



**PAUL M. ELLWOOD, JR., M.D.**  
**In First Person: An Oral History**

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**PAUL M. ELLWOOD, JR., M.D.**

**In First Person: An Oral History**

**Interviewed by Anthony R. Kovner, Ph.D.  
On September 16, 2010**

**Edited by Kim M. Garber**

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**EDITED TRANSCRIPT**  
**Interview conducted in Bondurant, WY**

**TONY KOVNER:** Today is September 17, 2010. My name is Tony Kovner. I'm a professor at the Wagner School at New York University, and I'll be interviewing Paul Ellwood, Jr. Dr. Ellwood went to Stanford University for both college and medical school. He did his pediatric internship at the University of Minnesota. After directing inpatient services for the Sister Elizabeth Kenny Institute, he headed its successor organization, the American Rehabilitation Foundation. Dr. Ellwood was clinical professor of pediatrics, neurology and physical medicine and rehabilitation at the University of Minnesota. Subsequently, he became executive director of InterStudy, the health policy research organization that succeeded the American Rehabilitation Foundation. In 1992, he became founder and president of the Jackson Hole Group. Paul, could you tell us a little bit about your background that led you to become a doctor and to adopt the values that you have today?

**DR. ELLWOOD:** My values stemmed from wonderful parents, experiences as a physician, and some literary role models. I was born at Stanford Hospital in San Francisco where my father had been an intern and my mother a student nurse. My parents were very supportive. Both were involved in charitable activities. My mother always had a family or two, usually immigrants, that she was looking after. My father had a family practice that was modest, largely neighbors, relatives and lots of old folks in the pre-Medicare era. Both of my parents felt that serving others was the most important thing to do in life. They didn't care about money. They didn't have much.

My father, especially, was interested in taking care of disadvantaged people. He worked at first for the Rockefeller Foundation in Alabama, on things like hookworm and tropical diseases that hardly exist anymore in the U.S. After working for the Public Health Service in California, he then went on to practice in Oakland, California, where I was raised.

Oakland, which currently gets a bad rap, was a great place to grow up, especially during the later '30s and '40s. On the ferry boat ride to San Francisco, we could watch the famous bridges – the Bay Bridge and Golden Gate Bridge – go up. I was allowed to go by myself to Treasure Island, site of the 1939 World's Fair, where I could see the China Clipper flying boats take off for the Orient. Then there were the family camping trips to the Sierras and Yosemite.

During the war in the Pacific, the harbor was filled with great aircraft carriers and Henry Kaiser's Liberty Ships. I heard about Mr. Kaiser and Dr. Sidney Garfield starting a health plan for the shipyard workers because the local doctors, like my father, had gone to war.<sup>1</sup> When I met Dr. Garfield in person at a dinner decades later, he confided, "I wish you would



**Great Lakes Naval Station,  
Waukegan, IL in 1945**

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<sup>1</sup> During World War II, demand for shipbuilding swelled the workforce at the Kaiser Shipyards in Richmond, CA, to as many as 90,000 over a short period of time. Henry J. Kaiser engaged Dr. Sidney Garfield, who'd had experience in running small hospitals to care for construction workers working on the Los Angeles Aqueduct and Grand Coulee Dam projects in the '30s, to set up a health care delivery system for the shipyard workers. After the war, with union support, Dr. Garfield was able to continue to develop his concepts of prepaid group practice in the Los Angeles area.

run my health plan.” Not a chance! Kaiser Permanente Health Plan was being managed ably by my admired friend and mentor Jim Vohs.<sup>2</sup>



**Serving in the Philippines, 1946**

After graduating from Oakland High, I joined the Navy and became Pharmacist Mate 3<sup>rd</sup> Class. I was assigned to a fleet hospital in Guiuan, Samar, in the Philippines. By coincidence, my dad’s ship had been torpedoed and beached at Guiuan during the battle of Leyte Gulf a year prior to my arrival there.

It was just kind of expected that I was going to be a doctor. I don’t think I ever considered anything else. The family business of trying to do some sort of public service is hereditary. My wife at that time, Ann, started the Minnesota Early Learning Design, or MELD, which specialized in teaching parents how to parent.

Each of my three children and their spouses is involved in some form of not-for-profit public service activity. Deborah is associated with a foundation that advises community foundations. Community foundations are for donors who have money to give away but aren’t sure how to do it, and so they give it to an organization in the community that helps them give their money away well. Deborah’s job is to help them organize their programs. Her husband, Andrew Dick, is a health economist who works with RAND.

My second daughter, Cynthia, is with the Milwaukee school system. She’s an Educational Leader responsible for the quality of 25 schools. She’s different than the other members of our family in that she feels you have to lay on hands – she wants to work directly with minority kids. Even though she’s got a Ph.D. in education from Stanford, she has been a classroom teacher and principal for much of the time. Her real objective is to motivate and educate minority children. Her husband, Robert Lowe, is Chairman of the English Department at Marquette. My son, David, an economist, is the Dean of the Harvard Kennedy School of Government. He’s the ‘welfare reform Ellwood.’ He developed Clinton’s welfare reform plan and was his Assistant Secretary for Planning and Evaluation.<sup>3</sup> His wife, Marilyn, is Mathematica’s Medicaid expert. Somehow the thing runs in the family, beginning with my parents and spilling over to my children and, hopefully, their children. My present wife, Barbara, has had a career as a medical educator and later as the chief operations officer of the Jackson Hole Group.

**KOVNER:** How did you come to work for the Sister Elizabeth Kenny Institute after completing medical school?

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The Kaiser Permanente news center is a helpful source for more information:

<http://xnet.kp.org/newscenter/aboutkp/historyofkp.html> . During this time, Paul Ellwood reports being influenced by this article about the Kaiser plan: de Kruif, P. Tomorrow’s health plan – today! *Reader’s Digest*, 61-64, May 1943.

<sup>2</sup> James A. Vohs devoted his entire career to various positions with Kaiser Industries in California, eventually rising to the position of president and CEO of Kaiser Foundation Health Plans and Hospitals.

<sup>3</sup> David T. Ellwood, Ph.D. (1953- ) is the Scott M. Black Professor of Political Economy and Dean of the John F. Kennedy School of Government at Harvard. He was Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, during the Clinton Administration.

**ELLWOOD:** I never had a life plan. I was not upwardly mobile. My eventual focus on health system reform was based on personal experiences. After completing medical school at Stanford, I thought I'd like to learn about polio. My professors persuaded me to try to intern at the University of Minnesota. The pediatric program there was led by the eminent Irvine McQuarrie<sup>4</sup> and had responsibility for the diagnosis and treatment of acute polio patients at Sister Kenny Institute.<sup>5</sup>

On arrival in Minnesota, I traded with another intern for the opportunity to work at Sister Kenny Institute during the major polio epidemic of 1953.<sup>6</sup> The institute was both a learning and reform experience. Sister Kenny's work was part practical and too much a cult. The way the patients were being managed was not always in the patients' best interest. The sister didn't believe in respirators. She didn't believe in tracheotomies. She didn't believe in cooling them off. What was an intern to do? When her disciples, called 'Blue Girls' because they wore blue uniforms, went home in the evening, patients who needed them to survive got tracheotomies, were placed in iron lungs, hydrated, and cooled off. As a result, the mortality rate dropped precipitously.

Polio is a frightening disease for families. The acute stage lasts five days. No systems were in place to inform family members of the disease's progression. I tried to call the acute stage families each evening to inform them as to how their loved one was doing. Because of the five-day progression of the disease, if the patient had little or no paralysis by the fourth day, we could be pretty reassuring. On the other hand, if on the first day the patient had C4-C5 cord involvement with shoulder weakness, chances were that the patient would end up on a respirator, because the diaphragm comes off the same level in the spinal cord as the shoulder muscles. Family and patients appreciated the diminished uncertainty. The mother of one of my patients in an iron lung wrote an article on polio impact for the *Saturday Evening Post*. She expressed some anxiety about her daughter being cared for by a young intern from California.<sup>7</sup>

**KOVNER:** Those experiences must have been profound for you.

**ELLWOOD:** The experience in working there, trying to cope with this Kenny cult, minimal supervision, and major responsibility for these vulnerable patients and apprehensive families was profound. After I'd been there three months, I traded with another intern to spend an additional three months there, because it was so technically challenging and emotionally disturbing. During that time, an elderly doctor who was responsible for Kenny's inpatient services died. Some of the attending physicians and leaders of the Sister Kenny Foundation approached Dr. McQuarrie, chief of pediatrics at the University of Minnesota asking, "Will you let Paul take over as head of the inpatient care at the Institute?" I was about six months out of medical school at the time. The head

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<sup>4</sup> Irvine McQuarrie, M.D. (1891-1961) was the first full-time chair of the pediatrics department at the University of Minnesota and served for 25 years in that position, from 1930 until 1955.

<sup>5</sup> Elizabeth Kenny (1880-1952) was an Australian nurse, or 'sister', who developed innovative and controversial ways of treating polio symptoms in an era when immobilization was the gold standard of care. In 1940, Sister Kenny came to the United States to introduce her ideas to physicians at the Mayo Clinic. She met with initial resistance, but won the support of several local orthopedists, who enabled her to care for patients at the Minneapolis General Hospital. Two years later, her treatment methodology was accepted, and the Sister Kenny Institute was established in Minneapolis. Today, the Sister Kenny Rehabilitation Institute is part of the Allina Hospitals & Clinics. For more information about Sister Kenny: <http://www.adb.online.anu.edu.au/biogs/A090570b.htm>

<sup>6</sup> Polio was widespread during the early 1950s, striking primarily children during warm weather months.

<sup>7</sup> Reiten, G. Our daughter had polio. *Saturday Evening Post*;227:17, 19, 1954.

of pediatrics said, “Paul earns \$25 dollars a month. If you’ll give Paul \$10,000 a year and the Peds department \$10,000 a year, we’ll let Paul run it. Because polio’s a summer disease, he can spend six months with the increased responsibility and the other six months at the university, taking conventional pediatric training.”

**KOVNER:** What were your experiences in running The Sister Kenny Institute?

**ELLWOOD:** Before getting into that, I’d like to mention the old fashioned soda fountain ice cream freezer in the Kenny Institute waiting room next to admissions. It was full of one pint cartons containing stool specimens from present and former patients. I took several cartons to Dr. J.T. Syverton’s virology lab at the University of Minnesota, where they succeeded in propagating all three polio virus strains using HeLa human epithelial cells – a first in the field of virology<sup>8</sup>. Coincidentally, the story of Henrietta Lack’s immortal HeLa cells is a 2010 *New York Times* best seller<sup>9</sup>.

