HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

James R. Neely

James "Jim" Neely

November 4, 1928 - November 28, 2014

Obituary

James R. Neely 11/4/1928 - 11/28/2014 Born in Gettysburg the only child of the late Wimbert 8. and Cleo Connor Neely. Graduated from York Springs High School in 1946 as class Valedictorian and from Gettysburg College in 1949 with a Bachelor of Arts degree. While a student at Gettysburg, Jim worked as a night clerk at the Annie M. Warner Hospital for 2 years and discovered he had a passion for healthcare delivery. As with all things he did, Jim turned that newfound passion into an action plan that resulted in a lifetime dedication to ensuring quality healthcare across the nation. After graduating from the University of Minnesota with a Masters in Hospital Administration in in 1951, Jim stopped off in Gettysburg long enough to marry Sarah Jane Reigle and then headed off to Jersey City to launch what was a remarkably notable career. Two separate stints totaling 13 years as Associate Director of the American Hospital Association during the time when both Medicare and Blue Cross Blue Shield were developed and rolled out, being the first full time Chief Executive Officer of the South Carolina Hospital Association, 10 years as President of the Pennsylvania Hospital Association, creator and first Chairman of the Board of the Pennsylvania Hospital Insurance Company (PHICO) and President of Health Alternatives Development, Inc. Jim had a dream but he was also a realist. He never waivered in staying true to his vision and never backed down from a good fight if that was what was needed. Jim is survived by his wife of 64 years, Jane, his five children (Linda Neely, Richard Neely and wife Shirley, Susan Neely Banks and husband Robert, John Neely, Thomas Neely and wife Suzanne), eleven grandchildren and seven great grandchildren. A funeral service is planned for Saturday, December 6th, 2014 at 11:00 A M at the Gettysburg Presbyterian Church (208 Baltimore Street, Gettysburg, PA, 17325) with Rev. Dr. David C. Wright, Rev Louis Nyiri and Rev. Harry G. Winsheimer officiating. All are welcome to join the family graveside at Sunnyside Cemetery in York Springs immediately following the service. There will be a viewing at the church on Saturday from 10:00 A M until the time of the service. In lieu of flowers, donations may be made to the Gettysburg Presbyterian Church.

JAMES R. NEELY

In First Person: An Oral History

Lewis E. Weeks
Editor

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James R. Neely

CHRONOLOGY

1928	Born November 4, Gettysburg, PA
1949	Gettysburg College, B.A.
1951	University of Minnesota, MHA
1950-1952	Jersey City Medical Center
	1950-1951 Administrative Resident 1951-1952 Administrative Assistant
1953-1957	American Hospital Association
	1953-1954 Assistant to Deputy Director 1954-1956 Secretary, Council on Prepayment Plans and Hospital Reimbursement 1956-1957 Assistant Director of Research
1957-1963	South Carolina Hospital Association, Chief Executive Officer
1963-1972	American Hospital Association
	1963-1964 Director, Division of Hospital/Blue Cross Relations; Assistant Director, Department of Finance, Planning and Association Services 1964-1966 Director, Division of Association Services 1966-1967 Director, Bureau of Finance and Planning 1967-1968 Director, Bureau of Membership Services 1968-1969 Assistant Director, Planning; Chairman, Management Council 1969-1971 Associate Director, Planning; Chairman, Management Council
1972-1982	Hospital Association of Pennsylvania, President
1983-1984	Health Alternatives Development, Inc., President
1984 -	The Equitable Life Assurance Society of the United States Director, Healthcare Program Alliances

MEMBERSHIPS & AFFILIATIONS

American College of Hospital Administrators, Fellow

American Hospital Association, Life Member

Gettysburg Hospital, Board Member, 1982-84

Harrisburg Trade Association Executives, President-elect (resigned before becoming president), 1983

Pennsylvania Governor's Task Force on Health Care Cost Containment, Member, 1982-83

Pennsylvania Health Council, President, 1975-76

Pennsylvania Hospital Insurance Co., 1976-1983

Pennsylvania Society of Association Executives, Board Member, 1982-83

State Hospital Association Executives Forum, President, 1983

AWARDS AND HONORS

American Hospital Association

Trustees Award 1984

Hospital Association of Pennsylvania

Trustees Award 1983

South Carolina Hospital Association

Honorary Membership 1982

BOOKS

Hospital Associations in Change. Chicago: The American Hospital Association, 1981

WEEKS:

We are sitting here in this beautiful house and I can't help but think that Gettysburg really is your home country. I noticed that you attended Gettysburg College before you went on to the University of Minnesota. How did you happen to study hospital administration?

NEELY:

Actually I guess Gettysburg College is the reason. My father was disabled, so I had to have a job when I was in college. I went to the job placement service at Gettysburg College and the job that was available and that interested me most was as night clerk at what was then known as the Annie M. Warner Memorial Hospital, the little community hospital in Gettysburg. Incidentally, I'm now on the Board of Trustees of that hospital. But, I started there in 1947 as the night clerk and really liked it so much that I went to the administrator, who by then had become a good friend, and said, "How in the world do I become a hospital administrator?"

He said, "You ought to do it differently than I did. You ought to go to school. I came up the apprenticeship route. Here's a list of all the schools in the United States."

At that time there were only ten or twelve hospital administration schools in the whole country and I wrote to every one of them for their catalog and picked three that appealed to me most. I was rejected by one, I was first alternate at the second one, and I was accepted at Minnesota. Jim Hamilton was the Professor of Hospital Administration at Minnesota.

Jim always liked to tell every one of his students that we were one of his experiments. He always told me that I was one of his experiments because at that point I was the youngest student he had ever taken into the Program in Hospital Administration. Of course then it was only five years old — a fairly new program.

As a matter of fact, because I had gone through undergraduate school in three years, I was on the Minnesota campus when I had my twenty-first birthday — in graduate school.

So that's how I got into hospital administration. It was a necessary part-time job when I went to college and I grew to love it and have been in it ever since.

WEEKS:

I have had many people tell me that Hamilton was a very unusual teacher.

NEELY:

The thing about Jim Hamilton which was extremely unusual was — well, really two things — the first thing was that he was the father-figure for a lot of us in the Program in Hospital Administration. Some anecdotes about that — for example, Jim used to say that hospital administration is a family

affair. You can't go into a community if your wife is not also acceptable in the community. And that is not a chauvinist statement. In those days, almost every administrator except the Catholic sisters was a male. So he used to say that your wife is very important. One of the things he would try to do would be to interview the wife at the same time that he interviewed the student to decide whether they would be accepted into the Program. I wasn't married when I went to Minnesota, so he didn't have that chance with me. And his wife, Sabra, had a wives' club where she gave the young wives good advice on how to be proper wives of hospital administrators.

The Hamiltons would have us all into their home to make us feel as though we were part of the "family." I don't know whether it is true or not, but I always suspected he also wanted to make sure we knew the social graces. At the first party at Jim Hamilton's house that I attended he served very powerful drinks. I can remember a whole punchbowl full of stingers and he kept urging people to drink more and more stingers. To this day I really believe that his mission was to find out whether we would drink too much or whether we could hold our liquor.

The second thing that was unique about Jim Hamilton is that he used case experiences for his teaching. He, of course, by that time had a great many years of experience as a hospital administrator and as a consultant. He had written many, many case histories of hospital problems and later published them in a book, but then they were just his teaching notes. Jim would give each of us a case to solve. He was absolutely marvelous at that because he, in that exercise, tried to behave like the toughest possible board member at a hospital that we might someday run. He really made us run the gauntlet. We would be subjected to all sorts of harassment and criticism and accusations of

stupidity. It was all a great big show. It was to see whether we had the mettle to respond properly to those situations without losing our temper or getting angry. A wonderful teaching technique!

WEEKS:

I have heard it said that he was a great actor. He could be very dramatic.

NEELY:

He was that too. I think you probably know that Jim Hamilton was at one time the boxing coach at Dartmouth College and he was physically tough as nails. And one of the most articulate men I have ever known. He really did act when he did those case studies. He acted like the chairman of the board who was out to make you feel about two inches tall. Most of us grew to love Jim Hamilton very, very much and hold his memory very dear in our hearts.

WEEKS:

Had he started his Hamilton Associates at that time?

NEELY:

Yes. He was then a consultant. That was one of his agreements with the University of Minnesota when he went there. Of course, the University couldn't pay him as much as he was worth, so he agreed that if they would allow him time to do consulting along with the teaching, he would come for the salary they offered. As a matter of fact, Jim personally subsidized the Program from his consulting income. He allowed the students to use his own personal library — the school couldn't afford one so good. He allowed his consulting associates to perform on the faculty and they brought a huge amount of experience. No way could the school have afforded them.

And, of course, Jim himself was so well known in the hospital field. He had earned the AHA Distinguished Service Award. He had been president of the

AHA when the chief elected officer was still called president.

Really I think he, as much as anybody, he and John Mannix together, had a lot to do with building AHA into the strong organization that it became. They pushed through the first big dues increase that put it on its way. So Jim had a host of friends across the country and he would use those friendships to call those people in to lecture.

I can remember that we heard from all the great and the near-great in hospital administration while I was a student. Just to be able to see and hear those people was a great treat. I have often said that I was born at a very fortunate time because within ten years a lot of those people had died. I was in one of the last classes that was able to hear some of those really fine, outstanding pioneers in our business.

WEEKS:

There were some giants back then, no question.

You went on for your residency at New Jersey Medical Center?

NEELY:

In those days you really didn't have a whole lot of choice about where you took your residency. Jim Hanilton was sort of an authority figure anyway, but it was customary for the professors of hospital administration in the small number of schools to arrange with the people whom they knew and liked and trusted and thought were good teachers — it was customary for them to arrange to send their students to those preceptors.

One of the well-known administrators whom Jim Hamilton was friendly with was a man who, believe it or not, was president of the American Hospital Association way back in 1928, the year I was born — Dr. George O'Hanlon who, when he was president of AHA, had been head of Bellevue in New York City, and

later went over to the Jersey City Medical Center. As I say, he had been a friend of Jim Hamilton's and that was one of the places Jim had an arrangement that once a year he would send them a resident.

