HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Gary L. Filerman

GARY L. FILERMAN

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
Lewis E. Weeks Series

Produced in cooperation with

Library of the American Hospital Association
Asa S. Bacon Memorial

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

LIBRARY OF THE AMERICAN HOSPITAL ASSN.

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

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

Gary L. Filerman

CHRONOLOGY

1936	Minneapolis, Minnesota. Born there November 16, 1936
1956-1957	World University Service, and Institute of International Education, Camp Kilmer, N.J. Director of Hungarian Student Refugee Center
1957	University of Minnesota, Office of Dean of Students, Junior Administrative Fellow
1958	University of Minnesota, B.A.
1958-1959	Mount Sinai Hospital, Minneapolis. Administrative Assistant, part-time
1959 (summer)	University of Minnesota, President's Office, Administrative Fellow
1959	U.S. National Students Association, Director, National Intercollegiate Workshop
1960	University of Minnesota, MHA Hospital Administration
1961-1962	Johns Hopkins Hospital, Administrative Resident, and Administrative Assistant
1962	University of Minnesota, M.A. Political Science
1962 (summer)	Brookings Institution, Guest Scholar
1964	University of Minnesota, Ph.D.
1964	Chile, Colombia, Peru, Venezuela. Field study, Lecturing, Consulting, Visiting Hospitals
1965	Minnesota Hospital Association, Project Coordinator, Acting Director, (March-June)
1965-1975	AUPHA, Executive Director
1965	University of Mexico, Lecturing, Consulting
1966	Colombia. Conducted Conference of Latin American Schools of Hospital Administration. Attended Conference of Pan American Federation of Associations of Medical Schools. (August)

1966	Colombia. Hospital San Juan De Dios, Bogota, and University Hospital, Medellin. Consulting. (June)
1966	Chile, Consulted for W. K. Kellogg Foundation of Preventive Medicine Curriculum; for Peace Corps on Nursing Program
1967-1972	AHA-BCA Advanced Fellowship Selection Committee
1967	Mexico, Hospital Administration Program. Consulting. (January)
1967	Colombia. WHO (PAHO) Conference on Medical Care Teaching. Invited observer. (August)
1967-1970	Job Corps Health Advisory Committee
1968-	Accreditation Commission on Education for Health Services Administration, Executive Secretary
1968	England, Belgium, Hospital Conference of Western Europe, University of Leuven Hospital Administration Program.
1968-1971	Joint Committee on Medical Care Education. Member.
1970	England. Institute on Health Organization for International Faculty
1970-1972	Committee for Effective Drug Abuse Legislation.
1971	England, Belgium, Germany. European Association of Medical Care and Health Administration Training Programs; University of Leuven; King's Fund College, London; (April)
1971	Argentina. PAHO (WHO). Consulted on Developing Programs for Health Administration. (September)
1972-	Health Administration Press. Editorial Board
1972	Belgium and EEC countries. Leuven University, Visiting Professor, Participated in organization of Institute for European Health Services Research.
1972	U.S. Senate, Committee on Appropriations. Testified.
1972	U.S. Senate, Committee on Labor and Public Welfare. Testified.
1973	U.S. House of Representatives, Subcommittee on Health, Testified.

1973	Canada, Conducted Institute on Canadian Health Services Organization. (June)
1973	Colombia, Guatemala. PAHO (WHO) Consultant to Regional Education Centers, and for national health planning for Guatemala (December)
1973-1975	W.K. Kellogg Foundation. Advisory Committee to Commission on Education for Health Administration
1973-1975	Council of Specialized Accrediting Agencies, Board of Directors, Vice Chairman.
1973-80	Washington University, School of Medicine, Adjunct Instructor
1974	England, France, Denmark, Finland. National Conference on Management Development for Reorganized National Health Service, U.K.; Institute of European Health Administration Programs; WHO-Copenhagen, consultant; Faculty Institute on Finnish Health Service Organization.
1974	U.S. House of Representatives, Subcommittee on Health. Testified
1974-	George Washington University, Adjunct Associate Professor
1974-1975	W.K. Kellogg Foundation Health Advisory Committee, member.
1974-1975	Committee on Health Politics, member
1974-1976	University of Pennsylvania, Leonard Davis Institute, HMO Management Program, Advisory Committee, member
1974-1982	American Council on Education, member Commission on Educational Credit and Credentials
1975-	AUPHA, President
1975	U.S. Senate Committee on Labor and Public Welfare. Testified.
1975	Finland, Denmark, Institute on Health Services Organization in Finland. (August) Planned Institute (May)
1976	U.S. Senate Committee on Labor and Public Welfare. Testified.
1976	U.S. House of Representatives, Subcommittee on Health. Testified