Running the Sister Kenny Institute was a challenge. I had no mentors; my management skills were not strong; my most substantial prior job was dumping boxes of pears on to a grader in a Del Monte cannery; and, advances in medical science were about to leave me technologically unemployed.

**KOVNER:** Why do you say that?

**ELLWOOD:** This was 1953. In 1954, Jonas Salk<sup>10</sup> and his collaborators were ready to test a killed-polio-virus vaccine. The world’s largest clinical trial was conducted in 1954, where 1.8 million children in Canada, Finland and the United States participated in a clinical trial of the controversial new vaccine. We didn’t even know whether the vaccine’s viruses were always dead. They weren’t.

In April 1955, two years after I got out of medical school and was trying to manage this small, but famous, polio hospital, it was announced that the Salk vaccine was 80 to 90 percent effective. During 1955, the vaccine was administered to children all over the United States and much of the developed world. It worked! There was an 80 to 90 percent decline of polio in one year.

This raised the question: Well, now what do we do? We are responsible for a polio hospital here, and we don’t have any patients to fill it. The paralysis, of course, lasts a long time, and we still had a declining number of severely disabled and respirator patients. We decided to try to convert the polio hospital into a rehabilitation hospital.

**KOVNER:** How did that process work?

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<sup>8</sup> Syverton, J.T., Scherer, W.F., and Ellwood, P.M. Studies on the propagation in vitro of poliomyelitis viruses: V, the application of a strain HeLa human epithelial cells for isolation and typing. *Journal of Laboratory and Clinical Medicine*;43(2):286-302, Feb. 1954.

<sup>9</sup> Skloot, R. *The Immortal Life of Henrietta Lacks*. New York: Random House, 2010.

<sup>10</sup> Jonas Salk, M.D. (1914-1995) spent the early part of his career investigating the influenza virus and then began to develop the polio vaccine. Dr. Salk’s work was made public in 1955. More information on his life can be found here: <http://www.achievement.org/autodoc/page/sal0bio-1>

**ELLWOOD:** Comprehensive rehabilitation wasn't widely known or used, so it was trial-and-error process to convert a polio hospital into a rehabilitation hospital. At first, we weren't very good at rehab. I can remember even putting people with emphysema into respirators. Some of the things that we tried were not effective. But we all learned on the job. At first, because of prolonged stays, all of our beds were filled. We were surviving financially. Then, as we got better at rehab, we started more rapidly emptying the beds. The hospital began losing money. I thought, *There's something perverse about the incentives in this business. The better we do clinically, the poorer we do financially.*

As a pediatrician, a father, and an undetected case of ADD, I had become interested in children with learning disorders. I thought, *Well, maybe we can look more closely at these children by hospitalizing them and filling our beds with kids with learning disorders.* Shortly thereafter, when making evening rounds, I encountered a ward of crying 5- to 10-year-old children – my son was about the same age – and I thought, *What are you doing here? These economic incentives are so powerful to fill these beds that you're harming these children.* Just like your own. That was my first real exposure to the powerful perverse incentives in health care. Suddenly the health system became my patient. I began thinking more and more about how the system worked and what could be done about it.

**KOVNER:** What was the next step in your career?

**ELLWOOD:** By that time at Sister Kenny and the University of Minnesota, I had gone from being a pediatrician to becoming a pediatric neurologist, focusing on rehabilitation. The Kenny Rehabilitation Institute joined the newly formed Association of Rehabilitation Centers (ARC)<sup>11</sup>. In 1960, shortly after we joined, the president of the Association of Rehabilitation Centers died; and, as the vice president, I became the president. Is there a pattern here? Serendipity instead of experience?

At this point I was just six years out of medical school. I was still nominally responsible for Kenny Rehabilitation Institute inpatient services, a first-year resident in Physical Medicine & Rehabilitation at the University of Washington in Seattle and president of a fledgling Association of Rehabilitation Centers. What should be the nascent ARC's mission?

I had gotten very interested in Peter Drucker's work on management at General Motors, especially the importance that he attached to quality control based on cost accounting.<sup>12</sup> I wondered if 'outcomes management' could be applied to health care, using impersonal quantitative measurement of health outcomes instead of medicine's traditional peer review? Later we read an article in *The Public Interest* by Robert Levine about the ability of large enterprises like health care to function in the public interest while, at the same time, performing what was essentially a public function.<sup>13</sup> Levine emphasized the importance of incentives and invented many of the ideas that are now being proposed as applied to global warming: where you give credits to an industry for performing some public good. So, our theories of health reform were evolving based on incentives and accountability for health outcomes.

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<sup>11</sup> The Association of Rehabilitation Centers is now known as the National Association of Rehabilitation Facilities.

<sup>12</sup> Drucker, P.F. *Concept of the Corporation*. New York: John Day Co., 1946.

<sup>13</sup> Levine, R.A. Rethinking our social strategies. *The Public Interest*;10:86-96, Winter 1968. Full text free here: [http://www.nationalaffairs.com/doclib/20080522\\_196801006rethinkingoursocialstrategiesrobertalevine.pdf](http://www.nationalaffairs.com/doclib/20080522_196801006rethinkingoursocialstrategiesrobertalevine.pdf)



There was a third hero that I had at that time – Theodore Vail.<sup>14</sup> Vail was the head of the telephone company from 1910 to about 1920. AT&T was the only major private telephone company in the world. The rest of them were controlled by government. Vail felt that if AT&T could do a good enough job and if they cooperated with regulators and if they could somehow organize the telephone company as if it had competition, it would be able to remain private. He then created Bell Labs, the world's greatest industrial laboratory as the phone company's source of internal competition. The labs produced seven Nobel prize winners. This led to an interest in health services research to make the existing health system obsolete.



Those ideas were fermenting in my mind at that time as we got more and more involved in rehabilitation medicine, an emerging but neglected field. Rehabilitation was unique in that it had some very political doctors associated with it. Fritz Kottke<sup>15</sup>, professor of Physical Medicine and Rehabilitation at the University of Minnesota, helped to establish the Democratic-Farmer-Labor Party<sup>16</sup> in Minnesota. Dr. Kottke's living room was used to plan Hubert Humphrey's campaign and political career. There was another rehabilitation professor in New York, Howard Rusk<sup>17</sup>, who had become a close friend of the Kennedys as a result of taking care of Joe, Sr.<sup>18</sup> These two rehabilitation doctors were deeply involved with politicians, and used their involvement to promote rehabilitation medicine. President Kennedy and Vice President Humphrey were persuaded to fund and promote rehabilitation. But was this the ideal approach to health reform – dependent on the ephemeral interests of politicians and the vested interests of a single specialty? When Johnson and Humphrey and Kennedy were gone, the political interest in that specialty waned. I felt that it was important for doctors to get involved in matters of health policy, but it would be best if they dealt with it more broadly than simply promoting their own specialty. Their real goal should be to work on the needs of patients, not on behalf of the clinical and, too often, economic interest of a particular specialty and, inevitably, some lucrative technology or drug.

My experience as a physician trying to be involved in local or national health policy is that you're there as a doctor, not as a politician. Your job is to represent patients, and the most powerful thing you can do and say as a physician is that your role is to represent the unrepresented, about

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<sup>14</sup> Theodore N. Vail (1845-1920) was the general manager of the National Bell Telephone Company and, in the 1880s, founded the Bell subsidiary, American Telephone & Telegraph, to handle long-distance service.

<sup>15</sup> Frederic J. Kottke, M.D. (b. 1917) was a professor in the Department of Physical Medicine and Rehabilitation at the University of Minnesota medical school.

<sup>16</sup> Hubert Humphrey was influential in bringing about the 1944 merger of the Minnesota Democrats and the Farmer-Labor Party that resulted in the Minnesota Democratic-Farmer-Labor Party. More information about the party can be found here: <http://df.org/about/history>

<sup>17</sup> Howard A. Rusk, M.D. (1901-1989) has been called the father of rehabilitation medicine. More information about Dr. Rusk can be found here: <http://whmc.umssystem.edu/invent/3981.html>

<sup>18</sup> Joseph P. Kennedy, Sr. (1888-1969) was a wealthy, influential businessman and politician, and father of President John F. Kennedy.

whom you know a lot. Physicians diminish themselves and the needs of patients by talking politics to politicians. Your real standing is as an individual who understands the science of medicine and is trying to improve the state of patients and the health of people.

The most effective doctors who testify are those who talk about their patients, talk about what they're going through. Congressmen are sometimes moved to tears because of their own health experiences and those of their families. Physician members of Congress are most helpful when they give up their professional biases based on autonomy, earning power, and reluctance to be publically accountable. I thought that Senator Bill Frist<sup>19</sup> played the dual role well.

My credibility and convictions are largely based on personal experiences and that's why I have not involved myself much in the complex economic and actuarial details of health insurance. Health insurance is a whole different arena. That's where Alain Enthoven,<sup>20</sup> who I worked with a lot, and I tended to share responsibility. Alain was very interested in CALPERS and the Federal Employees Health Benefit Program, which is what shaped his 'insurance exchange' proposals. That was Alain's territory and has real legs in 'Obamacare.'

**KOVNER:** What happened next in your career with the American Rehabilitation Foundation?

**ELLWOOD:** Our CEO, Dr. Frank Krusen,<sup>21</sup> died and, by default, I became head of the Kenny Foundation, which had been renamed the American Rehabilitation Foundation. But you have to understand that I never had a projected career except for a growing desire to help restructure the health system. That goal was quixotic since the organizations that I had responsibility for were tiny with little tangible clout. Most of the people that have been interviewed for this oral history series have had big, influential management jobs.

**KOVNER:** After moving from California, you spent most of your career in Minnesota. Why was that?

**ELLWOOD:** The thing that struck me about medicine in Minnesota was that it was admirable and tolerant of innovators. There was a lot of pressure within the medical community to do right by patients, not to cheat patients by doing unnecessary procedures, and so forth. I reached the conclusion that the force that was producing much of this ideal behavior in Minnesota was the Mayo Clinic.<sup>22</sup> I remember making rounds with Dr. A.B. Baker<sup>23</sup>, the professor of neurology. His

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<sup>19</sup> William H. Frist, M.D. (b. 1952) was a transplant surgeon prior to serving in the United States Senate from 1995 until 2007. His father, Thomas F. Frist, Sr., M.D. (1910-1998), and brother, Thomas F. Frist, Jr., M.D. (b. 1938) founded the Hospital Corporation of America in the '60s.

<sup>20</sup> Alain C. Enthoven, Ph.D. (b. 1930) is a health policy expert who worked at RAND, the Department of Defense, and Litton Industries before becoming a professor at Stanford.