The only question Jim asked me was did I want to go west or east.

I said, "I don't really care, but I guess east."

The next thing I knew was he told me I had a residency at the Jersey City Medical Center. I knew where Jersey City was on the map, but when I went there for my residency it was my very first visit to the town. I was never interviewed. I never saw the hospital until the day I showed up to start my residency.

WEEKS:

Then you stayed on beyond your residency.

NEELY:

Because I was so young, I was really too immature to be a hospital administrator. Mind you, I was only twenty-one years old when I finished my year at Minnesota and that is just simply too young to have the experience it requires for leadership. So I asked to be permitted to stay on — as a matter of fact, that is why Jim sent me there, because he knew that they would allow me to stay on — and I stayed on for another year and a half as what they called administrative assistant, but it was really an extended residency.

Jersey City was an interesting place and I was the last Minnesotan to go there. George O'Hanlon was peremptorily fired while I was there.

Jersey City, of course, was a very political town and I went there soon after the Frank Hague political machine was upset in an election. The people who won eventually wanted to get rid of anybody who was associated with Frank Hague. That meant that the ax fell on George O'Hanlon.

Even though George was still a pretty sharp man, he was eighty-three years old at that time. He read about his firing in the newspaper. They didn't have the courage to tell him. They put it in the newspaper that they were going to fire him. And that happened while I was there.

At any rate, Jim knew that they would keep me on at the Jersey City Medical Center.

The thing I found in Jersey City was a political situation the likes of which I had never seen. The system that Frank Hague had created to control the politics of Jersey City was absolutely unbelievable. There has been a book written about it. He had organized the whole town so that immigrants as they came into Jersey City ports — actually the Statue of Liberty and Ellis Island are closer to New Jersey than they are to New York, as you know — as they came into the Jersey City ports, Frank would have his political friends meet the immigrants and speak their language and help them find jobs and create a situation where they became totally indebted to the political machine in Jersey City.

Jersey City was organized so that there were block leaders and on top of block leaders were precinct leaders and on top of precinct leaders were ward leaders. The people became so indebted to the machine that they stopped thinking for themselves. If they needed a new washing machine, they would go to the block leader and say, "Where should I buy my washing machine?" They would say, "Well, Lew Weeks has been a good contributor to the party, you go buy your washing machine from Lew Weeks." They controlled the city in a manner that I had never before or since seen.

The hospital — actually Frank Hague was something of a hypochondriac. He used to take his handkerchief and clean off doorknobs before he would touch

them for fear he would pick up somebody's disease -- the hospital was built partly as a memorial to his mother, partly because of his own tendency to be a hypochondriac, but also partly for political patronage. If you were a good, loyal party member, you never paid a bill at the Jersey City Medical Center. If you were a stranger or the opposite party — hardly anybody was the opposite party — then you had to pay a bill. When I was there we didn't even have a collection office in the hospital. The billing and collection were done out of City Hall.

A couple of the people who were there when I was there later went to jail for some of the things they did by way of diverting purchases to personal gain and that sort of thing. I was naive then, I trusted everyone. I never knew those people were on the take.

The story that I was going to tell about the organization — I don't remember the numbers, but let me make up some — suppose there were forty-two precincts in Jersey City and suppose we had eighty-four jobs for maids. That meant that two maid jobs were assigned to each precinct. Our personnel office didn't do anything except keep track of time cards, because the way we got our non-professional personnel was to call the precinct leader and say, "We have a job open that is assigned to your precinct."

Pretty soon somebody would show up and say, "I've been assigned by the precinct leader to work in the hospital."

Those of us on the professional staff used to joke about it. We said the hospital had employees you could see maybe once a week move a muscle once or twice. It was really a dumping ground for old and loyal party members, many of whom simply were incapable of work anymore.

I have told a lot of people that Jersey City was a great training ground

because I learned how not to do things.

WEEKS:

I have heard of Mr. Hague, of course, but I had no idea that it was that well organized.

In your book I think it was, I think you made a statement that you felt that association work was really your field...

NEELY:

It was completely accidental. As you have gathered, after two and a half years in the Jersey City Medical Center, I had a belly full and I wanted to get out. Fortunately, I was personally kind of exempt from the political activity because I was viewed as a professional. And there was a clear distinction between the professionally trained people and the non-professionals who came out of the political ranks.

My immediate boss, after Dr. O'Hanlon left, was a man by the name of Dr. Gerald Sinnot. Dr. Sinnot was a very good friend of a lady who was then an AHA employee. Her name was Ann Saunders Friend. I think Dr. Sinnot was on one of the committees that she staffed. He mentioned to her that he had this, by then, administrative assistant back in the Jersey City Medical Center who wanted out pretty badly and did she know of any jobs. The man who was then Deputy Director of the American Hospital Association, Maurice Norby had a job opening for his own deputy or administrative assistant. He was deputy to George Bugbee and he wanted somebody who would be his run and fetch 'em. So when Ann Saunders Friend got back to the AHA, she told Maurice Norby about this man she had not met, but whom Dr. Sinnot had told her about, and I got a phone call out of the blue saying this is Maurice Norby.

Of course, I knew the name Norby because Maurice's dad had been a hospital

administrator in Milwaukee and before that a hospital administrator in the Twin Cities. He, as one of Jim Hamilton's friends, had been one of the lecturers at our program in hospital administration. So I knew Maurice's dad from that exposure. I recognized the name.

Maurice had to explain to me that he worked for the American Hospital Association and he had heard about me and wanted to interview me. He was coming to New York City in a couple of days and would I please meet him at the Astor Hotel in his room in New York City.

I went over to the Astor Hotel and the door to his room was standing ajar. I knocked and this voice came out, "Come on in." It turned out Maurice was in the shower when I got there. So part of my interview, at least, was conducted while Maurice was in the shower. He shouted out of the bathroom, "Make yourself a drink, there's a bottle on the table." So while I had a drink in Maurice's room and he finished his shower, we conducted part of our interview. Then he took me out to dinner, told me a lot about the AHA, and typically Maurice, he told me not only the good things but the bad things. I was so taken with the man's honesty and personality that when he offered me the job I accepted it that very night.

I never anticipated that I would make association work my career, but I found that it was such an exciting way to spend the rest of your life that I in many ways feel like I have ceased to be a hospital administrator and have indeed become an association administrator. I still consider myself to be a specialist in health care work. I don't think I would be comfortable being an association executive for the buggy whip manufacturers, but I have always been fascinated with association work from the day I walked into the front door of the AHA.

WEEKS:

The headquarters were on Division Street in those days in Chicago.

NEELY:

They were on Division Street. I am sure that many of your other interviewees have talked to you about the old Latin School and how it looked and so on. My own particular office was what had originally been part of one of the classrooms. They had partitioned off a corner of the classroom and that corner was Maurice Norby's office. I had something about the size of a closet which was adjacent to Maurice's office and his secretary, Mildred Ryan, had the other part of the el that was formed when they partitioned off the corner of the larger classroom.

Behind me was George Bugbee's secretary who later became one of my dearest friends, Renee Taniere, a French lady. So from the beginning, I was where all the activity was — between Maurice and George Bugbee.

WEEKS:

How many people were there on the staff at that time? '53, I am trying to get a picture of it.

NEELY:

I don't remember precisely, but I would guess maybe thirty to thirty-five people.

WEEKS:

Now this was near the end of George's tenure too, wasn't it? He was there another year or two wasn't he?

NEELY:

As I recall, George left in about 1955. So I was with George Bugbee for two years. A delightful experience because he is such a warm, kind human

being. In some ways like Jim Hamilton -- he tried to treat the AHA employees like part of his family. He would have you come into his home and would entertain you and of course his wife, Karin, was a perfectly delightful lady. So we all felt like we were part of the AHA family.

WEEKS:

They were very devoted too, weren't they?

NEELY:

To each other -- absolutely. I don't think I have ever met two people who were more in love.

WEEKS:

I could tell that from the way he spoke of her.

NEELY:

You know, of course, her family background from your discussions with George -- their stories about her acting family were fascinating.

WEEKS:

According to our paper, when Lynn Fontanne died a few months ago, George was at her bedside.

NEELY:

That may be, I don't know.

WEEKS:

I believe that he inherited the property.

NEELY:

That may be true too. I don't even know -- is Alfred Lunt still alive?

WEEKS:

No, he is dead.

I have had some pictures of what AHA was like in 1943, when George came

there and when Kenny Williamson came there and so on but by 1953 it had grown quite a great deal from maybe four or five employees to you say thirty or so and I am sure the services had grown a great deal too. What was the structure then? The House of Delegates had been formed back in the late 1930's hadn't they?

NEELY:

Yes. That was formed, as I recall, in 1937.

WEEKS:

But the regions didn't come until later.

NEELY:

The regions were much later. They were a Dr. Crosby product.

WEEKS:

The Washington office had been opened before Kenny was there wasn't it?

NEELY:

The Washington office was open and the director of it when I joined the AHA staff was a man by the name of Bert Whitehall — Albert V. Whitehall — one of the best public speakers I have ever known in my life. Whitehall could charm the skin off a snake. One of the valuable lessons I learned from Whitehall — I asked him how he became such a superb speaker and he said, "I have a couple of rules. The first rule is that I never talk about anything that I don't, at least at that moment, want more than anything else for my audience to know all about it. I never accept a speaking engagement if I think it's not an important topic.

My second rule is that I have always approached an audience on the basis that public speaking is an efficient way of communicating. Nobody gets stage fright when they talk to one person at a time. People only get stage fright

when they talk to a lot of people at once. You stand there and think in your own mind that this is an efficient way to talk to one person at a time, except that you are simply doing it all at once.