1976-1977	W.K. Kellogg Foundation, Task Force on Lifelong Learning
1977	Veterans Administration Scholars, program review.
1977-1980	University of Wisconsin, School of Business Administration, Advisory Committee on Health Care Fiscal Management, member
1978	England, Israel, Portugal. Explorations of African Health Management Development (U.K.); consultation on managerial and planning manpower training (Israel); Faculty Development (Portugsl). (August)
1979	Kenya, Ghana, Ivory Coast. AID Assessment of Health Services Systems.
1979	JCAH, Policy Advisory Committee, member
1979-1980	University of Massachusetts, Amherst, School of Public Health, Advisory Committee, member.
1980-	Portugal-Planned and Conducted First International Course on Health Administration Education.

AFFILIATIONS AND MEMBERSHIPS

Alabama Regional Medical Program, consultant

American Association for Canadian Studies

American Hospital Association

American Public Health Association, Fellow

Argentina Ministry of Welfare, consultant

Association of American Medical Colleges

Ben Gurion University, Israel, consultant

University of California, Los Angeles, School of Public Health, consultant

Centro de Education en Administration de Salud, Bogota, consultant

University of Chicago, School of Business Administration, consultant

Colombia Ministry of Health, consultant

University of Colorado, School of Medicine, consultant

Common Cause

Cosmos Club (Washington)

Duke University, School of Medicine, consultant

Educational Record, Editorial board

Federation of Associations of Schools of the Health Professions

Hospital Progress, Editorial board

Institute for European Health Services Research, Fellow

Journal of Applied Research in Health Administration, Editorial board

Journal of Health Marketing, Editorial board

Journal of Health Politics, Policy & Law. Editorial board

National Audubon Society

University of Ottawa, School of Management, consultant

PAHO (WHO), consultant

Royal Society for Health, member

Saint Louis University Health Center, consultant

Sierra Club

U.S. Army Academy of Health Sciences, consultant

U.S. Department of Labor, consultant

U.S. National Center for Health Services Research & Development, consultant

U.S. National Institutes of Health, consultant

U.S. Veterans Administration, consultant

Universidad de Antioquia, Colombia, consultant

University of Washington, School of Public Health, consultant

Wilderness Society

AWARDS

AUPHA
    Distinguished Contribution Award, 1979

B'nai B'rith
    King Gustav Award, 1957

Change Magazine
    Among 100 Young Leaders of the Academy, 1978

W.K Kellogg Foundation
    Graduate Fellow, 1961-1964

Leuven University
    Silver Medal, 1972

Milbank Memorial Fund
    Travel grant, 1964

Minnesota, University of
    Order of the North Star, 1959

Organization of American States
    Fellow, 1964

Phillips Foundation
    Fellowship, 1959-1960

WEEKS:

Please talk about your professional life, beginning with your college experience, if you wish.

FILERMAN:

There is a direct relationship between my undergraduate experience in Minnesota, how I got into field, and how I view some of its critical aspects such as the question of what kind of people we should be appealing to as a profession and also what kind of role expectations we should have for the health administrator at the community level.

In fairly recent months I've made a couple of speeches and written a couple of papers which have focused on the role of the administrator in society generally--the health administrator. The comments in such papers, I'm sure I know from past experience, will be taken by many of my colleagues as being critical of their current role. They will respond to it in very defensive fashion. But, I'm convinced that this field is at a very critical juncture in its evolution. How the profession itself deals with its self-definition, its role, how soundly it deals with its inadequacies, and how broadly is defines its potential--in the near future, I mean within the next three to five years--how effectively that's done is going to determine

whether professional health administration, as we identify it today, is just a transitory thing in the evolution of management of health and welfare services. That is, if as a distinct profession it will pass from the scene, or, if it is a field that, indeed, is going to continue to grow and prosper and achieve a more clearly distinctive place.