<sup>21</sup> Frank H. Krusen, M.D. (1898-1973), who practiced at the Mayo Clinic, has been called the founder of the field of physical medicine and rehabilitation.

<sup>22</sup> The Mayo Clinic (Rochester, MN) grew out of the early 20<sup>th</sup> century medical practice of Dr. William J. Mayo and Dr. Charles H. Mayo, brothers whose close relationship became a model for the organization's philosophy of teamwork. More information on the Clinic's history can be found here: <http://www.mayoclinic.org/tradition-heritage/>

<sup>23</sup> A.B. Baker, M.D. (1908-1988) was chair of the neurology department at the University of Minnesota and founder of the American Academy of Neurology.

patient had come from the Mayo Clinic. The intern on the rounds said, “Dr. Baker, do many of your patients come from the Mayo Clinic?” Dr. Baker said, “Yeah, half of my patients come from the Mayo Clinic, and the other half go there.”

We got interested in the Mayo Clinic and got to know some of the early people from there, like Walter Alvarez.<sup>24</sup> Dr. Robert Waller<sup>25</sup>, chairman emeritus of the Mayo Foundation, has been the longstanding chairman of InterStudy and the Jackson Hole Group. Mayo’s positive influence was so pervasive and admirable that I felt that it should be expanded. Maybe the Mayo Clinic could have branches all over Minnesota and in other states so that it would have the same kind of positive effect on the organization and behavior of the medical profession while raising the expectations for patients elsewhere.

In 1968, the Mayo Clinic wanted to start a medical school which meant they had to get some seed money from the state. I went to State Senator Harold R. Popp<sup>26</sup>, and urged, “Before the state gives the Mayo Clinic any more money, why don’t we insist that the Mayo Clinic establish branches around the state so that they can have the same positive influence over a wider and wider area?” That legislation passed, and I guess that was my first real contact with politics as it’s practiced by people who run small town drugstores and push around the Mayo Clinic!

Mayo Clinic wasn’t enthusiastic about the legislation and was rather perfunctory in their response. They set up a clinic in a doublewide in Cannon Falls, Minnesota, which was maybe thirty miles from the Mayo Clinic. They weren’t going to make a lot of difference there. But I had the bug by that time and was beginning to get interested in national health policy.

There’s one other little piece in the Mayo Clinic story. I persuaded a member of the Mayo board, Dr. Leo Black<sup>27</sup>, that maybe Mayo ought to try to expand to another state. The two of us visited Orlando, Florida, to explore the idea of a branch in Florida. The first ones to glom onto this delegation of two was Disney World. They could just see it; they’d have a model medical system there as part of Disney World. There was only one problem: we hadn’t confided to the Mayo Board that we were making the trip. The Rochester *Post Bulletin* newspaper carried news of our visit. That was the end of the idea of Mayo expanding to Florida at that time.

They ultimately did expand to Florida and Arizona with Dr. Black as CEO of the Jacksonville unit. But the Jacksonville and Phoenix branches have found Mayo, Rochester, MN, is difficult to replicate. I became convinced that isolation, the 90 miles of corn fields around Rochester, enabled the Mayo Clinic to create a unique, innovative and powerful medical culture. The polluting effect of being in the aggressive, more economically driven medical culture in Florida and Arizona may have made it difficult to reproduce the Rochester, MN, health culture.

The experience of trying to change Minnesota health care exposed me more deeply to the politics of health care. I thought, *Why not put together a little group that works on medical reform?* Think

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<sup>24</sup> Walter C. Alvarez, M.D. (1884-1976) was a professor at the University of Minnesota and a prolific author.

<sup>25</sup> Robert R. Waller, M.D. is the president emeritus of the Mayo Clinic/Mayo Foundation.

<sup>26</sup> Harold R. Popp (1903-1969) was a pharmacist from Hutchinson, MN, who was elected to the Minnesota state senate in 1958.

<sup>27</sup> Leo F. Black, M.D., has retired as the CEO of the Mayo Clinic (Jacksonville, FL).

tanks in health care really didn't exist at the time. The model was RAND,<sup>28</sup> but it was pretty much a defense-oriented organization. I thought, *Let's try to create a policy group that focuses on health care.* We labeled it the Medical Ecology Group. The foundation had enough money that we could hire five or six young people to begin working on health policy.

**KOVNER:** How did you get the foundation to agree to that?

**ELLWOOD:** By that time, I was in charge of the foundation. Enough people died for me to be running it! Not because I said, *Oh, boy, I'm gonna run a foundation!* The Medical Ecology Group turned out to be just a fabulous group of creative young people. One was Walter McClure,<sup>29</sup> an experimental physicist. Another was Rick Carlson, a lawyer. Another was Patrick O'Donoghue, who was an M.D. and an economist. Bill Copeland, a mathematician. Nancy Anderson, a sociologist. Hop Holmberg,<sup>30</sup> a hospital administrator. All of them were, incidentally, antiwar activists complete with the Hippie aura.

We began as a group focusing on Minnesota, always trying to get health care delivered by organizations that were willing to measure their results and whose real interest was in comprehensive care of patient populations. We managed to convince the governor of Minnesota to form a Governor's Commission on Health. I don't know whether it was the first one or not, but Governor Karl Rolvaag,<sup>31</sup> appointed me the head of his health care commission.

After working on health care in Minnesota, my career unexpectedly entered the national scene. In 1967, I got a call from Dr. William Stewart,<sup>32</sup> who was Surgeon General of the United States. This was an especially big deal because when I was in the Navy, I was a pharmacist mate 3<sup>rd</sup> class, eleven ranks below the Surgeon General of the U.S.! He said, "We've got a new law, Public Law 89-749, Comprehensive Health Planning.<sup>33</sup> We're uncertain what to do with it, and we know you've been doing this sort of thing in Minnesota. Would you come and give us suggestions as to how to implement it?"

Our little group thought, *Boy, we're going to be working on the United States of America now!* We prepared a report on how the federal government might go about implementing comprehensive health planning in the states. The conclusion was that the U.S. really did not know how to plan in health care and that we ought to track a number of states' planning approaches and get the Surgeon

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<sup>28</sup> RAND Corporation (Santa Monica, CA) was established in 1945 as Project RAND, contracted to the Douglas Aircraft Company, and tasked with military-related research. Three years later, the company was spun off as an independent not-for-profit private sector research organization, concerned with studying public welfare and security-related issues. More information can be found here: <http://www.rand.org/about/history/>

<sup>29</sup> Walter J. McClure, Ph.D. (b. 1937) began his career in theoretical nuclear physics, but became interested in health services research in the late 1960s.

<sup>30</sup> R. Hopkins Holmberg (b. 1939) was assistant executive director of the American Rehabilitation Foundation from 1965-1969.

<sup>31</sup> Karl F. Rolvaag (1913-1990) was the 31<sup>st</sup> governor of Minnesota, serving from 1963-1967.

<sup>32</sup> William H. Stewart, M.D. (1921-2008) served as U.S. Surgeon General during the Johnson Administration from 1965-1969. More information on his career can be found here: <http://query.nytimes.com/gst/fullpage.html?res=9B0CEFD61530F93AA15757C0A96E9C8B63>

<sup>33</sup> The Comprehensive Health Planning and Public Health Service Amendments of 1966, PL 89-749, was intended to decentralize the planning and funding of health care delivery by authorizing state and local planning efforts to determine the need for facilities and services.

General's office to gather together the best ideas and then begin applying them to the national health planning programs.

We had a nice bound report that we took to Washington to present to the Assistant Surgeon General. As we started presenting it, the Assistant Surgeon General began picking on us. He got a scowl on his face and said, "I don't need to take any more of this," and walked out. It was devastating. We packed up our stuff and were starting to leave. There was a young doctor, James Cavanaugh, waiting at the door. It turned out to be one of the Surgeon General's assistants. He said, "We know that Dr. So-and-so, the Assistant Surgeon General, did not like your report. But Surgeon General Stewart did like your report, and he used it as a basis for taking health planning away from the Assistant Surgeon General and putting it in *his* office."

Shortly after that, Assistant Secretary for Health Philip Lee,<sup>34</sup> whose sister had been a classmate of mine at Stanford Medical School, called and said, "Paul, I've been thinking about health services research. Would your group help us think through how to establish a program in health services research?" I had become a little bit familiar with health services research with a stroke prediction project at the Kenny Rehabilitation Institute. There wasn't much going on at that time, but Paul Densen and Sam Shapiro<sup>35</sup> at HIP in New York had been doing some rather interesting work, especially on how patients responded to medical care and how well patients could differentiate between good and bad care, reinforcing the notion that patients probably needed more information about the quality of sources of care.

Our group prepared plans for a National Center for Health Services Research and Development.<sup>36</sup> That was about 1968 or 1969. Phil Lee liked the report and used it as the basis for creating the National Center, which is now called AHRQ, the Agency for Healthcare Research and Quality. Again, the emphasis there was on accountability for health care along with evaluating various structural and incentive arrangements for organizing health care systems.

## CONVERSATION DURING THE BREAK

**ELLWOOD:** Did you ever read about Theodore Vail?

**KOVNER:** Yes, I have.

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<sup>34</sup> Philip R. Lee, M.D. (b.1924) was appointed to the new position of Assistant Secretary for Health and Scientific Affairs in the U.S. Department of Health, Education, and Welfare in 1965, during the Johnson Administration. More information can be found here: <http://history.library.ucsf.edu/lee.html>

<sup>35</sup> Paul M. Densen, D.Sc. (b. 1913) was in charge of research at the Health Insurance Plan of Greater New York in the late '50s and later became a professor at the Harvard School of Public Health. Sam Shapiro (b.1914) was a health care analyst working at the Health Insurance Plan of Greater New York in the '50s and '60s, before becoming a professor at the Johns Hopkins University.

<sup>36</sup> The National Center for Health Services Research and Development was established in May 1968 as part of the Health Services and Mental Health Administration of the Public Health Service of the U.S. Department of Health, Education, and Welfare (HEW). The Center was reorganized a number of times and has been known since 1989 as the Agency for Healthcare Research and Quality (AHRQ). More information can be found here: <http://www.archives.gov/research/guide-fed-records/groups/510.html?template=print>

**ELLWOOD:** He was an amazing man. The interesting thing about Vail was his goal in setting up Bell Labs<sup>37</sup> and trying to cooperate with regulators was to keep the telephone company private and out of the hands of the government. Like many long term visionaries, his successors lost his vision and began engaging in some monopolistic behavior. Ironically, Bell Labs produced seven Nobel laureates and their inventions made it practical to break up AT&T. The antitrust case that broke up Bell (AT&T) relied on the transistor, the stationary satellite, much of the IT technology from Bell Labs that allowed offshoot companies to become telephone companies without the need for AT&T long lines. The antitrust law broke up AT&T, but it was really the Bell Labs inventions that made it practical. How could Vail ever think that far ahead? I thought he was wonderful. I think *he* had ADD and should have anticipated that visionaries can lose control or even invent approaches that destroy their vision.