Frequently, what I do is pick one person out of the audience and talk to him for a little while and then I pick somebody else. That removes all my stage fright because, number one, I am convinced I want to talk about it, and number two, I am mentally convinced that I am not talking to a whole room full of people, I am talking to a lot of people one at a time."

I have always remembered that and people have said that I am a reasonably good public speaker. I think Bert Whitehall had as much to do with helping me with my speaking as anybody else.

WEEKS:

Before we leave Maurice Norby, is there anything you would like to say about his work, what he was doing at the time you came there?

NEELY:

You know of course from your interview with Maurice that he originally went to the AHA with the old Hospital Care Commission. Then he later became very much involved with the development of Blue Cross plans across the United States. In fact he had been involved with Blue Cross before he went to the American Hospital Association.

When I got there, of course, Maurice was the Deputy and did anything George asked him to do. But a large part of his responsibility was to maintain liaison with the Blue Cross plans across the United States. He was the liaison with the Blue Cross Commission where a man by the name of Dick Jones was then the Director. That automatically put him into responsibility for how hospitals were paid — paid not only by Blue Cross, but by government.

So Maurice's primary areas of responsibility were in the hospital payment area. He was the secretary of what was then called the Council on Prepayment Plans and Hospital Reimbursement. And, as a matter of fact, after I was there a couple of years Maurice made me his successor as secretary of that Council.

WEEKS:

Yes. I noted that you became interested in the relationship of AHA/Blue Cross.

NEELY:

Well, that was largely because of my assignment. I was Maurice's administrative assistant. I carried his bag and I went wherever he did. Whatever he needed I went and got it for him. So that meant that just by exposure I learned. I went to the Blue Cross Commission meetings with Maurice. He sat in the front row and I sat in the back row, but as a young fellow I learned to know all of the Blue Cross plan directors and it was kind of an automatic thing that I should follow in Maurice's footsteps because he taught me a whole lot about hospital reimbursement. As a matter of fact, my very first assignment at the AHA was to go with Maurice to the conference where the original booklet on cost reimbursement was written by the AHA. It was called "Principles of Third Party Payment For Hospital Care."

The conference was held at a hotel in Highland Park called Moraine on the Lake where all the national experts on hospital payment got together. Maurice ran it. I was there with him. Later, as his administrative assistant, I put together the first draft of that little booklet on hospital cost payment. Now, I wasn't very experienced or very knowledgeable at the time so I have to say that it went through a hundred revisions after I worked on it. A young man by the name of Harold Baumgarten, who worked for Dick Jones at the Blue

Cross Commission, and I, who worked for Maurice Norby, were assigned to prepare that first draft and then it went through a whole lot of rewriting, much of which was done by Rufus Rorem, who was then a member of the Council on Prepayment Plans and Hospital Reimbursement. So the way it emerged was far different from the way we developed it.

WEEKS:

While you were there did you learn anything about the relationship between Rufus and Maurice? The reason I ask is that Maurice was telling me about various things that he had done. For instance, one of them was when he went to Pittsburgh and started the Blue Cross program and it was an immediate success. They had a large enrollment, did it very quickly, everything was going fine and yet when Rufus called him and said, "Maurice, I need you," it didn't take much persuasion for him to drop all of this and go with Rufus. This happened two or three times in Maurice's career where Rufus must have had a great influence on him. He must have admired Rufus greatly because he left something he was doing. His original job — did he ever tell you about coming to Chicago for the first time?

NEELY:

I guess you are right. I had that backwards. He first went to Chicago to work for the Hospital Service Plan Commission, then he started working with the Hospital Care Commission. I had that just reversed. You are right, he first went there to work for Rufus Rorem.

WEEKS:

But the first time he went, he was up in Minneapolis, he had been teaching school for a hundred dollars a month or thereabouts and everything was very, very tough and he got a call from Rufus. Rufus had learned about him from van

Steenwyk. He came down to see Rufus during the winter vacation just before Christmas or just before New Year's...

Rufus talked to him for just a few hours and said, "I want you to come down and work for me for a month or two to organize my office — I'm trying to get this commission started here. He quit his job as a teacher -- in fact, helped his wife to prepare herself to temporarily take his job until they could find somebody else to teach the science course that he was teaching in high school. He went to work and the job lasted two or three months, then he went back to Minneapolis and started working for van Steenwyk.

NEELY:

That's part of his history that I didn't know, Lew. You know more about it than I do.

WEEKS:

But Rufus must have had a tremendous influence on people...must have convinced people that they wanted to work for him.

NEELY:

I knew Maurice had worked for van Steenwyk and I knew that when van Steenwyk went to Philadelphia — the Pittsburgh job, of course, was known to him and he persuaded his friend Maurice to come and take that job. I guess Maurice told you this. There was a hospital administrator in Pittsburgh at Montefiore by the name of Abraham Oseroff and Oseroff decided that he wanted to become directly and deeply involved in the operation of the Pittsburgh Blue Cross Plan and made it very uncomfortable for Maurice and so it was a fortunate opportunity to be able to come back to Chicago again.

WEEKS:

Maybe this had some effect. He told me something about Oseroff and that

he was a very dynamic driving type of man and he went with him many times to organization meetings when they were trying to enroll a company or employees of a company. I hadn't connected the fact that Maurice might have been dissatisfied because in the meantime his daughter had been born, while they were in Pittsburgh, I believe.

NEELY:

Yes, I believe she was born in Pittsburgh.

WEEKS:

They lived in quite a nice section and they were very happy in their lives.

NEELY:

Pittsburgh is a marvelously friendly town. You feel at home the minute that you walk into town.

WEEKS:

Rufus told me that there was a great difference between working in Philadelphia and working in Pittsburgh.

NEELY:

Pittsburgh is known for its friendliness, Philadelphia is pretty cold and aloof, you know. They look very carefully to see if you have the right pedigree in Philadelphia.

WEEKS:

While you were there, wasn't Maurice involved in the Commission on Financing Hospital Care? I know he wasn't directly running it but he was sort of a backstop for it.

NEELY:

Yes. Although he was not the director of it he was indeed involved with it. As I recall, Art Bachmeyer was chairman of the Commission -- then he died

and I forget who his successor was.

WEEKS:

First was the man from Kellogg, Graham Davis, then Bachmeyer, then a man by the name of John Hayes from New York City.

NEELY:

That's it. The staff director was Harry Becker as I recall. So he actually directed the activities.

They were housed separately so we didn't see them...

WEEKS:

Weren't they housed next door?

NEELY:

Nearby, but they were in a different building.

WEEKS:

Bob Sigmond...

NEELY:

Bob Sigmond was an employee of the Commission on Financing Hospital Care and he was one of the principals. He did a lot of the writing of the final report. I know that Maurice attended a lot of the meetings on the Commission on Financing Hospital Care. I never went with him to any of those meetings, so I wasn't personally involved in it.

WEEKS:

But according to Maurice, and according to George Bugbee, they originally wanted him to head this Commission because he had done such a good job with the Commission on Hospital Care in the 1940s about ten years before. But he didn't want this. This is when he came up with his famous story about his five year plans. Did he ever tell you about those? He tried to evade any

appointment as head of this Commission on Financing of Hospital Care because he worked out some kind of story about he had a five year plan -- he was going to take so much money and save it each year and then in the second five years, he would get a raise and he had it all worked out so that at the end of about three of these five year plans he would have the confidence, he would have enough money invested so that he could retire. He had a long story...

NEELY:

I never heard that story so I don't know anything about that.

WEEKS:

It really didn't amount to anything except that he used it as a delaying tactic.

NEELY:

I know that most of us on the staff viewed the old Commission on Hospital Care as the forerunner of the Hill-Burton Plan -- it really created the research documentation that showed where beds were needed. The Commission on Financing Hospital Care -- I think its major contribution was that it identified those groups in our population whose care was underfunded. For the first time it clearly identified the fact that the old people were the ones who were hurt most by not having their care paid for. I think that the Commission on Financing Hospital Care had as much to do with passing the Medicare program as anything that happened.

WEEKS:

It certainly had a great deal to do with it, yes.

NEELY:

Art Bachmeyer was chairman of the Commission on Financing of Hospital Care when I went there and now that you mention it I do remember that John Hayes

succeeded him. I had forgotten that Graham Davis had preceded Bachmeyer because Graham died before I joined the staff.

WEEKS:

He was ill and I think he resigned and died shortly afterward and Bachmeyer was persuaded to take over half time and then he died in the Washington airport...

NEELY:

Had a heart attack. He and Maurice were waiting for an airplane.

WEEKS:

And then Hayes came in. Hayes was a good friend of Bugbee's wasn't he?

NEELY:

Hayes was the administrator of Lenox Hill Hospital in New York City and for a long time wrote a humor column in the Hospitals magazine.

WEEKS:

Yes. I have heard that mentioned.

Jim Hague started about the same year you did too, didn't he?

NEELY:

No. Jim Hague came after Dr. Crosby was there. There really wasn't any director of public relations before Dr. Crosby. There was a magazine and a publishing activity. Jim came as public relations not as publications. Later he took on the publications activity, but he came with Crosby because Crosby had known him at Hopkins. And if I had to put a date on when Jim Hague got there, it would probably be 1956.

WEEKS:

Was Foley still on the staff when you came?

NEELY:

C. J. Foley was on the staff. His father Matthew Foley was long dead.

WEEKS:

He was the son of Matthew Foley.

NEELY:

He was Matthew Foley's son.

WEEKS:

He was editor of Hospitals for a while.

NEELY:

C. J. was editor of Hospitals when I went to AHA in 1953 and Michael Lesparre was there on the staff and Arnie Rivin was there on the staff. They were the principal editorial staff. Martha Miller was responsible for subscriptions and advertising and that sort of thing.

WEEKS:

Now you spoke of Ann Friend...was she a personnel person?

NEELY:

She came as personnel. She later broadened out to include all of the management skills -- planning, evaluation and direction and so on. But originally she came in the personnel role.