At this moment that's an open question, because I think the field is being moved in on and being challenged by a number of other professions, medicine, general management, and so on, which are demonstrating either competence and/or a claim to authority in an area where they've not shown a great deal of interest before.

My point is that up to this time health administration has been able to flourish, virtually unchallenged. But, today and in the next three to five years as a result of all sorts of societal and professional change, that's not going to be true anymore.

All of this goes back, I think, to the basic philosophy and operating style that grew out of a very activist undergraduate experience. I became an activist because I have an older brother, Lee, who was active in a group called AZA, which is the junior boy's group of B'nai B'rith. I admired his leadership and he got me interested and active in the organization. I became a national leader, an officer, and that was starting in high school.

It's the same process as DeMolay and a lot of other activities of that variety. It encourages political activity on a small scale--high school, local chapter, and so on. Then for the ambitious or aggressive person, it provides the opportunity to go on to leadership roles on a broader scale. But the most significant, lasting thing it does, is it gives you some skills--verbal skills, articulation skills, communications and organizational

skills. It encourages you to become active in all kinds of social change activities, whether they are of philanthropic nature or political nature. I think the fact that I became involved in those kinds of activities, at a fairly early point, was critical to my idea of who I am, what I want to do, and how I do it. I guess it's the thing that determined for me at a rather early point that I would probably never work in a profit-making environment, that my commitment would always be of a social service nature. I don't have any philosophic argument with the profit-making world. I just feel that my own value system and purpose is served by being in the "social service" sector. I think all that comes from that early experience. It was a good one.

When I was an undergraduate I had to work all the way through school and one of the good places to look for work at the University of Minnesota, like many big universities, was around the medical center. I actually went over to the student employment office, which was the last place you admitted you went to look for a job. They had listed a job with the student health service, which as I look back on it, was a horrible job. The job was to sit literally in the bowels of the Student Health Service, down about three stories below the ground, and verify microfilm records by looking in a viewer and going through tapes hour-after-hour.

So, I did that several hours a day and it was in that connection that I met Glen Taylor, who was the administrative director of the Student Health Service. He also had as a side business the operation of both the Minnesota Hospital Association and the Upper Mid-West Hospital Conference. Glen, had a well-established pipe line of young fellows that he had picked up through the Health Service or the other enterprises who did odd jobs for him in one of those three spheres in which he operated. Many of these fellows have gone on

through the program in Minnesota and are out in the field. I fell in with that group.

Glen was not a program graduate himself. In fact, I have a feeling that there was no particular love between Taylor and James A. Hamilton, but he did have a great respect for the program graduates. By being the executive of the state hospital association, of course, he was in a position where he knew everybody in the state--he knew most of the leadership in the country--and was tied in with the AHA and so on. He was naturally supportive, and I am one among many who owe Glen Taylor a great deal. So he was a good contact for an undergraduate to have, even if you spent most of your time down in the Health Service reading microfilms.

There was another tie-in. I think that at the time I started working for Glen, I was the vice president of the student body. Glen and the Student Health Service always had a tough time relating to the student government political structure. They wanted to be better understood, and better utilized, and be considered more responsive to the students as their consumers. They woke up one morning and discovered that they had the vice president of the student body captured right in their basement. The director of the Health Service was Dr. Ruth Boynton, quite a famous person in the student health service movement. I didn't know her very well but she took some advantage of my Health Service connection and got me involved on some of their student government committees. So, there was that sort of serendipitous overlap.

I worked myself out of a job there--eventually the microfilms run out. I went to Taylor, with whom I developed this broader relationship because I worked for him one week a year when the Upper-Midwest Hospital Conference

met. Through that I was also meeting LeTourneau and Crosby. Actually I really did meet them, they didn't meet me. I'd meet them at the airport and drive them in, or carry their luggage, make sure the water was in their glass when they spoke, run messages to them from the telephone, or something like that. As I say, no one would ever remember my face in the crowd, but I was quite impresseed.