**KOVNER:** I'm a partisan of the style of management that instead of talking about it, you actually do things and learn from doing things.

**ELLWOOD:** As you notice, I've written virtually nothing. I think there are speeches and articles that other people have written about me, but I'm not a conscientious writer. I thought that instead of hoping that some politician will read what you wrote in, say, *The Atlantic* or *Health Affairs*, why not see if you can reach the politician or the hands-on leaders directly?

**KOVNER:** That's important and that point has to be made.

## INTERVIEW: PART 2

**KOVNER:** In the late '60s, you were advising Phil Lee about the Health Services Research Act, and then wasn't your group involved in the work that went into the HMO Act?

**ELLWOOD:** Phil Lee chose Paul Sanazaro to run NCHSRD.<sup>38</sup> Paul, in turn, convened a small group of individuals who had differing points of view to advise him and to advise the Secretary of HEW. Sanazaro's small group consisted of Marty Feldstein,<sup>39</sup> Rosemary Stevens,<sup>40</sup> Kerr White<sup>41</sup> – all giants in medical thinking and health policy. From them I learned a great deal about where health policy was going and how it's made.

In the meantime, our fledgling Medical Ecology Group had begun to work on things other than health, like public welfare. Our best contact in welfare policy was Tom Joe<sup>42</sup>. Tom, a blind

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<sup>37</sup> Bell Labs (Murray Hill, NJ) was founded in 1925 by AT&T. Over 30,000 U.S. patents have been granted to Bell Labs, where groundbreaking work has been done over the years on, for example, fax machines, speech synthesizers, computers, transistors, digital cell phone technology, and voice over internet. More information can be found here: [http://www.usatoday.com/tech/news/2006-12-01-bell-research\\_x.htm](http://www.usatoday.com/tech/news/2006-12-01-bell-research_x.htm)

<sup>38</sup> Paul J. Sanazaro, M.D. (1922-2006) was appointed Director of the National Center for Health Services Research and Development in 1968.

<sup>39</sup> Martin S. Feldstein, Ph.D. (b. 1939) has been a professor of economics at Harvard for over 40 years.

<sup>40</sup> Rosemary A. Stevens, Ph.D. (b. 1935) was on the faculty at Yale and later at Tulane during the '70s and subsequently became a professor and dean at the University of Pennsylvania. She is a prolific author on topics related to health policy.

<sup>41</sup> Kerr L. White, M.D. (b. 1917) trained as an internist and became a renowned health services researcher associated with Johns Hopkins University.

<sup>42</sup> Thomas C. Joe, Ph.D., a social policy analyst, received a MacArthur Fellowship in 1986.

Korean genius with a Ph.D. from the University of California, was an expert on what they called in California, ‘federal buck maximizing’: how to classify people on welfare so the state gets the maximum federal matching funds. Tom and our group of medical ecologists began collaborating on welfare policy. I talked with Tom on a flight going from Minneapolis back to Washington. We got to talking about health policy and how it related to his work in welfare policy. Tom said, “You’ve got to meet my boss.” I said, “Who’s your boss?” He said, “His name is Jack Veneman.”<sup>43</sup> I worked for him when he was an assemblyman in California, and he’s now Undersecretary of HEW.”

Tom Joe arranged for me to share some of my ideas on health care with his boss. We met on February 5, 1970, in a hotel room at the DuPont Plaza in Washington with Veneman and Tom Joe and Dr. Tom Georges from Philadelphia.<sup>44</sup> Dr. Georges was an African-American public health physician, who I subsequently learned was at this meeting to make sure that ‘Ellwood was being honest’. The background on why Veneman might want to meet with anybody about health care was that President Nixon had realized that Teddy Kennedy was coming up with some health policy ideas, really his first national health insurance scheme, that were going to upstage the Nixon Administration.

They had to have a health policy, and they didn’t have one. Veneman was charged with coming up with one. They weren’t getting anywhere. Veneman’s opening line was, “We understand you’ve been thinking about health policy. What are your ideas?” We spelled out the idea of organizations competing on the basis of price and quality, pretty much a competing prepaid group practice model. I preferred group practice at the time. We went through it all, and Jack Veneman said, “Hey, these sound like good ideas. I think that this is what we ought to do.”

We were joined then by Lew Butler.<sup>45</sup> The conversation went into the night. By the end of the night, we’d pretty well spelled out the entire HMO policy. However, there were some points of contention. I preferred group practice as the structural model. Lew Butler said, “Look, we’re going to be relying on market forces here and people making choices. Why don’t we let the market decide what is the ideal organizational arrangement?” I acceded to that, but after the Mayo Clinic experience, I was committed to group practice.



The second issue was ‘profit or not-for-profit’. The argument was made: HEW had been observing nursing homes and the need for more of them, and while the church homes and

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<sup>43</sup> John G. Veneman (1925-1982) was Under Secretary of the U.S. Department of Health, Education and Welfare during the Nixon Administration, from 1969-1973.

<sup>44</sup> Thomas W. Georges, Jr., M.D. (b. 1927) was Secretary of the Pennsylvania Department of Health in the late 1960s and went on to become chair of the Department of Community Health and Family Practice at Howard University College of Medicine in Washington, D.C.

<sup>45</sup> Lewis H. Butler (b. 1927) was a California attorney who served as the first head of the Peace Corps program in Malaysia and later became Assistant Secretary for Planning and Evaluation in the U.S. Department of Health, Education, and Welfare from 1969-1971. More information can be found here:

[http://www.jfklibrary.org/Historical+Resources/Archives/Archives+and+Manuscripts/fa\\_butler.htm](http://www.jfklibrary.org/Historical+Resources/Archives/Archives+and+Manuscripts/fa_butler.htm)

nonprofits were very good, they were not expanding at the same rate as the private homes. Butler said, “If we want this to affect the whole health system, we’re going to have to allow for-profit arrangements.” But what kind?

The third issue was the measurement of results. Here was another chance to introduce the notion of measuring health outcomes as a means of determining who and what was effective and giving consumers information about where to go for care. I don’t believe that consumers can differentiate very well once they’re sick, especially in emergency situations. But at the time they buy insurance, they can. It seemed to me to be desirable to have outcome information to aid consumer choices, and gather evidence for guidelines.

The issue of ‘skipping’ was raised by Congressman William Roy and his assistant Brian Biles.<sup>46</sup> I tried to make the point that if there’s skipping going on, we’ve got to measure it. We’ve got to determine whether or not people are being selected on the basis of being well and whether providers are providing inadequate, cheap care in order to compete in this marketplace. This had little appeal to the Nixon Administration.

In the meantime, Kennedy’s proposed health bill, which our people were working on too with Phil Caper,<sup>47</sup> did contain a health outcomes provision that was perfect. If we could apply it today, it would have been a major advance. I wish I’d seen it 40 years later in the Obama bill.

The non-group structural arrangements remained an issue. Since Medicare staffers were skeptical, Butler sent me off to meet with the American Medical Association, which historically had objected to group practice, especially the Kaiser Permanente Health Plan, to find out if there were any other ways to organize physicians. I met with Bert Howard,<sup>48</sup> executive vice president of the AMA, who said, “We’ve got something going on in Stockton, California, with the medical society there that might work.” The medical society was trying to keep Kaiser out of town. They had set up their own HMO-like entity, where the medical society fee for service members were at risk, to provide services on a prepaid basis to cannery workers. It was sort of a medical society insurance company. We dubbed it ‘IPA’ – independent practice association – and brought that idea back to Butler and Veneman. They thought that was fine. It was a way to placate the AMA and gave us another model. Incidentally, medical societies continued to fight the HMO policies using the ‘skipping on quality’ argument.

**KOVNER:** What happened? It seemed like the operation was a success, but the patient died? Or how would you describe it?

**ELLWOOD:** The patient didn’t even live at first! I remember at the time of the 1970 Veneman-Butler meeting, there was a popular song by Peggy Lee, “Is That All There Is?” I thought, *Is that all there is?* It was so exciting to be advocating these ideas for all this time and then finding these big shots willing to buy them and take them to the President of the United States.

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<sup>46</sup> William R. Roy, M.D. (b. 1926), Democrat, was a 2-term Congressman from Kansas. Brian Biles, M.D. served on the staff of several House and Senate subcommittees, was an executive with the Commonwealth Fund, and is a professor at The George Washington University.

<sup>47</sup> S. Philip Caper, M.D. worked as a staffer for Senator Edward M. Kennedy in the 1970s. He went on to found the Codman Research Group.

<sup>48</sup> Ernest B. Howard, M.D., (1910-1993) served in various executive positions at the American Medical Association from 1948 until 1969.



Well, it wasn't all there was. The original idea was to incorporate HMOs into Medicare. Jack Veneman met with Ways and Means Chairman Wilbur Mills<sup>49</sup> at a barbeque. The two of them talked it over, Veneman a Republican and Mills a Democrat. Wilbur Mills said, "Fine." So Tom Joe named it Part C. The Ways and Means Committee was meeting at the time on Medicare. At the end of its markup meeting, Wilbur Mills had forgotten to bring up Part C. Veneman stood up at the meeting and said, "Mr. Chairman, we have this additional idea that you and I talked over, called Part C," and described the HMO idea. In 15 minutes, the committee adopted it. However, when the idea reached the Senate Finance Committee, which also has to act on Medicare legislation, they killed it. Jay Constantine, chief Finance Committee staffer, didn't like the idea at all and was already working with the AMA on the peer review (PSRO) legislation, and so it died<sup>50</sup>. HMOs would not be included in Medicare!

HMOs had to become a private sector program instead of a public program. It took two years to finally work it through the Congress. One striking thing about that time in political history as compared to the present context – there was total bipartisanship. Total! Here was the hated Nixon Administration proposing these ideas that were agreed upon at a barbeque between a Republican Undersecretary and the powerful Democrat Wilbur Mills.

When it came time to move it over to Paul Rogers<sup>51</sup> and Bill Roy in the House health committee, it was like theater. Our guys would sit down together and meet with Democratic staffers, like Brian Biles of the House Health Subcommittee, and they would write the hearing script: "The Chairman, Paul Rogers, is going to ask this question. The Secretary, Elliot Richardson,<sup>52</sup> will answer in this way," and that's the way it was done.