George Bugbee used to talk about developing his five foot bookshelf. You may have heard of that from other people but his dream was that AHA would, among other things, become a technical resource for hospital administrators to improve their skills and much of this would happen not only by the development of educational conferences but by the development of books and magazines. George euphemistically referred to that as his five foot bookshelf.

One of Ann's responsibilities was to work with the personnel committee to

produce a book on how to manage personnel in hospitals.

WEEKS:

I know there were quite a few of those manuals developed at that time. All the departments like housekeeping, purchasing and so on.

NEELY:

That was one of the staff's prime responsibilities. The one that they had the most trouble with was the accounting manual. That was such a controversial subject at the time that it just took years to develop it, but finally that was produced too.

WEEKS:

Uniform accounting was what they were trying to get through wasn't it? Among other things...

NEELY:

That's right. And all of the accountants who were really bona fide accountants had a different opinion of how it ought to be made uniform.

WEEKS:

Yes, I can remember Rufus talked about that. He served on a committee on accounting and he threw up his hands finally. There were five people on the committee as I remember it and there were five different ideas. He was chairman and he said if any two of you will agree, I think the rest of us will go along...but no two would agree.

NEELY:

The funny part of this, or the ironic part of it is, one of the strong arguments for AHA to become a large viable service organization was that they could do such things as developing an accounting manual. The argument was that if hospitals would do their accounting uniformly then they would have

more appeal to generous donors because they would then be able to state on some sort of uniform basis how much charity they did in the community. So one of the strong arguments for increasing the dues to create a service organization was the need to have a uniform accounting manual. As it turned out it was one of the longest to develop of any of the manuals that AHA developed.

WEEKS:

Even as late as 1963 when I was at the University, we got a request from somebody at HEW to appraise the value of trying to collect certain kinds of information from the patients' bills. We looked at a lot of different systems and discovered that there was no way possible that we could get information that they wanted out of billing because it wasn't uniform. Some hospitals would bill day by day and have itemized services for each day. Others would have a billing system that grouped all of the charges for the whole stay and you owed so many dollars for the ancillary and so many dollars for board and room but you didn't know day to day what the charges were that were put in the ledger. I don't think it was until Medicare came along and some of these other government programs that we began to get more uniform systems for cost reporting or billing, etc. I'm sure we are not there yet.

NEELY:

We are still a long way from uniform billing, but closer to uniform cost finding.

WEEKS:

As a matter of interest, nothing more, George Bugbee told me about his great embarrassment with Kenny Williamson when he recommended Kenny Williamson for the Health Information Foundation and Kenny worked for them for three or

four years. Then George thought it would be nice if Kenny would come back to AHA and go to Washington. They hired him...Kenny had gone to Washington and then the director of HIF died and the job of director was offered to George. I think George was very embarrassed because he felt what would have happened if "I hadn't hired Kenny away," he would have been offered the director's job. Did you ever get any sense of that embarrassment?

NEELY:

I suspect the embarrassment was more in George's mind than any place else because nobody can predict a man's death usually. I knew Kenny and I knew George and I never sensed any anger or bitterness on Kenny's part at all.

WEEKS:

No. I'm sure. I talked with Kenny about it and I'm sure there wasn't but George — George was my first interview and in this interview he spoke of this and what an embarrassment it was to him.

NEELY:

Who was the man who died?

WEEKS:

Admiral Blandy, wasn't it? This Foundation had been orginally set up by the proprietary drug manufacturers and it was called the Health Information Foundation. What they wanted to do was to collect as much information as they could about health and then publicize this so that the public would have the benefit of what they had discovered. Their big claim to fame was their household interview survey which Odin Anderson conducted. It was the basis of what the National Center for Health Statistics uses now in their interviews. They have some kind of household interview system that they have developed.

NEELY:

I know that Michael Lesparre, who was on the editorial staff of Hospitals magazine when I went to AHA, left AHA to take a job with Medical Economics magazine and then when George went to New York with the Health Information Foundation, he quickly grabbed Michael Lesparre and pulled him in there.

I guess, as I recall, Mike was with George as long as he was with the Health Information Foundation. He then came back to the AHA in the Washington office with Kenny, only after George went to the University of Chicago.

Incidently, Michael Lesparre would make an excellent interview. I don't know whether you have him on your list. He has a great deal of institutional history. I was with him last night and he was reminiscing about some of the interesting things. Another one who even preceded me and was gone before I got there is David Kinser.

WEEKS:

Oh, yes. He's in Massachusetts now?

NEELY:

He is in Massachusetts. His would be a very interesting interview about the early years.

WEEKS:

George said Michael Lesparre didn't like Chicago, or his wife didn't like Chicago, or something, and that he was very happy to go east.

NEELY:

Mike was never married. It must have been another reason.

WEEKS:

After Kenny went to Washington which would be in about 1954 or 1955, did you have any contact with him? You must have had if you were assisting Norby.

NEELY:

Oh, sure. You bet. I did not know Kenny Williamson while he was in Chicago. He left before I came and he was already at the Health Information Foundation. I later became much involved in the same sort of thing that Kenny did while he was originally on the staff — membership promotion and working with the allied hospital associations, and so on. So I have read a huge amount of what Kenny produced during those years that he was in Chicago. In many ways the things he did were, I think, very inspired. He did some superb work. And then obviously I got to know him when he came back on the AHA staff of the Washington office.

WEEKS:

He did some of the early work that you were connected with later. He helped found some of the state associations, didn't he? There weren't very many when he came there, I don't suppose.

NEELY:

He worked very hard at founding the associations and helping finance them. He was all over the United States pursuading states that they ought to create associations. And, of course, the whole idea was that state and metropolitan and regional associations could create a strong support system for AHA and do things that there was no way the AHA could have done alone.

The folks who were involved with that activity had some highly organized, fairly rigid ideas about how those local organizations ought to be created. They wanted an association in every state to keep track of legislation — primarily, state legislation. But then they said there also ought to be associations in the cities to take care of the special problems that the cities had because a lot of cities were responsible for charity. There really

weren't very many state governments that had taken on the responsibility for charity in those days. So the city associations were largely to be responsible for relationships with the charity sponsors — the donors of money for the sick poor.

The regional associations were supposed to conduct education programs for all the people who work in hospitals. It was felt that if every state or every city did that it would be too expensive and the states ought to get together into regions. That was partly Kenny's idea and partly Dr. MacEachern's idea.

WEEKS:

Trustee magazine was his baby too, wasn't it? Didn't he start that?

NEELY:

Yes. I believe so.

WEEKS:

He worked with volunteer groups too, with ladies' auxiliaries and that sort of thing.

NEELY:

When I joined the staff, Trustee magazine was already being published but people have told me stories about getting the AHA Board to agree to publish Trustee magazine. It was a very controversial decision. There were a number of people on the board who took the position that, "I'll tell my trustees what I want them to know and I don't want AHA to get in the middle of that activity. They may tell them something that I don't want them to know." It was not a unanimous decision. I know one of the people who was particularly identified as a strong opponent of Trustee magazine was an administrator from Milwaukee named Stuart Hummel. So that was not an easy thing for Kenny to sell.

WEEKS:

But he apparently did a good job. At least he got it going.

How about your contact with him after you came to work for AHA and after he was in Washington? I've been trying to get a picture in my mind of what the Washington office does. I assume from my conversations with Williamson that he knew most of the people in Congress of importance, I mean committee chairmen and this kind of thing. He could walk into an office and talk about a bill or he could get them to approach the association for information. Was this the role they were trying to build? The fact that here they were representing six or seven thousand hospitals and are quite willing and quite eager to advise you if you want advice or gather information if you want it. Was this the type of approach they used?

NEELY:

I think most lobbyists will tell you that the United States Congress is so big and so diverse and the congressmen have so many different interests that any lobby sort of zeros in on those particular representatives and senators who have a special interest in their field of endeavor, whether it is banking or health or education.

So AHA's, as almost any other lobbyist's — their principal method of lobbying is to single out those who have an interest in health affairs and then to work particularly hard with the staffs of those congressmen. So I think Kenny's lobbying approach was to get close to the staff members of the senators and representatives who were on the committees that related to health affairs.

I know when I went out to become a state association director I sat down with Kenny Williamson and asked for his advice. He gave me some very useful

ideas. He said, number one, in those days — no longer true today — remember that you go in as the representative of a community charity. That gives a congressman an automatic alliance with you because you represent a field that's doing good in the community and congressmen like to be identified with that sort of work. He said that puts a particular responsibility on you -- it's almost a priestly responsibility. You must always be totally honest and forthright or you will lose for hospitals that reputation of a community service organization.

So he said rule number one, you should assume that all of the representatives and the senators, even at the state level, are your friends.

Number two, you should always be absolutely honest with them. And number three, you should view your role as being somebody more knowledgeable in hospital affairs than they are; and, therefore, you are uniquely able to give them information which they can't get anyplace else. He said always be honest in the information you give them, always tell them both sides of the picture — both the up side and the down side — so that they don't walk up a blind alley and get bludgeoned unexpectedly by some opposition that they don't know is coming.

Obviously, hospitals are no longer the darlings of the Congress but in those days they were.

WEEKS:

What are the comparative roles of the head of the Washington bureau, such as Jack Owen is today, and the chief executive of the hospital association like McMahon? Is it best for McMahon to appear only on stated occasions before a committee, of course he would probably be summoned before a committee. But if he is there as a representative of the hospital association

can he overexpose himself? Can he go too often? In other words, when do you use the Washington bureau and when do you use the boss?

NEELY:

Well, it's a difficult question, because in a large part it depends on the personalities of the people who are involved. But the whole business of lobbying for hospitals changed in 1965 when Medicare was passed.

When I first got into hospital association work, the average hospital could take government or leave it. There were no regulations that were onerous. There were some hospital licensing laws but they weren't tough. The Joint Commission had the tough regulations. The licensing laws weren't tough. There were even some states that didn't have licensing laws. The thing that government did was give out money. If you wanted the money, you could apply for it, and if you didn't want the money, you could ignore government. So government was sort of a take-it-or-leave-it friend really. It gave money. They were trusted to collect data. There were really people on the staff of the then Public Health Service who were real bona fide experts in health care and people would turn to them for expert advice because they were properly viewed as highly trained people who knew their business. They were not regulatory bureaucrats.