But, it came to the end of this job and I went to see Taylor and I said, "Do you have anything else?"

He said, "No." But he said, "Go to any hospital administrator in town and tell him I sent you. Don't go to the personnel office, go to the hospital administrator."

The first hospital on my way home on the bus was Swedish. So, I stopped there and I went in to see Ray Swanson, the administrator. I literally walked right into his office and said, "Glen Taylor sent me to see you and ask you about a job."

He said, "Well, if Glen sent you, you must be a good kid, and I'll find you something."

That's actually the way it happened. So he put me to work sorting patient mail, A,B,C, in little boxes, at the Swedish Hospital. I worked at Swedish for, I've forgotten how long, but it was at least a couple of years. I eventually worked my way up to being the relief person at the information desk in the lobby during lunch hour. But generally I was restricted to my basic talent which was knowing the alphabet and being able to sort patient mail.

It was in that period, because of a number of young fellows working at the hospital that I got exposed to the idea that there was a course in hospital administration, and that was a pretty good thing to do. (All of that group

went on into the field.) I was, at the same time, continuing to be very active politically.

That was about my third year, and my fourth year of undergraduate work. (I have to specifiy that because I stayed on as an undergraduate an extra year, so I didn't really have sophomore, junior, senior years. It was about that time I decided that was what I wanted to do. I wanted to apply for the HA program. I kept hearing these stories about how tough it was to get in; they scared the hell out of me. The first two years of my undergraduate record, academically, were poor. I was a pre-med student, because that's what every kid in my neighborhood was, who was flunking quantitative methods in chemistry, and discovering all kinds of other things I never heard of before. I'm sure for three months I was pre-law and then for three months I was in political science, I think I was a philospher for at least six months, went through all those gyrations. But, the result of that was I decided to really involve myself in education. I developed a number of interests, political science and other fields, and began to pull myself up academically as I did. It's not an unusual phenomenon. Somewhere in that third or fourth year I did decide on the target. I wanted to be a hospital administrator. This was largely because as the part-time jobs developed, I had an opportunity to see this role model. It appealed to my sense of activism, the leadership role, being involved in medicine, but also in administration, and political science. It seemed to pull it all together in a real person. Taylor very much epitomized that, also Ray Swanson and the people I saw at Swedish. But up to that point, the real influence was Glen Taylor.

Eventually I took a job at Mt. Sinai. At that point I could go into the administrator's office and say, "I want to be a hospital administrator." So,

not only did I have, at that point, the experience of having worked at the Health Service and worked at Swedish, but I had that identity. I was one of the young fraternity. The administrator, Dr. Ben Mandelstam, was the man who had built Mt. Sinai fifteen years before. He immediately really reached out and tried to create a working situation that would prepare somebody to go into the course.

I've learned since that one of the strengths of this field is that so many practitioners do exactly that. I've advised many young people that have come into my office to do just what Glen Taylor did for me. In other words, I told them to go and see somebody I know and tell them I sent them. I've always told them to go into the boss' office and say I want to be a hospital administrator, and not go the personnel office. It has paid off time and time again because they are looked upon not as another employee but frequently as a young colleague who aspires to that role. I think one of the beauties of the field is the way the administrators do reach out to young people to create those opportunities. Well, that's what Mandelstam did for me. So my fifth and last year as an undergraduate I worked at Sinai and during the summer replaced each person in the business office as he or she went on vacation, which really was an optimal experience. Then during the first year of the program I worked in the admitting office because Dr. Mandelstam had decided that was the best place to see the total operation. I could work ten, fifteen hours a day on weekends, put in twenty, thirty hours a week, and study between admissions. So it was an ideal arrangement.

