to become increasingly discontented with the shortcomings.

So I would say that by the mid-nineties that we are going to see a rather sharp swing of the pendulum back to a concern about what has happened to health, what is happening to the access to health care. I have predicted from a public platform that that change in society's attitude and the clear crisis

of the access and quality problems will come together with a concern by business corporations. Business will have tried everything they can think of and will still find the health care bill too high. Business will still be involved in international competition which to them seems unfair considering what they have to load into their prices. Also they will be concerned about the number of companies that provide no health insurance for their employees. Some of that cost gets shifted off on companies that do. I see those forces coming together. If I were a betting man, I think I would bet that sometime between 1995 and the turn of the century that we finally will see national health insurance.

WEEKS:

I noticed the other day that someone proposed national health insurance again. We haven't found a reasonable way to do it. I am not entirely sold on the statement that the British system is bad, at least for the British. It may not be good for the Americans.

GOTTLIEB:

We would have our own version. I am not sure the National Health Service of Britain would work in this country, because we are not Britons, and we have different history and traditions. But we will have -- whether it is mandatory insurance coverage for those who are working and some compatible arrangement for those who aren't -- we will have what amounts to a universal health care coverage, mandated and controlled by the federal government. When I look at the way the forces are now arrayed, I would bet that we will have national health insurance by the late 1990s.

WEEKS:

Will fee-for-service go by the board then?

GOTTLIEB:

Probably. Then you have all that power. It's largely a government responsibility. It's all on the tax rolls. There will be more reason to try to control costs. You also have more power; it's more monolithic. In the pluralistic system we have now has certain advantages but it is a lot harder to control.

WEEKS:

I talked with Miles Hardie of the International Hospital Federation when he was here last month. One of the questions I asked him was whether there still was the "brain drain" from Britain. We were talking about the large increase of physicians in this country. To my surprise he said they were not experiencing the same number of physicians leaving Britain to go to the colonies. This has sort of been reversed. They are staying home now. So there must be some satisfaction.

GOTTLIEB:

Some. We are faced with an oversupply of physicians, at least a lot of people think we are. It just doesn't look as attractive as it did before. It doesn't look as attractive to prospective medical students either.

WEEKS:

Do you have any other wise words to say?

GOTTLIEB:

I don't know how wise the words have been so far, Lew. I guess the only thing I would say is that I find we have more changes in the health field in the past three than we had in all my prior 30 years. It's exciting. I tell

the kids that if you are truly a professional you may find times like this tough to deal with, but they are terribly, terribly interesting and fascinating. They are a real challenge to a professional. It's just unbelievable, if you are really a professional. I wish I were 20 years younger. I could really be mixing it up more with this current stage of transition, and be around to see how it plays out. Basically all of my work for the past 25 years was looking at the long-range results of what I do rather than the immediate results. I have got to be around to see how it plays out. In the meantime I am still having a ball. I would think anybody coming into the health field now regardless of their values, but I wish more had my kind of values, would find it fascinating.

WEEKS:

As you say, we have lived through a period where changes have been so dramatic, not only in the health field, but in many other things. I hate to think of the time that will come when we can't participate.

GOTTLIEB:

It will happen.

WEEKS:

It will happen. Death and taxes. They are changing the tax bill maybe they will change the longevity bill.

GOTTLIEB:

The real test is whether we are going to turn around enough young people who have a well-developed sense of values relating to working with individual human beings, and a reasonably developed sense of ethics, morality, social justice. It doesn't have to be everybody but we have to have a solid core.

You mentioned the University of Michigan program recently being rated

first among the programs. One of the little known things about that program, even when I get angry with them, or some of the faculty, that even as they have a strong quantitative approach to health services management and as they focus on the business enterprise role of health care, that they have not given up on the idea of trying to impress their students with a sense of ethics. That's the real test.

Not so long ago we put on a seminar for a major business corporation for their senior executives. One of the people we had speaking was a hospital executive, and he is a good one. Thinking he was talking to business executives, and therefore they would want to know how business wise he was, he talked about the fact that they no longer when they hired management people for his organization, they were no longer hiring people with a master's degree in hospital administration, they were hiring MBAs.

I was sitting at the speakers' table at that program. I looked out over that audience. I could see gasps. The body language was terribly negative. He didn't sense that, and went on. At lunch with some of the senior officers after the meeting -- the speaker wasn't there, but there were some of the senior officers of the corporation, and I, and some staff there -- that speech was the one thing they latched on to and talked about. It was fascinating because what they said was, "We hire MBAs for all our management and finance positions, but we don't want to see those kinds of guys running a hospital.

WEEKS:

I have really enjoyed this, and thank you very much for your contribution to the oral history collection.

Interviews in Ann Arbor

June 3, 1982

July 17, 1986

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