The thing that happened in 1965 was that all of a sudden government started writing rules about how hospitals were going to be paid and those rules were very controversial and a whole lot of fights developed. The state hospital associations became angry that the American Hospital Association was not doing as good a job as it should have done in the lobbying activity. One of the things that was demanded of Alex McMahon when he came into the presidency of the AHA was that he had to give a much more ever-present

visibility in Washington than any of his predecessors ever had because that was where the hospitals were demanding AHA performance.

So, as you know, Alex rented an apartment in Washington and spends a great deal of his time there. I really do not know with accuracy how Alex and Jack Owen divide their responsibilities. I would guess that Jack Owen does the day-to-day contact work and Alex McMahon is responsible for coming in for policy negotiations. But there was only a necessity for that after 1965.

George Bugbee lobbied through the Hill-Burton Act and he deserves all the credit that he has gotten for that; but except for that, relationships with government were relatively minimal.

WEEKS:

Crosby didn't have to do much when he was in.

NEELY:

Not very much at all compared to the representation responsibility after 1965.

NEELY:

I think that one of the things that caused Dr. Crosby great grief was the fact that his brand of running the association was no longer very acceptable among the members, because they were demanding this presence in Washington which he wasn't as comfortable doing. They were insisting that Kenny Williamson take on a more aggressive role and, as you know, the elected officers of the AHA put great pressure on Dr. Crosby to change directors of the Washington office. That worried Dr. Crosby probably more than anything else that I know of. It caused him constant grief. It may even have contributed to his death. He was strong enough to say no to the elected officers, but I don't know how long that would have lasted. And it wasn't

long after Dr. Crosby died that the elected officers of the Association demanded Kenny Williamson's head. That was all part of that business of the demands by the state association for a more aggressive presence in Washington. In fact, the state associations were even threatening to set up their own lobbying apparatus in Washington if AHA didn't become more active.

So Alex came in with an absolute mandate to become a visible, articulate spokesman in Washington and he has done that and he has done it creditably.

WEEKS:

I noted the difference too and I was wondering how it came about.

NEELY:

In no way would I want to cast any aspersions on Dr. Crosby — he was a leader in a different time when adversary lobbying was not necessary. And you can pinpoint the date precisely — on July 1, 1965, the whole picture changed and AHA's role changed and the demands changed. It took a couple of years for AHA to catch up to that.

WEEKS:

Yes, I remember that convention that year.

Before we pass on to your South Carolina experience, I wonder if you want to make any comment on Dr. Crosby, what kind of man he was, how he worked, how he thought. I don't have very much on Dr. Crosby.

NEELY:

Dr. Crosby was a statistician and a physician and a humanitarian. His mind worked more like a computer than any human being I have ever known. For example, I would go out to a meeting and I would come back and say, "Dr. Crosby I met so and so." You could just see the little connections come into place and he would say, "Oh yes, he worked at such and such a place and his

cousin is so and so and his uncle was such and such a person, and he was born in..." you could almost see the computer printout. He had an unbelievable capacity to absorb detail.

The second thing was that Dr. Crosby was—I would have to say that I don't think he was a tremendously good organizer — he was a physician and physicians have to see and smell and touch. They don't like to diagnose over the telephone. They are here and now type people. Dr. Crosby would come in in the morning and if something occurred to him in the automobile on the way to work, he would tell the first person he saw. It didn't matter whether it was that person's responsibility or not — "You'll get it done." If the person was good at organization, the person would go say to the one who was responsible for that, "Why don't you do this, the boss wants it." But if the person was not good at organization, or aspired to power, they would assume that Dr. Crosby had just given them a new title and try to do it themselves and mess up organizational lines without meaning to do it. It was right then on his mind and he told it to the first person he saw and he constantly violated this sort of organizational principle. He really had to have his hands on the problem, he didn't want to handle it long distance.

The other thing is that he was a man of tremendous humanitarian instincts. You've heard the stories about how he grew up in the Salvation Army and how he ran errands for the Army and how his parents would give him a nickel and that gave him a choice, he could either ride the bus across town and walk home, or he could walk across town and ride home, but he couldn't ride both ways. So he grew up in very frugal circumstances. As far as I know his widow still has a little cornet on the wall that he used to play when he was in the Army band — Salvation Army band.

I can recall that when one of our employees had a baby who was born with some very bad birth defects, Dr. Crosby personally went out and bought a little silver cup and saw that the baby was given that cup. So he had a lot of love for his fellow man. In many ways an extremely complex individual because of his tremendous intelligence and his tremendous capacity for detail and his almost total avoidance of what people would call typical organizational structure. But once Dr. Crosby became loyal to you he was loyal for life.

WEEKS:

I talked to Earl Perloff before he died and he was talking about taking a trip after the Perloff committee had done its work -- to Europe — and he spoke so highly of Dr. Crosby. He was honored to be a friend. To me, what little I have seen of Dr. Crosby, I have never met him or talked to him personally, I had a feeling that he was a difficult man to approach, that he was a little reserved, possibly, or aloof maybe.

NEELY:

Well, he didn't make friends with you the first time you met him. No, he had to learn to know you, but once his loyalty was built, it was there. It was hard to grow into a friendship, but it was hard to lose the friendship once you made it.

WEEKS:

That's good in itself. Were you there when the new building was built or was this after you left?

NEELY:

I was there when the ground was broken, I was not there when it was occupied. I was in South Carolina.

WEEKS:

I assume, from what I have heard, the idea was to invite all the health organizations to become tenants...such as Blue Cross.

NEELY:

That was the concept.

WEEKS:

And make the rent reasonable so that would be an incentive for them to come in.

NEELY:

Of course the building was built in two sections. Blue Cross did not come into the original building. When they made the addition, the second structure, then Blue Cross came in.

WEEKS:

I was wondering whether he was looking forward to a time when there might be an association of the associations, or a council of these associations all in the same building.

NEELY:

I don't think he ever saw an organizational takeover or coalition or anything like that. I think he believed that if they were all under one roof they would talk to one another and never become competitors.

WEEKS:

It would be a family type of situation.

In 1954, I have you listed as secretary of a council.

NEELY:

That was then the Council on Prepayment Plans and Hospital Reimbursement. That's the one I took over from Norby when Maurice decided I was old enough

and strong enough and smart enough to take on some responsibilities of my own.

WEEKS:

I have just some minor questions here that occurred to me. I see that you are listed in 1956 as assistant director of research. What kind of research were you doing and was this for HRET?

NEELY:

HRET has been in existance for years and years and years. I don't even remember the date that it was organized but it predated my first joining the AHA. So, yes, it was done within the context of HRET. Dr. Crosby, of course, always maintained his close ties with medical statistics, he was always part of that group. One of his great friends was the professor of biostatistics at the University of Minnesota, Dr. Alan Treloar. Dr. Treloar was an Australian and world renowned for his ability in biostatistics. He and Dr. Crosby had huge respect for one another because of their statistical backgrounds.

Dr. Crosby persuaded Dr. Alan Treloar to come and join the association staff. The first thing Alan asked for was an assistant. I was young and Dr. Crosby was trying to give me exposure into all sorts of different things and he asked me whether I would like to become Alan Treloar's assistant. It was a promotion and I said yes. I did it for six months. Dr. Treloar was tremendously smart, tremendously friendly and a good friend of mine, but as some researchers do, he spent so much time involved in little teeny-weeny detail that it drove me crazy. I don't mean to demean what Dr. Treloar did. He was a brilliant man and a good friend and I liked him. But we would spend the whole week talking about whether it was appropriate to call a hospital a hospital or whether it ought to be called a hospitarium. Or, we had never heard of the word hospice, but we invented the word and we talked about

whether the name hospital should be changed to hospice. That just didn't have enough action in it to satisfy me.

So I went out and hunted another job and eventually took the South Carolina job when Dr. Crosby was out of the country. When he came back from the trip, he made me feel about as high as a worm's belly.

He said, "Well, you know how much I enjoy having you on the staff. Why didn't you tell me you were dissatisfied?"

I didn't have a good answer for him. I solved my own problem by finding another job that had more action orientation to it. But Dr. Crosby always viewed that as a certain disloyalty. And I have always regretted that in a way. I've never regretted going to South Carolina, but I regretted not telling Dr. Crosby that I was unhappy because I owed that to him. I didn't come through as I should have.

WEEKS:

Would you talk a little about your experience in South Carolina?

NEELY:

I was the first full-time executive in South Carolina. I suppose the funniest thing that happened to me was that I was born and raised in the area of Gettysburg and I wasn't at all sure how they were going to treat a northerner in the deep south, particularly somebody from Gettysburg. I told the man who was then president of that association — I went with the title of director — I told the man who was president, please don't tell anybody that I'm from Gettysburg, let them get to like me first. And at the very first meeting that we went to — I had only been there one week — he introduced me as the new director of the South Carolina Hospital Association who was from Gettysburg, PA.

I was terrified because I thought that was immediately going to put me on the wrong foot with everybody there. He knew what I didn't know and that was that the real true southerners don't really identify people by where they were born — they identify people by how they live and what they say and how they behave. So it wasn't a bad thing to have done at all, but he sure frightened me that first week I was in South Carolina.

The Association grew and prospered. I was there for six years; six of the happiest years of my life. I loved South Carolina. But then Madison Brown called in 1963 and asked would I please come back to the AHA staff. They had some particular things they needed done and I had proven that I could run a state hospital association and it was now time to return to the mother's womb and he offered me a substantial increase in salary. I took it and returned to staff of the American Hospital Association in 1963. So I was in South Carolina from 1957 to 1963. I must say that some of my dearest and closest friends are still in North and South Carolina. They are fine, wonderful people with whom I developed warm relationships, and I'll never forget them.