Part of the reason they were so successful in this negotiation was the individuals working with me were grungy antiwar activists. So was Brian! I made them get haircuts before we met with the Nixon people, made them put on suits. Their suits, I know, were from their high school graduation. At any rate, in 1972 and 1973, we really did have a bipartisan government. We had a chance to witness it firsthand. We had no significant lobbyists to cope with or competing health policy wonks except the traditional 'single payor' people.

**KOVNER:** What happened after the HMO Act was passed? What went wrong with it?

**ELLWOOD:** You could probably guess, on the basis the way I've organized my disorganized life, that I have ADD. In grammar school, my parents didn't pressure me much about how I did in school, but I can remember they did care about one report card, which had an 'A' in scholarship and an 'F' in citizenship. I kept whispering with my neighbors during class. I was a disrupting influence. I'm sure I would have been on Ritalin if they'd known about it at the time. But at any rate, my diagnosis changed after the HMO Act was passed. I developed what you might call Asperger's syndrome. I cared about only one thing, and that was getting HMOs developed, and

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<sup>49</sup> Wilbur D. Mills (1909-1992), Democrat, was elected 19 times as Congressman from Arkansas, serving from 1939 until 1977. He was chair of the House Ways and Means Committee from 1958 to 1975.

<sup>50</sup> Professional Standards Review Organizations (PSROs) were established in 1972 as a mechanism to control the cost and quality of the Medicare and Medicaid programs.

<sup>51</sup> Paul G. Rogers (1921-2008), Democrat, served for 24 years as a Congressman from Florida. He was chair of the House Subcommittee on Health and the Environment.

<sup>52</sup> Elliott L. Richardson (1920-1999) served as Secretary of the Department of Health, Education, and Welfare in the Nixon Administration from 1970 to 1973.

spent my time and that of our staff going around the country, trying to get various kinds of organizations to form HMOs or to enroll their employees in them.

**KOVNER:** You were spectacularly successful.

**ELLWOOD:** I wrote an article with Mick Herbert for the *Harvard Business Review*, ‘Health Care: Should Your Company Buy It Or Sell It?’<sup>53</sup> It was a fascinating time. I met with the head of Federated Department Stores and Dayton Hudson store. Mo Lazarus, the head of Federated at the time, was connected with the Harvard Community Health Plan. But when I pitched them for the idea of their stores sponsoring HMOs, guess what the question was: ‘How many square feet does it take?’

I found that each industry I visited had its peculiar way of measuring what the impact might be on their principal business – like moving the shoe department up a floor and putting a doctor in there. McDonald’s was a lot of fun. When I met with them, I thought, *Gee, whiz, they’re clean, they have good parking, they’re accessible, their staff is nice.* McDonald’s founder Roy Kroc had the right idea. I met with their executives all day in a small round room they called their think tank where they sat to discuss big, new ideas. I thought the meeting went really well. At the end of the day, I said, “Well, what do you think? Are you going to try anything new like this?” They said, “Yeah, yeah. We’re gonna go into breakfasts.”

But we did convince two or three big companies to try it. One was Westinghouse, which was going through a kind of transition. They thought they ought to get into services. The most unusual one was the John Deere tractor company. I think they’ve still got an HMO.



**KOVNER:** Yes, they do. Why is the health sector so intractable to reform?

**ELLWOOD:** The national effort to restructure health care and health insurance began and failed with Ray Lyman Wilbur, M.D.,<sup>54</sup> the Hoover Administration’s Secretary of the Interior. We’re still trying. It was further set back by World War II when employers began offering health insurance benefits to circumvent wage and price controls. The legendary author of Medicare, Wilbur Cohen, confided to me that presidents,

<sup>53</sup> Ellwood, P.M., Jr., and Herbert, M.E. Health care: should industry buy it or sell it? *Harvard Business Review*;51(4):99, July/Aug. 1973.

<sup>54</sup> Ray Lyman Wilbur, M.D. (1875-1949) was dean of the medical school at Stanford during World War I and then served as Secretary of the Interior in the Hoover Administration.

including Kennedy and Johnson, hated dealing with health care – too complex and bad politics. My experience is based on providing solicited and unsolicited advice to seven presidential administrations. I've never met a president in person.

The same reluctance applies to powerful community leaders. I had occasion to be trying simultaneously to persuade Irene du Pont,<sup>55</sup> of what might be called 'America's corporate state,' and James Mason, M.D.,<sup>56</sup> head of the Mormon Church's hospital system in Utah, to start up HMOs for their populations. Both leaders and states were interested, but ultimately felt that health care was too personal to impose a new system on the people of their states.

A meeting convened for us by Chuck Pilyard, the president of Goodyear, with his colleagues, the CEOs of Firestone and Goodrich, in the tire city of Akron, Ohio, concluded with disappointment. "We have agreed to compete in the tire business, but not in the personal and charitable activities like health care in our home city of Akron."

In 1976, early in our campaign to convert the American way of medical care to HMOs, problems surfaced in our local Minneapolis and St. Paul Medical Society IPA. We were proud of it – a pioneering venture where individual private physicians shared risk and responsibility for the cost and quality of care for a population. The executive director of the medical society called because one of his physician leaders insisted on putting patients in the hospital that did not belong there.

I suggested that one of my staff with insurance expertise, Richard Burke,<sup>57</sup> might help. After Burke was hired he undiplomatically kicked the offending physician out of the health plan. We didn't recognize the significance of this seemingly minor local event. From this inauspicious experience, Burke went on to start United HealthCare, where insurers instead of physicians managed care. More than that, it forecast the decline of the type of HMO where independent physicians and hospitals could collaborate to provide health care at competitive costs. We didn't recognize it as the birth of 'managed care.'

The HMO movement was slow going at first. By 1980, most enrollment plans were typical nonprofit Kaiser-like prepaid group practices with a total national membership of less than 10 million. By 2000, there were 81 million enrollees in 650 largely for-profit managed care plans, with the ensuing backlash against HMOs.

What went wrong? Political expediency in the initial plan designed to promote HMO growth led to the inclusion of three mistakes: for-profit plans, independent practice associations, and the failure to include outcome accountability. An additional factor was inconsistent health policy caused by the passage of time and six changes of U.S. presidents. There was the disrupting influence of amendments to the HMO Act, especially the Reagan Administration's decision to promote for-profit HMOs. Antitrust tax policies discouraged large, nonprofit mergers. There was a shift of nonprofit and mutual insurers to actuarially-driven for-profit firms and ERISA's encouragement of self insurance by employer health plans.

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<sup>55</sup> Irene du Pont, Jr., was of the family that founded E.I. du Pont de Nemours and Company of Wilmington, DE.

<sup>56</sup> James O. Mason, M.D. (b. 1930) ran the multi-hospital system operated by the Church of Jesus Christ of Latter-Day Saints, which later became Intermountain Health Care, in the early '70s. Subsequently, he went on to run the Centers for Disease Control, among other government positions.

<sup>57</sup> Richard T. Burke (b. 1944) founded United HealthCare, Inc., in 1974.

The big lesson for me is that political expedience should not distort what you have observed to be sound ideas. Beyond that, our own failure to get accountability enacted meant that we did not have the outcome measures to prove who was good or who was bad. One thing that worries me about the Obama health plan is that it is a creature of political expediency loaded with good, bad, and untested options. The fatal weaknesses of the HMO are embedded in the new legislation.

**KOVNER:** Doesn't the accountable care organization (ACO) concept in the new legislation relate to your original ideas?

**ELLWOOD:** Depending on regulations, accountability and cost effectiveness features could be helpful, but the structure, incentives, enrollment, and overt political threats undo some of the ACO's strongest features; and, I fear, doom the whole idea. Then there is the intention to reject Don Berwick,<sup>58</sup> one of the Obama Administration's wisest leaders. The stronger MedPAC could circumvent Congressional meddling, too.

Another thing that happened which is perhaps of interest: The *New England Journal of Medicine* and the Massachusetts Medical Society annually sponsor the prestigious Shattuck lecture. In 1988, Dr. Arnold Relman<sup>59</sup>, who was the editor of the *New England Journal* at the time, invited me to give the lecture. One of the advantages of getting to do it is they don't edit your stuff. You get to say what you think.

I devoted the Shattuck lecture to 'Outcomes Management: A Technology of Patient Experience.'<sup>60</sup> It was an effort to describe institutional arrangements for measuring outcomes based on patient experience and making the results available to patients and providers. After I gave the paper, Bud Relman, said to me, "Paul, I don't think this is going to make *USA Today* tomorrow. This one is going to be a slow burner." Now, let's see, that was 1988, and if it's in the Obama legislation it burned real slow. But the other thing that Bud said was, "Paul, I was hoping you'd give the lecture on salaried multi-specialty group practice." He was right – maybe we should have combined in the lecture the entire InterStudy legacy emphasizing structure, incentives, outcomes accountability and health services research.

**KOVNER:** Your remarks earlier about the Mayo Clinic and about Bell Labs prompt me to ask another question. You've written in the Stanford alumni publication that the keys to sustaining meaningful health reform include a quasi-regulatory agency that is responsible for quality and cost, overcoming the notion that doctors are the only people who understand health care, and coming up with payment systems that force the organization to reward collaboration. What would a model of health care delivery look like which would embody those three principles? I'm struck by what you said about Bell Labs' role in the telephone company and by what you said by the influence of the Mayo Clinic on other kinds of health care, as being part of the answer.

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<sup>58</sup> Donald M. Berwick, M.D. (b. 1946) was appointed by President Obama as the head of the Centers for Medicare & Medicaid Services. He had previously been the CEO of the Institute for Healthcare Improvement and is a professor at Harvard.

<sup>59</sup> Arnold S. Relman, M.D. (b. 1923) was the editor of the *New England Journal of Medicine* from 1977 to 1991. He is professor emeritus at Harvard Medical School.

<sup>60</sup> Ellwood, P.M. Outcomes management. *The New England Journal of Medicine*;318:1549-1556, June 9, 1988.

**ELLWOOD:** We learned from the HMO reform efforts that major structural changes in our massive health system take 20 to 25 years. Medicare, after 45 years, is still a work in progress, and always will be. The initial public policies often contain defects that require subsequent correction if they are to maintain the original objective of containing costs, consistent quality and insurability. The private health system is inseparable from the public one in terms of inconsistency of performance. Then there is unforeseen technological progress that can disrupt everything – such as information technology and personal genomics.

To cope with remote and unforeseen developments, I've felt we needed a quasi-public regulatory agency similar to the Federal Reserve. Its goal would be to contain medical inflation without jeopardizing quality of care. Its tools would be outcomes accountability, and devising evidence-based and cost effectiveness guidelines to be applied by the health sector, consumers, and policy makers.