The reasons I took a fifth year of undergraduate work were three. One was that I had dropped out of school twice. One was to work as a full-time employee for Adlai Stevenson in the primary campaign against Kefauver. The

second time was the Hungarian revolution, when through a series of peculiar events I ended up as the director of the student side of the refugee reception center at Camp Kilmer, New Jersey. The third factor was that programs only admitted people in the fall. So, as a result of those first two adventures, I was off cycle and I would have graduated at the end of the fall quarter, and couldn't have started the program 'til September. Hanging over my head was that wonderful phenomenon of the day called "The Draft," so you couldn't give yourself three months, six months, or nine months of vulnerability if you were going to go into a school that started in the fall. You had to prolong your graduation. You had to have a draft shelter and my draft shelter was to go to school an extra two quarters. The benefit of that was that I was able to finish five undergraduate majors, just by adding three credits, six credits and so on. Instead of having graduated with a major and two minors I graduated with all majors. I've never regretted that. It was a good investment.

Along the way an interesting issue was raised, and that was the question of going into the program, and being Jewish. Now, I had never been very conscious of being Jewish in the sense of experiencing discrimination. As I said, I'd been very active in a national Jewish group, I'd been very active on campus, and I guess received every leadership award the University of Minnesota gives anybody. I never felt any sort of discrimination, but somewhere along the line I was given the impression that I might encounter some problem getting into the Minnesota program. So, I went to see Mr. Hamilton. Of course, I was working at Mt. Sinai. I went to see Mr. Hamilton about it and asked him what was the significance of being Jewish for going into the field.

His answer was that it would be a real factor in the field, that Jewish boys who went through the program either went into Jewish hospitals or into city hospitals. Also that the number of Jewish boys they would accept was limited by how many they could place, which was also true of Catholic boys, for much the same reasons. He explained that was simply that hospitals were largely denominational in sponsorship so that the course would select according to its contacts and its ability to place within those arenas.

Well, for the first time I was upset about the question and I went then to talk to two fellows I had become very friendly with, Ray Amberg, who was the director of the University of Minnesota Hospitals, and Eugene Staples, his associate. Staples is now the director at the University of West Virginia, Amberg has since passed away. Amberg told me to just ignore anything Hamilton told me, about anything, as a matter of fact. There was another source of friction in the Minnesota environment. Staples told me that from Hamilton's perspective it might be correct, but to ignore it and to not permit Hamilton to confine me in any way, at any point, on that basis. But at the same time, he urged me not to withdraw from pushing into the Minnesota program. I did know that Minnesota was hard to get into and that Hamilton kept tight control of every aspect of the program, so I was very concerned. But Gene Staples gave me good advice and a confidence in my own sense of direction at what could have been a tough point.

About the same time I did something else. I went to Chicago and I applied for the Northwestern program. I wrote to some others. I remember I met Laura Jackson at Northwestern and I vividly remember being struck at the time by the contrast with the application process for Minneosta. Minnesota maintained an image of selectivity and there was a question as to whether or not I would get

in. They made it very clear that if I was one of the chosen it would be a great favor. When I talked to Laura Jackson it was like applying for public school. There was no question about whether I'd get in or not, there was only the question of when I'd send the check. I didn't realize it at the time, but in retrospect it tells us a great deal about the roles that those two programs were playing in the field at that time.

I did get into the Minnesota program and I was not a particularly significant member of the class. I was not in a particular leadership position or anything, I was just an average member of the class. I would say that at that point I was not a great admirer of Jim Hamilton. There is no question that Hamilton accomplished an immense amount of education with that program. Hamilton is an extraordinary educator, but I had been exposed to enough varieties of educational experience so that I think at that point I was already aware of the difference between style and content. I was rebellious but I would have been a litle bit more so if I hadn't been so dammed scared.

There was something about the group process in that program, which was very intimidating and at the same time motivating. That's exactly what he wanted to accomplish. He was like a staff sergeant. Hamilton was convinced, and I think he was right, that successful administrators first of all had style. You had to believe it to do it and to believe it you had to learn how to act certain ways--carry yourself a certain way, to express yourself a certain way. He convinced us that we were decision makers, and there is a style to decisiveness.