WEEKS:

Did you develop something in the way of a Blue Cross contract?

NEELY:

The hospitals in South Carolina were very, very unhappy with Blue Cross and their cost reimbursement. Blue Cross didn't have as much strength in South Carolina as it does in a lot of northern states. I think they had 12% market share which in a small state like South Carolina wasn't very big. So we created a committee to negotiate a contract with Blue Cross.

That was a little tedious because I was a tenant in the Blue Cross building and now I found myself negotiating a very controversial subject with

the landlord. Some of those negotiation sessions were antagonistic to say the least. We managed to develop a much, much, much improved Blue Cross payment formula. The hospitals were delighted with it. Blue Cross accepted it and even though my relations with my landlord were strained for a while, I was pleased when I left South Carolina to go back to AHA, the president of the Blue Cross plan said — well, told his staff, he didn't tell me this directly — "I think we have just lost one of the best friends we have ever had."

WEEKS:

That was a nice thing to say. When you got back, you first got into the Blue Cross relations?

NEELY:

Right back where I left, yes. I had been the secretary of the Council on Prepayment Plans and Hospital Reimbursement. Madison Brown was by that time secretary to the Council on Financing and even though he carried the title, I went back doing essentially the same thing I had done when I left. Plus, I had some additional administrative responsibilities that I did not have when I was there before.

WEEKS:

Then later you got into the Division of Association Services which lead to your...

NEELY:

I had been, of course, director of a state hospital association. I was the only one on the AHA staff at the time who had hands-on experience running an association out in the field. I loved it. I loved South Carolina; I loved the work; I felt like I knew a lot about how AHA ought to change its relationship with the associations. It was my view that AHA ought to treat

the associations as allies, that they ought to treat them as friends who could do things in the field that AHA could not do for itself. And that required taking them into the family and letting them become part of the AHA, not in a policy creation way, but in terms of AHA feeding information to them and letting them have special knowledge of what was going on, asking for their help on projects that they could do better than we could do.

Up until that time, the associations were treated as just another constituency. In fact, they were even invited to join as members if they wanted to pay dues. And there was a person on the staff whose responsibility was to handle that constituency. One of the changes that I am thankful I was able to bring about was — what I said was the relations with the associations should not be funneled through one voice and one mouth and across one desk. Everybody on the AHA staff should recognize that those allied associations were there to help. Everybody should feel free to use them and communicate with them and work with them and help them and get help from them. So we totally changed the relationship that AHA had with the allied hospital associations while I was in that position. Something that I felt was necessary and I'm glad we did.

WEEKS:

At this time were you able to do much as far as determining what the responsibilities of each were? ...such as the state versus the regional, versus the metro?

NEELY:

We tried very hard. Obviously when you fool around with people's turf they worry a lot. There have been a whole series of efforts at the AHA and among the allies to find what each should be responsible for. And that dates

clear back to Kenny Williamson and Dr. MacEachern when they first encouraged those various associations to organize. I certainly continued that and I believe continued to strengthen those definitions, but it continued long after I left AHA. It is still going on today. And it changes.

WEEKS:

As you mentioned, when Medicare went into effect this made a great change too in the fact that national advocacy was laid at the doorstep of AHA more than it was the state associations or the metros. And as you are suggesting, this is not a static thing, it is something that is in flux and will change as time goes on.

NEELY:

After I left AHA the second time, and Leo Gehrig was director of the Washington office, they developed a program which really depended on the states to help AHA with its lobbying. They came to realize that Connecticut could do more with the Connecticut senator than somebody in Washington could do. That Utah could do more with the Utah senator than somebody in Washington could do. So they developed a whole new protocol, called the Partnership for Action, by which whenever there was a legislative crisis, AHA could call upon the state association to do its local contact work. It improved AHA's ability to lobby immeasurably, but it also created a new kind of turf fight. AHA said "We are going to depend on the state hospital association to organize the local lobbying effort." Then the metropolitan hospital associations got their noses out of joint. "Why are they calling on the state association and not the metropolitan association?" AHA said, "It is up to the state association to use you if they want to. We are not going to get in the middle of that disagreement." So once again that turf definition evolved. Now it is very

well accepted that local lobbying is clearly the responsibility of the state hospital association. But it took three or four years to work that through before everybody agreed that you could not have duplication, you could not have two or three people telling two or three different stories to the same senator.

Now AHA is very dependent on those local associations for their assistance in lobbying.

WEEKS:

That's the old grass roots theory.

NEELY:

Absolutely.

WEEKS:

What other positions did you have?

NEELY:

By the time I left the American Hospital Association, I had the title of Associate Director for Planning. Essentially, I moved away from the allied association relationship and into the president's office. We had, at that time, I don't remember how many associate directors -- Dan Schechter was one, Dave Drake was one, a doctor was one, -- and we were really the third echelon of management. The second echelon of management was Jim Hague and Madison Brown, and then Dr. Crosby, of course, was the top management. My own particular responsibility was for planning. I was there and involved when the American Hospital Association adopted its position supporting certification of need which at that time seemed to be the right thing to do. Ten years later it was just as right that they abandoned that position, but at that time it was the right thing to do.

In addition to that responsibility, there were, under the associate directors, bureaus, and I was the Chairman of the Management Council which was all the bureau directors. They would get together and meet and make recommendations -- they were the fourth echelon in management — and I was chairman of that group. Not that I had line management responsibility for them, but that we'd meet and I would transmit their recommendations for administrative action to the management echelons above me.

WEEKS:

Then of course, the big question is why did you leave the second time?

NEELY:

Well, Pennsylvania is my home state. It's a very big state with a lot of resources. The president of the association, or then he was called the executive vice president, was retiring and I wanted to come back to my state and do the thing that I had spent twenty years learning how to do and that was running an association of some substantial size.

The Hospital Association of Pennsylvania had about twenty employees when I came here in 1971. If you were to add together the employees of the association and all the subsidiaries, including the insurance company, it now has well over 200. We had a substantial growth and I'd like to think that we were good at a lot of things. I suspect the thing we were best at was representation and advocacy. In the middle of heavily regulated New York, New Jersey, Maryland, even West Virginia now, Pennsylvania was and still is sort of an unregulated oasis in the Middle Atlantic states.

WEEKS:

What did you do when you entered your office and said I have an association? What kind of problems did you look for?

NEELY:

I didn't have to look. When I came to Pennsylvania, there was an insurance commissioner in this state in office by the name of Herbert Denenberg who was famous all over the United States. He had decided that the route to political power was to vilify the hospitals. It was made absolutely clear to me when I was hired that I was to develop a strategy to soften Commissioner Denenberg's blows. I believe that we were able to do that. I believe we did it successfully. But that was clearly the first problem I had to deal with.

Another thing was that when I came to Pennsylvania we were right in the middle of the Federal Wage and Price Control Program for hospitals. Because of the peculiarities of our fiscal year, when it begins and ends, we were particularly hurt by the wage and price program. Fortunately, one of our representatives was a good friend to hospitals and he was minority chairman of the House Ways and Means Committee. His name was Herm Schneebeli. We were able through Herm Schneebeli to get some regulatory changes through which helped hospitals with our peculiar fiscal year.

You see almost 100% of the hospitals in Pennsylvania are on a July 1 - June 30th fiscal year. Other places, the majority of the hospitals are on an October 1-September 30th fiscal year. But in Pennsylvania, strangely, we have almost 100% of our hospitals on that July 1-June 30th year. And because of the way the regulations were worded we simply had to get them changed. It caused all sorts of hardship -- that was one of our early successes. A lot of people were very grateful for our having been able to do that.

WEEKS:

You talked of developing an insurance company...

NEELY:

In 1975, as was true in all the United States, here in Pennsylvania the insurance carrier for hospitals just abandoned the State and left over 140 uninsured hospitals — and no insurer was willing to write malpractice insurance for those 140 hospitals. The carrier that abandoned us was Employers of Wausau. They simply said that our line of business was no longer profitable. We had all sorts of emergency meetings to try to decide what to do. The end result was that we created our own insurance company which has now become one of the largest hospital malpractice carriers in the country.

That company originally started writing hospital malpractice; they branched out into physician malpractice and workers' comp and even property. The only line they won't write right now at this time is auto. They are licensed in seventeen states and continue to grow. It has become a major -- they have assets of over $200 million — it is a major subsidiary of The Hospital Association of Pennsylvania.

WEEKS:

Does that contribute to the income of the Association?

NEELY:

Not at all.

WEEKS:

It's entirely separate.

NEELY:

The Association selects the board members and the president of the Association serves as chairman of the board. But there is not any attempt to make money off the insurance operation for the Hospital Association of Pennsylvania — at least not at this time.

WEEKS:

But it has been able to operate in the black?

NEELY:

Every year. It is a very successful company.

WEEKS:

If they have $200 million in assets, it must be.

Would you like to talk about your 1980 project? The Hospital Associations in Change book?

NEELY:

Well, it really dates way back — I have been involved in almost every effort since 1953 to define the relationship between AHA and what are now called the allied hospital associations. Even when I was at AHA the very first time, I didn't have responsibility for association relations — Howard Cook did — but he was nice enough to take me along to the meetings and I met the state association directors and learned to know them. And as I told you a few minutes ago, when I came back the second time and took on the responsibility for allied association relations, they were frankly pretty bad. There were new directors, or executive vice presidents, or executive secretaries, or whatever title they had, in almost every state in the United States. And because they were largely ignored by AHA they were distrustful of AHA. I set about trying to improve that relationship.

The first time that I wrote a book on relationships between AHA and the allied associations, we conducted a whole series of projects — only one of which was to talk about how those relationships evolved over the years. Although I was not officially listed as author — AHA publications were authored anonymously in those days when they were written by a staff member —

I was the one who authored a book called "Study to Delineate Proper Relationships Between the American Hospital Association and Allied Hospital Associations." I spent a lot of time with that back in 1967 and '68.