We learned from the HMO experience that transforming an industry of this scale – and the American health system is the largest industry in the world – requires a huge cultural shift. Consumers are going to have to be much more in on what's going on and treated in an entirely different way. They're going to have to trust that their providers are doing a good job. They have to be sought out routinely as to what impact health care has on personal lives. The only way to do that is to create some reliable and durable mechanism to measure the effectiveness of individual providers and health care organizations and interventions to improve people's health.

**KOVNER:** Is there any parallel in the way consumers purchase other goods and services that could be applied to health care?

**ELLWOOD:** There are entities, public and private, like Consumers Union and J.D. Power and even Amazon that measure automobile mileage, aircraft safety, and consumer satisfaction, but none of it is of a similar scale or of a life and death transforming nature. The key notions here are that health care is always a work in progress. The political environment during that period of time is going to change. The technology of health care is changing. The attitude of doctors and hospitals and patients are changing. We have to have some sort of institutional mechanism that measures and preserves the effectiveness of this industry in producing health over extended periods.

If it's going to take 20 years, or 30 years, or 50 years, it has to be isolated from politics as much as it can be. Our best metaphor is the Federal Reserve system. The Federal Reserve manipulates interest rates, and money supply, but what do you manipulate in health care? You attempt to manipulate results, outcomes, and cost effectiveness. The Federal Reserve has had to deal with a whole variety of good and bad banking mechanisms, but they've always had the same end point: How is the economy performing? Is it growing? Is inflation under control?

We need a similar thing in health care. What is health care for? It's to keep people healthy and to get them healthy. Therefore, the measure that is the analogy to inflation is 'health outcomes.' We have to create an agency to collect health outcomes data, isolate it from the rest of the government and the rest of the health system, and then use its findings to determine what it is that's worth spending public or private money on for health care. Also, use the data to change the value system, to change doctors from isolated and unaccountable professionals into groups who are supposed to produce health, and where you measure whether or not they're doing it and at what cost.

How do you manipulate the health economy? There's only one way you can do it. If an intervention is not effective in producing health, you don't pay for it with public funds, including tax exclusions. Sure, let people go ahead and pay for it themselves, but not the government, which buys most of the health care in the country. Congress should say to the 'federal health board,' or whatever you want it to call it, "We're running over budget. What outcomes can we buy for what we've got?" The expenditures for health and eligibility levels are political decisions.

**KOVNER:** Let's now go to the Jackson Hole Group. How did that Jackson Hole Group succeed and fail? Why did the federal government solicit the Jackson Hole recommendations? What has it been like being a leader and a member of this group for over 20 years?



**Barbara and Paul Ellwood**

**ELLWOOD:** First, it was a privilege to participate in and learn from the group. The Jackson Hole Group was formed to further study and promote the HMO idea, identifying what was going wrong, what was going right, what should be added to it. We began by inviting an eclectic group of citizens and leaders in health care to our condo in Jackson Hole, Wyoming.

I'd like to mention my wife Barbara's role as the organizer of the Jackson Hole Group meetings. She is the one who coordinates, manages big egos, and makes sure that the guests show up on time.

The initial emphasis was on building the HMO movement. When the HMO movement had taken off and was beginning to go in directions we weren't happy with, we began shifting the focus towards the next generation of health care policy and organization.

We always broke in the middle of the day so that attendees could go rafting or snow-shoeing to increase the discussion's candor and relevance. They accepted that they were working on some larger, longer-range health reform objectives. We met a total of about 30 times, always a different cast of characters. Certain people were invited to most of the meetings – Alain Enthoven, the health economist, and Glen Nelson, MD,<sup>61</sup> my closest advisor on the changing realities of medical practice, for example. The emphasis ultimately shifted to devising the next stage of health policy, going after some of the things that had been left out, like malpractice, expanded coverage, and continuing to push the idea of outcomes measurement and how it might be done. Recalling the Jackson Hole Group experience, perhaps we should have focused more on the failings of the HMO policy.

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<sup>61</sup> Glen D. Nelson, M.D. was CEO of the Park Nicollet Medical Center (Minneapolis) and vice chairman at Medtronic, among other positions.

We usually did not allow the media to attend but would occasionally invite a journalist, such as Michael M. Weinstein, an editor from the *New York Times*, a former academic economist and Laura Landro from *The Wall Street Journal*. Laura was a journalist who had leukemia and had figured out how to manage her cancer by going to the Web and sources like the National Library of Medicine.



**Break during Jackson Hole Group 1994 meeting. Among the participants pictured are Dr. Nancy Dickey, the first woman to become president of the American Medical Association (standing), and Minnesota Senator David F. Durenberger (at the rear).**

Mike Weinstein of *The New York Times* contacted me during the 1992 presidential election campaign. He reported that in the New Hampshire primaries, one of the candidates, Senator Robert Kerrey<sup>62</sup>, had a health plan. Kerrey, incidentally, attended the Jackson Hole Group meetings. Another candidate, Governor Bill Clinton, needed a health plan. Would we send the Jackson Hole Group's Managed Competition ideas to Ira Magaziner<sup>63</sup>, who was working for Clinton?

Soon we noticed that the rhetoric on health care of the Clinton campaign became the managed competition proposals of the Jackson Hole Group. When Clinton was elected and Mrs. Clinton was designated to be responsible for health care, we wrote a letter to the new president

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<sup>62</sup> Joseph Robert Kerrey (b. 1943), Democrat, was the Governor of Nebraska from 1983 to 1987 and a US senator from 1989 to 2001. He was a presidential candidate in the early '90s.

<sup>63</sup> Ira Magaziner (b. 1947) and Hillary Rodham Clinton led the Task Force to Reform Health Care during the Clinton Administration. He later became the Chairman of the Clinton Foundation Policy Board.

suggesting our eagerness to help. This letter was signed by a ‘Who’s Who in Health Care in the United States.’ I got back a form postcard that read something like, “The President always appreciates Americans who are interested in the betterment of the country. Thank you very much.”

After the election Ira Magaziner and Mrs. Clinton ignored us. The Clinton health policy team, unlike the Johnson, Nixon, Carter administrations, limited our access to the policy-generating process. That situation persisted. Finally, it was possible to meet briefly and perfunctorily with Mrs. Clinton, but we were ‘the enemy.’ We were ‘the health industry insiders.’

One of the things I learned at the very beginning from our comprehensive health planning experience is that you don’t want to publically surprise political policymakers. You don’t want to undermine them, especially when they’re working on things that you believe in. So we did not criticize what was going on within the Clinton Administration. Alain Enthoven did a little bit, but not much. The Secretary of the Treasury Bentsen<sup>64</sup> did read one of these criticisms, I understand, and warned that our opposition jeopardized the entire Clinton Health Plan.

In the meantime, we began meeting independently with the Senate Finance Committee, which at this point was headed by Senator Patrick Moynihan<sup>65</sup> who had become a friend because of my son David’s role in welfare reform. The Senate Finance Committee began devising an alternative health proposal that was really rather good, but it didn’t look like it had much chance of going anywhere. Again, it was bipartisan. Republican John Chafee<sup>66</sup> was the informal leader. His collaborators were from both parties.

David Ellwood, who was at that time Assistant Secretary for Planning and Evaluation in the Clinton Administration, called to say, “Mrs. Clinton wants to meet with you.” That was the first time she’d reached out to us or listened to anything our group had to say. The meeting was attended by Mrs. Clinton, David Gergen<sup>67</sup>, and David Ellwood.

Her message was: We want to make a health deal with the Senate Finance Committee. I asked, “How familiar are you with the Oslo negotiations over Israel? You’re *that far apart*.” Mrs. Clinton, “Well, we know a lot about the Oslo Accord and are very interested in a comparable process.” What she said was needed was a go-between to help coalesce things. She suggested I meet with Senator Chafee about the possibility of some sort of a collaborative arrangement with the Clinton Administration.

The next day, I went to John Chafee’s office. He was busy, on television. He finally came out of his office and said, “Paul, I’m late to catch a plane to Rhode Island. Won’t you come along in the car with me?” I thought, *We’re gonna have quite a bit of time with the senator to make our pitch for Mrs. Clinton*. We got to where the underpass is located in front of the Capitol when all of a sudden red lights went on and we got stopped. I thought, *Fine, there’s more time to talk to Senator Chafee about these ideas*.

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<sup>64</sup> Lloyd M. Bentsen, Jr. (1921- 2006), Democrat, represented Texas in the House and later in the Senate.

<sup>65</sup> Daniel Patrick Moynihan (1927-2003), Democrat, served as senator from New York from 1976 to 2001.

<sup>66</sup> John H. Chafee (1922-1999), Republican, served as senator from Rhode Island from 1976 to 1999.

<sup>67</sup> David R. Gergen (b. 1942), has served as an advisor to four U.S. presidents, is a political analyst for CNN, and is a professor at the Harvard Kennedy School of Government.



Finally Chafee put down the car window. By that time, he'd missed his plane. Chafee said to a nearby policeman, "How come we're stopped?" The reply was, "Presidential motorcade." With that, Chafee swore and said, "You tell that woman to come and see me herself." The next day, I got a call from a staffer on Mrs. Clinton's plane inquiring what had happened. I described it but she never followed through. That was literally the end of the Clinton health plan. The two sides never met. The Senate Finance Committee failed to pass its own plan by one vote.

**KOVNER:** Was that the end of the Jackson Hole Group?

**ELLWOOD:** No, the Jackson Hole Group went on. We had one pending, serious objective – outcomes management: measuring and making available information about health care for consumers and providers, ultimately having the government pay for what works. We had a series of meetings where we worked around this idea of accountability to the consumer and employer involvement. Finally, we had a meeting where the group was going to, for the first time, vote on something, and that was whether or not the insurance companies would adopt outcomes management, health care accountability for their clients.



**Site of the Jackson Hole Group meetings**

The insurers' spokesman was Bill Roper<sup>68</sup>, who had headed CMS, and CDC, a great person in public health. At the time, he was a vice president at Prudential. He announced that the insurance companies were not prepared to go along with outcomes accountability – something about the 'perfect being the enemy of the good.' It was the only time at a Jackson Hole meeting where I lost my cool and shouted indignantly at him. The next meeting, with no insurers present, the group decided to create *something* that could advance this idea of accountability in health care.

The result was the Foundation for Accountability (FACCT), headed by David Lansky<sup>69</sup>. FACCT went on with the idea of trying to convince provider and employer groups to be accountable. I don't know how long FACCT lasted. Several years. David was a great leader and had wonderful staff. They couldn't crack it. We were trying to circumvent the whole notion behind confidentiality, professionalism and doctor-patient relationships.