The idea was if there was anything that a Minnesota graduate knew how to do it was to make a decision, live with it, and go on from there. But as I say, there was a very strong dosage of style, his style toward the students

which was not always backed up in the substance of what we were getting. Now, there's no question that I benefited greatly from the experience. If nothing else, the elitism of the Minnesota program was a great asset, and has continued to be a great asset. Incidently, it's a kind of elitism which from my present perspective I'm not certain serves the public well. But for a young profession making its way, and through Hamilton's eyes, it is one of the fundamental building blocks. It was an effective instrument toward the broader objective.

As the program wound down and one began to look ahead, the critical decision was where to take a residency. I believe that two of my choices were Johns Hopkins and Strong Memorial, so I was definitely interested in a university hospital setting. I, at that point, saw myself as interested in university hospital administration. Hopkins was somewhat selective in spite of their institutional arrangement with Minnesota in which Minnesota virtually picked the resident. Hopkins retained a veto and you had to come out for an interview. If they decided you didn't have two heads, you were admitted to that ongoing residency relationship. Of course, I was interviewed by a Minnesota graduate Mac Detmer and so it was quite incestuous. But the motivating factor in picking Hopkins was the prestige of the name. I didn't know anything about the residency. The director of the hospital, Dr. Russell Nelson, was at that point a major figure in the field. Shortly after that he was AHA President so that kind of visibility for the institution through the administrator added to the stature of going there.

If I had known what kind of a residency it was, I might not have gone there. Maybe I would have anyway because of the prestige of it. I thought later, as I was in the residency, and I still believe, that the residency

experience I had demonstrates some of the fallacies of the residency, some of the traps that the field has fallen into, such as confusing the prestige of the institution with the quality of the residence, or the stature of the administrator with the quality of the preceptorship.

Obviously what I'm saying is that it, for many reasons, was not a very good residency. Part of the reason was that it was a delegated residency. The hospital's director, Russell Nelson, was not an accessible person to the residents, although he was carried on the books at the university as the preceptor. I'm sure he never attended a preceptor's conference. He had no knowledge of the program. Beyond that he wasn't interested and, in fact, didn't really believe in it. He really didn't think that was the way you learned hospital administration. So, he delegated it to an assistant by the name of Chuck Goulet, and that's a pretty important factor in my life because later on Chuck Goulet was the executive secretary of the AUPHA. Russ Nelson believed that the way you learned to run the Johns Hopkins Hospital, and this is a direct quote was, "You start in the storeroom killing cockroaches and work your way up, or you started on a clinical service as a physician."

Somehow those were not equal. But, I say it was not a good residency because Nelson believed in the separation of the administrative side of the house from the medical side of the house and that the only people who bridged that gap were the medical administrators, the physician administrators. So the residency would by definition be limited to the administrative side of the house. It was also limited in the hierarchal sense because you were delegated to an assistant administrator. I suppose that I had five hours with Nelson that year and only because I fought for it. In fact I had a good residency, but it was in spite of the residency program. There was another fellow there

taking a residency with me, and I think he had a much less satisfactory experience because he didn't push against the constraints. I actually once attended a board meeting for about an hour, but I did so because I was permitted to carry in the plans from the Planning Office and lay them on the table while they were discussed. But I would not have had that opportunity unless I pushed the fellow running the Planning Office to let me come with him into the room. The other resident never saw the inside of the board room when it was in use. So, one had to create his opportunities in that situation. I created a number of them which were important to my eventual interests. The most pivotal was that I became interested in the work of a unit of the Johns Hopkins University, which was housed in the hospital, called the Operations Research Division, headed by Dr. Charles Flagle. When I started to do my thesis for Minnesota I developed a project idea having to do with geriatrics; Flagle became interested in it. At Goulet's suggestion, I went to see Flagle for technical help and eventually gravitated more and more toward that unit within the hospital. First, they were much more supportive of the thesis activity than anybody in the hospital's administration was. By luck I had come up with a project idea which would integrate something that they were interested in with what I was interested in. In fact, it introduced them to a new idea, namely, how their pioneering work in patient classifications systems and its application to resource allocation might be used to measure the impact upon hospitals of certain patient mix groups from a cost-utilization standpoint. The question that I was working on being essentially: Did people over 65 use more services than people under 65, and if so what were the characteristics of the utilization?