Then after I came to Pennsylvania, although not as an AHA employee but as a member of an AHA committee, I was again involved in an effort to redefine the relationship between AHA and the allied associations. Everybody was saying at the committee meetings that they wished my original work in 1967 would be updated. So I agreed that if they would allow me to take credit for it as my fellowship paper for the American College of Hospital Administrators, I would take on that work as a personal project. So really what I did in 1980 was update what I had originally done back in 1967.

I have always had an interest in history. I had been much involved in the emerging changing relationship between AHA and the allied associations because of that personal background and personal interest in history probably better able to do it just from my own personal memory plus institutional records than anybody in the country. I don't claim that it is a brilliant piece of work or that it is timeless prose, but I happened to be the right person at the right time who was able to make that contribution.

WEEKS:

Speaking of history — in going through this — I haven't read this as carefully as I should — but I am wondering about the directors, the executive secretaries or whatever the title may have been of AHA. Of course I came across the first one who was Dr. Walsh. I have the dates down here of 1915 to 1917 — at least I estimated that those were the dates — when he left to join the service during World War I. But I have him as a part time executive in Washington, DC. Is that right?

NEELY:

You are asking me to remember details from when I did all of that research four years ago, Lew, and I'm not sure I can precisely document it. He left to become part of the military and then came back and I think did some more work for AHA after he came back.

WEEKS:

Let me read what I have here and see if we can come to some conclusion. I have him as leaving for World War I and a man by the name of Howell Wright of the Cleveland Hospital Association apparently filled in for him part time. I'm just wondering — was that in Cleveland or in Washington — probably they maintained an office somewhere.

NEELY:

I think that was in Cleveland.

WEEKS:

Then in 1919, there was a man by the name of A. R. Warner, an M.D., who according to these figures served until 1927 and then died. Then Walsh came back again for a short time. But this leads me up to the question...when did headquarters...when was the headquarters established in Chicago and when did Bert Caldwell come?

NEELY:

I am going to have to refer to my own notes again, Lew, I do not remember those dates.

WEEKS:

I couldn't find a reference to Bert Caldwell and I always had an impression that Caldwell had been there quite a while when Hamilton sort of forced him to resign and George Bugbee came in from Cleveland.

NEELY:

He was there for a while and I cannot tell you the exact number of years. It is in the book. I can find it if you want me to take the time to look it up. I don't remember from memory. As a matter of fact, some place in my research notes, I wrote down precisely how long each AHA director was there -- from what year to what year. I don't think that ended up in the book as a table, but I have a table among my working notes where I had listed each of those people and the years they were there.

WEEKS:

I know that Caldwell was at Division Street, but I don't know where he came from or how. I know he was in the first World War. He was the head of a hospital in France, I believe, during World War I. I always assumed he came back from the war and started to work at AHA but according to this it was later.

NEELY:

It was much later. And I simply don't know the year.

I never knew Bert Caldwell. The only anecdote I know about him is Maurice Norby said he used to bring his dog to work.

WEEKS:

Norby said that his office — when Norby was working for Rorem, they were housed in that building and he had helped Caldwell in some of his reports although he did not work for Caldwell directly. And he said that when Caldwell would have a question he wouldn't call him on the telephone, he would yell and expect Norby to answer him.

I think we should discuss your Health Alternatives Development.

NEELY:

I told you a few minutes ago that Pennsylvania was sort of an unregulated oasis on the East Coast and obviously the hospitals wanted to keep it that way. We had successfully, for years, held off the desires of government to become more and more regulatory in the state.

What happened a couple of years ago was that big business in the state became restless. I began to see big business creating a partnership with government so that together they would demand regulation of health care costs. We got a new Republican governor and one of the first things he did was appoint a study task force on health care costs. I was a member of that. I really went into it thinking that business would be our ally and would be opposed to regulation, in favor of free enterprise. Instead, I found businessmen who were so angry at rising hospital costs that they were ready to adopt even more stringent accountability and regulation than the regulators were. It became very apparent to me that we were going to start losing our battle that we had spent ten years to win because when big business and government combine forces against hospitals, you know you are in deep trouble.

We had all sorts of meetings at the Association — strategy sessions, planning sessions to figure out what to do. We tried to narrow down our options. One option was to simply try to fight all attempts at regulation until we lost. In time, maybe faces would change, the pressures would change, but we were pretty sure that we would lose because it was a losing battle.

The second option was to join regulators and say, yes, we will submit to regulation providing you give us the right to help write the regulations so they will be less onerous. And we decided that every place we had seen that strategy tried, the hospitals ended up losing the battle because the

regulators the first year would have friendly regulations, and the second year a little less friendly, and the third year a little less friendly.

The third option was to say that we believed in market place competition and would like to see an environment created where hospitals would become price competitive. That's great theory and I certainly endorsed it. The problem is that when you are president of the hospital association that is a difficult policy to implement because in price competition there are winners and losers and the president of an association cannot be in a position of playing favorites. It is also difficult to push something that you know very well will hurt some of your members seriously.

While I was debating this, Bob Cathcart, who is president of Pennsylvania Hospital and a former chairman of the board of AHA came to me and said, "I'd like you to leave your position and try to develop a strategy to create a price competitive environment in Pennsylvania using only selected hospitals." I was persuaded away from the hospital association position to try to implement the policy we had developed.

We spent ten months developing a good program. Part of that time was spent assuring ourselves that we would be supported by hospitals and a lot of doctors — although there were some dissident doctors. And after all of that, I had to go out and raise capital to create the enterprise that would implement the program that we had developed. I was totally unsuccessful in raising the capital we needed. We had to have $5 million, I succeeded in raising $3.5 million and it was simply too risky to start up with that. There was a great danger that if we became operational we would move into the red zone and never come out and we thought that was a dishonorable thing. So we decided it was far more honorable to admit that we could not raise the

necessary capital and abandon the effort.

The four hospitals that had sponsored the effort were very generous in giving over a quarter of a million dollars apiece, but they simply did not have the resources and their boards were unwilling to come up with more money while we continued to hunt for capital. So we were faced with their inability to continue our research and development effort and our inability to find capital, and we abandoned the effort.

WEEKS:

What was the program? What did you hope to do?

NEELY:

The keystone of it was that we developed what would have been the first operational alternate delivery system that depended on joint venturing of hospitals and doctors with a sharing of risk between them. Most of the other — all of the other alternative delivery systems that I am personally familiar with — the doctors are at risk for the doctor part of the business and the hospitals are at risk for the hospital part of the business, or the insurance company is at risk, but there is no other program where the hospital and the doctors are jointly at risk for the services of both. And that was the unique feature of our business. I'm still convinced that it's a good plan and I'm convinced that within ten years a lot of the alternate delivery systems will move in that direction.

WEEKS:

Would you market this like you would an HMO?

NEELY:

It would be marketed like any other health insurance. The same way HMOs are marketed, the same way PPOs are marketed, the same way Blue Cross or

commercial insurance is marketed.

WEEKS:

This is just another alternative...

NEELY:

This is another alternative.

WEEKS:

And the principal difference was on the risk factor.

NEELY:

The joint sharing of risk between a hospital and those members of its medical staff who choose to join in. Now, there were other features that were somewhat unique, but that was the keystone of what we were trying to do. That was the thing that was totally different.

WEEKS:

I'm sure that if you had been able to get the $5 millions, you probably would have been able to get it rolling.

NEELY:

There is absolutely no question in my mind but what the market was ready, no question in mind but what we could have gotten hospitals and doctors to participate, no question but what we would have had enrollees and quickly. But the problem with our venture was that if you make hospitals and doctors jointly at risk, you have to go through a full one year cycle before you can close your books on the year — before you can decide how much bonus hospital and the doctor get for good performance and how much penalty they get for bad performance. That requires a huge amount of capital because the insurance company is fully at risk for twelve months and so that meant that our start up capital needs were higher than the other alternative delivery systems that

have started up.

There have been HMOs started for a fourth of what we put into research and development. But our peculiar form of providing rewards and incentives forced us to go through a full twelve month cycle and that, of course, demanded more capital and that is what we were unable to raise. We thought we could raise the capital from hospitals themselves. As a matter of fact, and I take personal responsibility for this — I should have recognized it and didn't -- hospital board members who are normally businessmen and risk-takers — businessmen who have gotten where they are by taking risks — when they sit on hospital boards, they view their role entirely differently than they do with their own business. When they sit on a hospital board, it is their responsibility to preserve and protect the community's assets that are put into the hospital. And you just don't take those assets and put them into a new business venture.

I had three months to raise the capital that I needed to raise and I spent two of those three months trying to get the capital from hospitals because we wanted to be owned by hospitals and doctors. I learned too late that the hospitals would not or could not come up with the money. By the time I went out to the venture capital markets, there was too short a time to generate it.

WEEKS:

Was this in one community?

NEELY:

State-wide — the state of Pennsylvania. And it was our plan to go outside the state within twelve months.

WEEKS:

The four hospitals were merely putting...

NEELY:

They merely financed the research and development effort. We had to find the capital to become operational. Well, I won't say they never had any intention of financing becoming operational, but it quickly became apparent that it was going to far outreach their ability to pay for it, and so our reserves and up-front working capital had to come from other sources than the four who had financed our research and develooment.

WEEKS:

In your research and development had you come up with any answers to the question of how to pay physicians? Would it be on a fee-for-service?

NEELY:

Oh, yes. We had answers to all of those questions — how to pay physicians; how to pay hospitals; what our benefit structure should be; what the reward system should be; what the incentive system should be; what the penalty system should be; how the utilization and quality control program was going to work. We had answers to all of those questions. The one thing that was lacking was that we were a little bit slow in getting our actuarial work done because it was such a new scheme that the actuary didn't know — every step of the way was new ground. So it took a while to get our actuarial work done — longer than we expected. Even that was done by the time we finally closed down.

The one step that was missing was our inability to raise the capital for the necessary reserves that we had to have to be safe.

WEEKS:

Will the idea be good tomorrow?