**KOVNER:** Why was the insurance industry opposed to this?

**ELLWOOD:** I don't know. We'd been meeting with these guys for years. The insurance leadership at that time were very good people. I can remember Jamie McLane<sup>70</sup> from Aetna saying,

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<sup>68</sup> William L. Roper, M.D. is the CEO of UNC Health Care System and dean of the medical school at the University of North Carolina (Chapel Hill). He was the director of the Centers for Disease Control in the early '90s.

<sup>69</sup> David Lansky, Ph.D., was president of the Foundation for Accountability from 1995 to 2004, and later became the President & CEO of the Pacific Business Group on Health.

<sup>70</sup> James W. McLane was executive vice president at Aetna Life & Casualty and later became president and chief operating officer of NovaCare, Inc.

“You know, we’re no longer in the insurance business; we’re in the health business.” They really bought into the key notions that we had. I don’t know why they rejected that idea but perhaps they anticipated that the real opposition would come from physicians, hospitals and insurer actuaries.

**KOVNER:** They missed a tremendous opportunity.

**ELLWOOD:** Another postscript to that phenomenon of these insurance people who acknowledged that they were going into the health business is that few of them kept their jobs. They were replaced by people with an actuarial, risk averse, and profit mentality.

**KOVNER:** Right. That’s what happened.

**ELLWOOD:** FACCT didn’t succeed. Next came the Bush Administration, with their Part D drug benefit idea. I went to the drug companies and to people in the Bush Administration, thinking, *At least we can measure whether or not drugs are effective.* That was a terrible, naive blunder. It just alerted their pharmaceutical lobbyists to fight the evidence-based accountability concept, because when the drug has gotten through the clinical trials, the Food and Drug Administration, and you’ve got your patented drug on the market, you get to keep it as a monopoly for a number of years. Why have some post-market measurement that shows that it doesn’t work? So they killed the idea of any sort of systematic outcome measurement of the drugs Medicare was to buy.

Another thing that we didn’t talk about yet, and that’s auspices. I often wondered whether it might be better to be operating from the kind of academic base you operate from, Tony. Our freelancing style made it hard to raise money and reduced our credibility. I think I was resented by some people in academic settings. We probably should have written more because the paucity of peer-reviewed articles reduced our academic credibility.

The money-raising part was also difficult for me, in part, because this was such a personal venture, an unsponsored small group of people working together. If we failed to convince the source of funds that they ought to make a grant to the organization, I felt it personally. It was a repudiation.

**KOVNER:** What is your legacy? How would you like to be remembered?

**ELLWOOD:** I think I’ve told you a story of failure.

**KOVNER:** No, not at all.

**ELLWOOD:** Well, the door had been opened to restructuring the health delivery system. Along the way, I’ve gotten to know and work with those who are devising and applying superior ways to produce health. Health care inflation was controlled for several years. We’ve had unparalleled opportunities to try to reshape our health system. But would you like to be labeled the ‘Father of the HMO?’ On the other hand, I’d like to hope President Obama’s Affordable Care Act is based on the same principles that shaped my career. Maybe this time the country will succeed in positively reshaping our health system’s structure, incentives, culture and accountability allowing for vastly expanded coverage.

President Obama, Don Berwick, and others who must implement the next wave of health reform are faced with even more formidable barriers – too many options and loopholes, and a vastly more savvy and aggressive medical-industrial complex. But in my 40 years of observing presidents and their staffs’ attempts to reform health care and expand its availability, this Administration has the most overt commitment and best resources. Tony, what advice would you give Don Berwick and his successors at CMS?

**KOVNER:** We’ve gotten to where we have measurable results. Once the financial mechanism is related to the measurable results, then behavior changes. We need more research to see what works. Something I’ve been working on is evidence-based management. Let’s take the same ideas as in evidence-based medicine and apply this to management. But when I go to talk with a CEO, I always hear, “Your ideas are great, but we have more important things to do. We can’t spend time measuring.” So I say, “You’re using evidence now, but you’re not using the *best available* evidence to make your decisions.”

**ELLWOOD:** Exactly. We need to expand our approaches beyond the traditional HMO/ACO idea of competing medical groups serving populations. Sid Garfield’s Kaiser plan is 80 years old but it is still the gold standard.

I was struck in the political battles over the Obama health proposals by how selfish Americans have become about health care and other public goods that we all depend upon – seniors on Medicare fighting the idea of trying to make Medicare more epidemiologically sound and efficient so that savings might be available to take care of poor people or the young and uninsured. Somehow we must recognize that our health system is a shared responsibility.

Let’s take advantage of the instant accessibility, increased productivity, shared responsibilities and the evolving capacities of mobile information technologies like smart phones. In doing so, we’ve got to avoid the interoperability problems that have plagued electronic medical records. Let’s deploy the combination of disruptive information technologies that have triggered popular revolutions, created new user communities, provided instant search and increased productivity. IT-based care should emphasize openness, collaboration with largely free apps based on solid science.

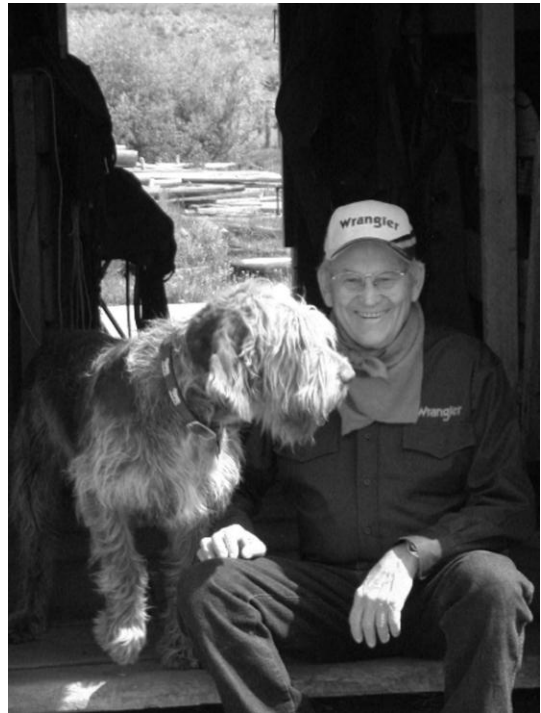
Call it ‘DocUSA.gov.’ Think of it as an evolving combination of mobile information technologies, the insatiable cloud search and critique algorithms of Google and Amazon and the shared networking of health seeking experiences. Its key features would include mobility, emergency responses, internet clinical advice and consultation, outcomes collection and analysis, monitoring prescription refills and feedback, and on and on. ‘DocUSA’ – the idea is to provide as much care and support as we can using the internet, computers, and especially mobile devices. The ‘DocUSA’ system and apps would be available free to anyone as a publically recognized, science-based, and evolving technology. ‘DocUSA,’ here I go again! Wish I had another 40 years to work on this stuff.

**KOVNER:** Thank you, Paul. This has been a wonderful interview and a chance for me to listen to one of the great men in health care delivery.

**ELLWOOD:** You’re nice to say that. Thank you.

## CHRONOLOGY

- 1926 Born July 16, San Francisco, CA
- 1944-1946 U.S. Navy  
Pharmacist Mate 3c (X-ray tech), Asiatic Pacific Theater
- 1949 Stanford University  
B.A. with distinction
- 1953 Stanford School of Medicine  
M.D.
- 1952-1954 University of Minnesota  
Internship in Pediatrics
- 1953-1954 University of Minnesota  
Fellow in Pediatrics
- 1953-1958 Elizabeth Kenny Institute  
Director of In-Patient Service
- 1954-1956 University of Minnesota  
Fellow in Pediatrics assigned to  
Neurology
- 1955-1957 University of Minnesota  
Fellow in Neurology
- 1956 Argentine Health Ministry  
Special advisor on poliomyelitis and rehabilitation techniques
- University of Minnesota  
1957 Assistant Professor of Pediatrics  
1958 Clinical Assistant Professor of Neurology and Pediatrics  
1962 Clinical Assistant Professor of Physical Medicine and Rehabilitation  
1959 Member of the Teaching Faculty of the Graduate School
- 1958 National Institutes of Health, Neurological Diseases and Blindness  
Special consultant
- 1960 University of Washington  
Residency in Physical Medicine and Rehabilitation
- 1957-1961 Elizabeth Kenny Foundation  
Assistant Medical Director



Kenny Rehabilitation Institute and Sister Elizabeth Kenny Foundation  
(later known as: American Rehabilitation Foundation)

1958-1962 Medical Administrator

1962-1963 Assistant Director

1963 Executive Director

1972- InterStudy  
Executive Director

1992-2002 The Jackson Hole Group  
Founder and President



## MEMBERSHIPS AND AFFILIATIONS

American Congress of Physical Medicine and Rehabilitation  
Chair, Committee on Professional Education

American Hospital Association  
Member, Committee on Rehabilitation

Association of Rehabilitation Centers  
Board member  
President

Community Health & Welfare Council  
Member, Economic Opportunity Committee

Institute of Medicine  
Member

Minnesota Epilepsy League  
Board member

Minnesota Governor's Citizens' Council on Aging  
Chair, Medical Section  
Member

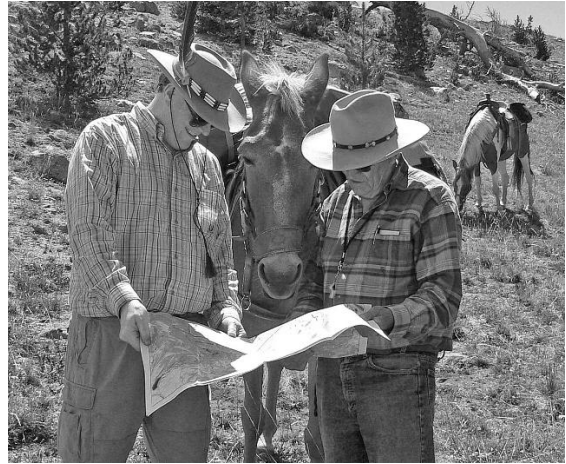
Minnesota State Medical Association  
Member, Committee on Aging

National Conference of Rehabilitation Centers and Facilities  
President

National Conference on Stroke  
Member, Committee on Professional Education

National Health Council  
Board member

US Public Health Service  
Member, Council on Community Health Services  
Member, National Advisory Community Health Committee



## AWARDS AND HONORS

- 2010 Lifetime Achievement Award, Stanford Medical Alumni Association
- 1988 Shattuck Lecture, Massachusetts Medical Society
- 1962 President's Citation, Committee on Employment of the Handicapped
- 1959 Certificate of merit, scientific exhibit, American Medical Association
- 1958 First award for scientific exhibit, American Academy of Neurology
- 1958 Certificate of merit, scientific exhibit, American Academy of Neurology
- 1957 Award, Ministry of Public Health, Republic of Argentina
- Gold Key, American Academy of Physical Medicine and Rehabilitation