NEELY:

I am an enthusiastic supporter of it as many people are. I think it will be just as good tomorrow as it is today and not only that, I think a lot of organizations will turn to it. I think ultimately a lot of the HMOs and PPOs will adopt the joint venturing that we pioneered.

WEEKS:

I have been wondering about all the forms of delivery that are now on the scene, as you say, HMOs and the PPOs and all the others and the variations within each one of these. Do you think there is going to be a shakedown here finally and we will end up with two or three modes of health care delivery and the rest will fall by the wayside or change and become merged with these other efforts? The reason I am thinking of this is just the step that is being taken by Blue Cross now that they are trying to combine their HMOs across the country to set up a national system.

NEELY:

I don't think there is going to be any single system survive, Lew. I think that government will continue to pay for the aged and those who can't pay for their own care for whatever reason — because of disability, inability to earn income, whatever it is. I think they will have certain payment requirements which are quite different from those of the HMOs and PPOs. I think the HMOs and PPOs will have some payment systems which are different than the traditional Blue Cross and commercial insurance.

I think what we are going to end up with is a multiplicity of payers in the market place. And I think that's very good. Here in Pennsylvania, 60% of the private insurance market — actually, more than that — is controlled by Blue Cross. That is almost an oligopoly. It is my opinion that while Blue

Cross is a fine organization for which I have a huge amount of respect, I just don't believe in oligopolies. I think there ought to be more players in the marketplace. And that isn't to say anything bad against Blue Cross/Blue Shield. And I think that will happen.

WEEKS:

Maybe I should state my question differently. I think I was thinking that in the future, sometime down the road, for an organization to be strong and survive will it have to be national?

NEELY:

I think we are already seeing trends that that is going to happen. Whether it has to or not, I think it will.

WEEKS:

This goes back to John Mannix.

NEELY:

You are seeing, for example, two or three major corporations emerging that are taking over the little teeny-weeny HMOs and making one vast chain of HMOs. There are a couple more organizations that are now moving into that market place and trying to become a national chain of HMOs. My guess is that you will end up with very few small independent alternate delivery systems in the future. I think they will be merged into some sort of a coalition or series of coalitions.

WEEKS:

This problem has existed for many years. I can remeber John Mannix saying that one of the problems that he had when he went to Detroit to start the Michigan Blue Cross in the early days, that when he went to sell somebody like Ford or General Motors or J. L. Hudson -- particularly Ford, Chrysler and

General Motors -- they wanted something that would cover their employees any place in the country. I suppose that this in turn lead to John Mannix starting the John Marshall Insurance Company because I think that he sincerely felt that there was a need for it. I'm certain in my own mind that he didn't do it for any profit he might make out of it because, as I remember, he did insist with the board of John Marshall Insurance Company that there could be no more than one percent paid to investors out of the revenues. So that certainly was not much inducement for anybody to buy stock in the John Marshall Insurance Company but apparently this is what he had in mind. So we still have that same problem. I look at HMOs cropping up all over and then I look at Blue Cross saying we're going to combine all our HMOs and have a network. I don't know whether they have covered the whole country yet or not...I doubt if they could.

NEELY:

I don't they think they could do it yet. I think they will soon be able to. I think U.S. Health Care is moving in that direction. I think Health America is moving in that direction. There is a coalition of HMOs led by the Puget Sound group, along with the Harvard group and HIP in New York and an HMO out of Minneapolis, and they are trying to create a national coalition of HMOs. So a lot of people in the HMO business are moving in that direction now for a lot of reasons. The national network of being able to provide benefits is one of the reasons, as you say, but another reason is that there are efficiencies in bigness. There is profit to be made from subsidiaries. There is a stagnation that occurs if you don't grow.

I think all the heavy-hitters that are in the business are recognizing all those things and are quickly moving to some sort of national coalition.

WEEKS:

Are the insurance companies going out of HMOs?

NEELY:

No, indeed. They are moving into it as fast as they possibly can.

WEEKS:

They are going out of investor-owned hospitals I assume somewhat.

NEELY:

The biggest insurance investment in investor-owned hospitals was when INA owned Hospital Affiliates.

WEEKS:

Didn't they sell that?

NEELY:

Did they ever! They sold it for a huge profit. That's what this congressional investigation that is underway right now is looking into because — isn't it Gradison from Ohio who is conducting the investigation — his claim is that just the sale, just the profit on the sale of INA created a whole new expense that shouldn't be burdened on health care costs.

But I think that was the last major insurance investment in investor-owned hospitals. They may hold little bits and spots here and there but that was the last big, big, big investment.

WEEKS:

Those were the ones sold to HCA, weren't they?

NEELY:

INA sold to HCA, yes.

WEEKS:

Did they retain their Ross-Loos Clinic? That is an HMO, I believe.

Is there anything that you would like to add? Is there any activity that you've been in that you would like to put on record? You have worked on many task forces.

NEELY:

Nobody who lives in an age believes that they've been much of a participant in creating the history. If I have anything unique in my memory it is some of the early days at AHA. Maurice Norby, as you know, is a great storyteller. Some of the funny, funny, funny stories he told me about van Steenwyk and Rufus Rorem and Colin and Basil MacLain would entertain future generations for years to come but I don't think they would contribute a whole lot to an institutional history of the American Hospital Association. And I suspect a lot of other people have already told you about that early history.

The second thing where I think I am probably uniquely qualified is to talk about the evolving relationship between AHA and the allied associations. I wrote a book on it — two books, really. Much of what I have to say about that in detail is in those books and so anything we covered here would be almost a superfluous duplication of it.

We have covered the essentials of it. If anybody in future generations wants the detail of it, they can always go to the books. I'm sure that AHA will keep at least one copy in the library with enough dust off of them so that people can find the books.

I guess two of the areas where I can make the most contribution have been well enough covered.

There is one other thing, however, and it has to do with the fact that I was on the AHA staff when Medicare was passed in 1965. One of the things that

Kenny Williamson felt most proud of was the fact that he negotiated into the law as it was finally passed that there would be an intermediary between hospitals and government so that government would not be a direct payor for Medicare. He felt that putting that buffer in there would somehow protect hospitals against onerous government bureaucratic regulation. It has not turned out to be so, but the truth of the matter is that he was very proud of that accomplishment when he did it.

And, of course, Blue Cross plans across the United States were largely the children of hospitals. They were created by hospitals and certainly by pressure from the American Hospital Association. As you know, AHA owned the Blue Cross name and symbol for years. So when Medicare passed, AHA immediately said, "We've got to get our friends in Blue Cross named as the intermediary for Medicare." They are our children; they are our creature; they will be our friends; they will protect us against onerous government regulation. It became my primary responsibility with my various assignments with the American Hospital Association to travel the length and breadth of the United States to try to persuade hospitals all over the country to name their Blue Cross plan as their intermediary.

As I recall, I spent four months on the road where I saw my wife maybe two weekends out of the four months — just going from one area to another. In most places the Blue Cross relationship was very, very good, and it was not a difficult job. It just required explaining to them what — to the hospitals — what their options were. In a few jurisdictions there were terrible relationships between the Blue Cross plan and their hospitals and there it was much more difficult to persuade the hospital that they ought to designate Blue Cross as their intermediary.

Having gone through that effort for four months, came the moment of designation. AHA developed a form, mailed it to the hospitals. That was, I guess, like a political campaign. It's election day now and you find out whether you have been successful in persuading the electorate that your position is right. I think something like 86% or 88% of all hospitals in the United States designated Blue Cross to be their Medicare intermediary. I have always considered that to be one of AHA's achievements, largely I suppose because I worked so hard at it myself.

I can remember sitting down with my good friend John Mannix, whom I have loved and admired for years. I said, "John, there are moments in this effort when I had great qualms of conscience because I was not sure I was doing the right thing. You guys in Blue Cross have been my friends for years and — as I told you earlier in the interview, I spent a long time on that side of AHA's activity — and for years you have been friends of hospitals and now you are going to become an agent of government and government is going to start compelling you to do things that you would not necessarily do of your own volition. Isn't that going to turn the hospitals and you into adversaries?"

John insisted that would never happen. Well, clearly my worst fears have been realized and it has turned hospitals and Blue Cross plans into adversaries in many sections of the country. I like to tease John every now and then and tell him that even the greatest of men can make misjudgments about the future.

But that is one part of AHA's institutional history that is not very well recorded. I know on a couple of occasions the folks on the AHA staff have asked me to retell that story.

WEEKS:

It is interesting because it is surprising how many people now claim responsibility for thinking up the idea of the intermediary.

NEELY:

I think that can be 99% attributed to Kenny Williamson.

WEEKS:

I know he mentioned it but others have mentioned that they or someone else for one reason or another — there are many stories. I believe this is the correct story. And to add a P.S. to this, the intermediaryship has saved the necks of many Blue Cross plans financially.

NEELY:

Yes, you are right.

WEEKS:

In fact, I think the tail is wagging the dog now.

NEELY:

In many cases. And who knows, maybe some of the adversary relationships would have developed anyway because a lot of people were complaining about the cheek to jowl relationship that hospitals and their Blue Cross plans had and they were critical of Blue Cross for not becoming tough controllers of hospital costs and tough protectors of the subscribers' money and that sort of thing. Who knows, it might have come without Medicare, but Medicare surely pushed it along.

WEEKS:

I'm sure we are going to be facing many, many more regulations in the next few years — beginning with DRGs and whatever they do to physicians, I'm sure they are coming next — nursing homes I guess are coming next, aren't they?

NEELY:

I don't know. I would guess physicians would come before nursing homes.

WEEKS:

All I know is that they have a group studying nursing homes. Maybe it won't come in sequence that way but it is on the horizon. I'm sure they are thinking of physicians too.

NEELY:

One of the congressmen — I forget his name, but on one of the major House committees — gave a speech just last week in which he said that he expected physicians to be brought under the DRG program within three years. I think he is probably right.

WEEKS:

I know your time is short until you leave for your appointment. Thank you for the interview. It has been very constructive.

Interview in York Springs, PA

April 18, 1984

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