## SELECTED PUBLICATIONS

- Ellwood, P.M., Jr. Does managed care need to be replaced? *MedGenMed: Medscape General Medicine*;3(5):5, Oct. 22, 2001.
- Ellwood, P.M., Jr., and Lundberg, G.D. Managed care: a work in progress. *JAMA*;276(13):1083-1086, Oct. 2, 1996.
- Scheuer, B.S., Ellwood, P.M., Jr., and others. Empowered patients buy more efficient care: roundtable of experts. *Business & Health*;14(6):35, 38-40, 42, June 1996.
- Ellwood, P.M., Jr. How doctors can regain control of healthcare. *Medical Economics*;73(9):178-180, 185-188, 191-192, May 13, 1996.
- Ellwood, P.M., Jr., and Enthoven, A. *Responsible Choices for Achieving Reform of the American Health System*, Apr. 1995.
- Ellwood, P.M., Jr. Ellwood explains his theory, terminology on outcomes method of managing care. *Modern Healthcare*;19(2):30, 32, Jan. 13, 1989.
- Ellwood, P.M. Outcomes management. *The New England Journal of Medicine*;318:1549-1556, June 9, 1988.
- Ellwood, P.M., Jr. Health care delivery update: part 2, banking on quality, the call for a quality reserve system. *Consultant*;28(4):92-93, 99-100, Apr. 1988.
- Ellwood, P.M., Jr. Health care delivery update: part 1, Trends, less and more integration. *Consultant*;28(1):86-88, 91-92, 95, Jan. 1988.
- Ellwood, P.M., Jr. Ellwood says 'supermed' concept gaining ground, expects up to 10 within decade. *Review - Federation of American Health Systems*;19(2):69-70, 72, Mar.-Apr. 1986.
- Ellwood, P.M., Jr., and Paul, B.A. But what about quality? *Health Affairs*;5(1):135-140, Spr. 1986.
- Ellwood, P.M., Jr. Alternative delivery systems: health care on the move. *Journal of Ambulatory Care Management*;8(4):1-3, Nov. 1985.
- Ellwood, P.M., Jr. Future: role medical groups/doctors? *Group Practice Journal*;33(5):12-15, Sept./Oct. 1984.
- Ellwood, P.M., Jr. The future shape of health care systems. *Health Care Strategic Management*;2(9):27-30, Sept. 1984.
- Ellwood, P.M., Jr. How competition is reshaping health care. *Hospitals*;58(14):116, 120, July 16, 1984.
- Ellwood, P.M., Jr. Ellwood's MeSH idea links physicians, hospitals in business partnership plan. *Review - Federation of American Health Systems*;17(4):36, 38.



- Ellwood, P.M., Jr. When MDs meet DRGs. *Hospital Medical Staff*;12(12)2, 6-8, Dec. 1983.
- Ellwood, P.M., Jr., Malcolm, J.K., and Lewis, K.A. Competition: Part I, what part will you play in the medical care 'firms' of the future? *Group Practice Journal*;31(4):8-10, July/Aug. 1982.
- Ellwood, P.M. Managing the new medical marketplace. *Sixth Annual Malcolm T. MacEachern Commemorative Lecture*. Chicago: Northwestern University, J.L. Kellogg Graduate School of Management, May 20, 1981.
- Ellwood, P.M., Jr., and Ellwein, L.K. Physician glut will force hospitals to look outward. *Hospitals*;55(2):81-85, Jan. 16, 1981.
- Ellwood, P.M., Jr., and Malcolm, J. HMOs and health delivery reform. *Hospital Administration Currents*;24(3):9-14, May/June 1980.
- Christianson, J.B., Malcolm, J., and Ellwood, P.M., Jr. The St. Louis Park Medical Center. *Medical Group Management*;26(6):44-47, Nov./Dec. 1979.
- Ellwood, P.M., Jr. Ellwood says the name HMO stigmatized but not the concept. *Review - Federation of American Hospitals*;12(5):24, Oct./Nov. 1979.
- Malcolm, J., Ellwood, P.M., Jr. Competitive approach may ease problems in delivery system. *Hospitals*;53(16):66-69, Aug. 16, 1979.
- Ellwood, P.M., Jr. Business tools up to influence health care. *Hospital Progress*;60(1):6, 10, 12, Jan. 1979.
- Ellwood, P.M., Jr. Companies' interest in health care may bring an upsurge in HMO activity. *Review - Federation of American Hospitals*;11(4):29-30, June 1978.
- Ellwood, P.M., Jr. The importance of the market. *Journal of Health Politics, Policy and Law*;2(4):447-453, Winter 1978.
- Ellwood, P.M., Jr., and others. Private sector cost containment initiatives. *Industry and Health Care*;7:75-87, 1978.
- The Health Care Alliance. Collected papers, in: *National Commission on the Cost of Medical Care*. Vol. 2, 153-156, 1978.
- Ellwood, P.M., Jr. The importance of the market. *Report of the National Forum on Hospital and Health Affairs*, 75-87, 1977.
- Ellwood, P.M., Jr., and McClure, W. *Joint Memorandum for the Carter Transition*, revised Nov. 17, 1976.
- Ellwood, P.M., Jr. Concept, organization and strategies of HMOs. *Journal of Nursing Administration*;3(5):29-34, Sept./Oct. 1973.

Ellwood, P.M., Jr., and Herbert, M.E. Health care: should industry buy it or sell it? *Harvard Business Review*;51(4):99, July/Aug. 1973.

Ellwood, P.M., Jr. Implications of recent health legislation. *American Journal of Public Health*;62(1):20-23, Jan. 1972.

Ellwood, P.M., Jr., and others. Health maintenance strategy. *Medical Care*;9(3):291-298, May-June 1971.

Ellwood, P.M., Jr. Health maintenance organizations: concept and strategy. *Hospitals*;45(6):53-56, Mar. 16, 1971.

Ellwood, P.M., Jr., and Hoagberg, E.J. The plight of the public hospital: 3, problems of the public hospital. *Hospitals*;44(13):47-52, July 1, 1970.

Ellwood, P.M., Jr. How can change in methods and interrelationships within the health care industry be brought about? *Archives of Physical Medicine and Rehabilitation*;50(10):549-555, Oct. 1969.

Ellwood, P.M., Jr., and Anderson M.N. Consumer power: the dilemma of health and welfare services. *Rehabilitation Record*;10(4):1-6, July/Aug. 1969.

Ellwood, P.M., Jr. The rehabilitation-industrial complex: toward a new rehabilitation market. *Journal of Rehabilitation*;35(2):18-21, Mar./Apr. 1969.

Ellwood, P.M., Jr. Can we afford so many rehabilitation professionals? *Journal of Rehabilitation*;34(3):21-22, May 1968.

Program for survival: A proposed course of action for the health insurance industry. *ARF Memorandum Series*;B-2, Feb. 1968.

*A Study of Methods of Implementing Comprehensive Health Planning in the States.* [ARF 749 Project, U.S. Public Health Service Contract 108-66-304, Section C], 1967.

Ellwood, P.M., Jr. A promising partnership of voluntary health agencies and government. *NY Journal of Dentistry*;37(1):9-11, Jan. 1967.

Ellwood, P.M., Jr. Quantitative measurement of patient care quality: 2, a system for identifying meaningful factors. *Hospitals*;40(24):59-63, Dec. 16, 1966.

Ellwood, P.M., Jr. Quantitative measurement of patient care quality: 1, measures of care. *Hospitals*;40(23):42-45, Dec. 1, 1966.

Ellwood, P.M., Jr. Voluntary health agencies and government: a promising partnership. *JAMA*;198(2):149-150, Oct. 10, 1966.

Bergstrom, D.A., Ellwood, P.M., Jr., and Grendahl, B.C. How hospitals and industry work together: 1, rehabilitation experts confer with manufacturers on design of hospital beds. *Hospitals*;39(23):101-106, Dec. 1, 1965.

- Krusen, F.H., Kottke, F.J., and Ellwood, P.M., Jr. (eds.) *Handbook of Physical Medicine and Rehabilitation*. Philadelphia, PA: W.B. Saunders, 1965.
- Ellwood, P.M., Jr., and others. Rehabilitation facilities and social trends. *Journal of Rehabilitation*, May-June 1964.
- Ellwood, P.M., Jr. Goal of rehabilitation. *Proceedings of the 4<sup>th</sup> Western Conference of the American Association of State Compensation Insurance Funds*;Section 5:13-19, May 1962.
- Ellwood, P.M., Jr. Independent living and the independent physician. *Journal of Rehabilitation*;27:16-17, May-June 1961.
- Roasenda, J.P., and Ellwood, P.M., Jr. A review of the physiology, measurement and management of spasticity. *Archives of PM&R*;42, Mar. 1961.
- Ellwood, P.M., Jr. Cerebral lesions in infancy. *JAMA*;174:1958-1961, Dec. 10, 1960.
- Ellwood, P.M., Jr. Neurological examination of the infant: newborn to 12 months. *Postgraduate Medicine*;27(5):653-662, May 1960.
- Ellwood, P.M., Jr. Poliomyelitis: a nursing challenge, in: Myers, J.A. *Tuberculosis and Other Communicable Diseases*. Springfield: Chas. C. Thomas, 1959.
- Ellwood, P.M., Jr. *A Rehabilitation Program for Nicaragua*, Oct. 1958.
- Kleinman, H., Rodgers, D., Ellwood, P., and others. Epidemic of ECHO or 'aseptic meningitis' in Minnesota, 1957. *Bulletin of the University of Minnesota Hospital & Minnesota Medical Foundation*;29(10):Mar. 15, 1958.
- Rodgers, R.S., Ellwood, P.M., and others. Urological complications of poliomyelitis. *The Journal of Urology*;76(4):447-452, Oct. 1956.
- Ellwood, P.M., Jr. Infectious and post-infectious encephalitis. *Minnesota Medicine*;39(3):169-172, Mar. 1956.
- Syvertson, J.T., Scherer, W.F., Ellwood, P.M. Studies on the propagation in vitro of poliomyelitis viruses. *The Journal of Laboratory & Clinical Medicine*;43:286-302, Feb. 1954.
- Tobin, J.O'H., Ellwood, P.M., and others. The specific diagnosis of poliomyelitis by use of a human epithelial cell strain HeLA (Gey) in continual culture. *Proc. Gen. Soc. Clin. Res.*;27:127, 1954.
- Tobin, J. O'H., Ellwood, P.M., and others. Poliomyelitis and aseptic meningitis. *Bulletin of the University of Minnesota Hospital & Minnesota Medical Foundation*;26:234-244, Dec. 10, 1954.

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