All of which was then, as now, a politically important issue. That was in

the days of some of the earlier discussions of the current era of national health insurance and medical care for the aged. My project seemed to fit in with it. Well, anyway, Charlie Flagle was a great help with my thesis and eventually it was published by the Operations Research Division as one of their monograph series. I missed an "A" on it which I've always thought was ironic because it was the only thesis from that year or several years on either side of it to have been published.

It was that connection with the university group in the hospital which re-directed me away from the notion of being a hospital administrator and really opened the question as to whether I would take an advance degree. Curiously enough, what I really wanted to do was to take a law degree. I saw the combination of hospital administration and law as having tremendous potential. I still do and I think a lot people do. At that time it seemed the ideal combination of credentials, and I applied to the University of Chicago Law School. Shortly therafter one of the deans came through Baltimore on a recruiting trip. I arranged to visit with him and told him why I was interested in law school. I remember that conversation very well. He discouraged me, saying that he thought I would find law school boring; that my chances of getting in were good, my chances of getting out were poor; that it was intellectually the least satisfying kind of education one could pursue and that there would be very little in the educational program that actually had to do with what I wanted to do, which was health applications. He really did everything he could to discourage me, and succeeded. He said, "We'd probably admit you, but the prognosis isn't good." That ended my courtship with law school.

It was about that time that Minnesota was developing its doctoral

program. The fact that it was developing its doctoral program interested me but Minnesota didn''t. I did not really want to go back. It wasn't anything negative about Minnesota, which had been very good to me, but I just wanted to go someplace else.

I remember investigating some other schools, particularly Columbia, which said in their catalog that they had a doctoral program in health administration. I devoted quite a lot of effort to investigating the Columbia situation and I couldn't find that doctoral program. They kept telling me that there were some doctoral students around--two or three of them--but nobody knew them and I could not find them. It all impressed me as very disorderly.

Hamilton somehow found out about it and he really encouraged me to apply to Minnesota. I also looked at Iowa and a couple other kinds of doctoral programs. I investigated a doctoral program in political science at the University of Canberra, Australia, and applied for a fellowship there. I was accepted but the fellowship didn't include travel, which was more money than existed on the face of the earth. So that exotic escapade ended.

I think I was pretty much steered back to Minnesota by the combination of the discouraging results in investigating other places. The instate tuition and Kellogg support--all of those things, I think, were why I ended up going back there. It also is a statement of opportunities at that time:they were very limited, really to Iowa and Minnesota. Both were pioneering, what was then and is now, a critical need.

The doctoral program at Minnesota on balance I think, knowing what I do today about doctoral programs, was a pretty good one. It suffered from over-organization and it never really broke sufficiently with the professional

education model. Hamilton knew little but professional education. He'd been enamored all his life with the MBA at the Amos Tuck School. He had been very successful with the MHA in the school of public health model, so to the extent that the doctoral program reflected his influence, it did a lot. It was sort of more of the same. It required, for example, a minimum of two years and as much as three years of course work, much of it prescribed. From the standpoint of education in terms of what you were exposed to, in breadth and depth, that represented a very good education in a very good university. On the other hand, in terms of education from the standpoint of self-definition, making the optimum use of the resources of the university from the perspective of the individual and his growing understanding of his needs and interests, it was quite limited because you didn't have the flexibility. A good part of the judgment as to what was appropriate for you and what wasn't resided with Hamilton. So that if I went to Hamilton and said I've decided I want to take a three-course sequence in philosophy of science or art history, whether or not I was able to do it depended on whether he thought that made sense. That in turn depended to a great extent, on how it fit with his idea of what you needed and the extent of his contacts with the other departments. His circle of contacts on the campus was, in other words, limited. The doctoral program brought the Minnesota HA program into contact with the greater university for the first time in many years.

When I was in Baltimore, I became interested in some international activities. There was a very large international colony at Hopkins--students and others, the medical personnel. I was a good friend of a Ruth Eisenhower who was the daughter of the president of the university, Milton Eisenhower. Well, Ruth was the president of the International Club and so partially

through that I became involved in a lot of those activities. There was an interesting phenomenon taking place in the world at that time called "Project Hope," this was a very visible thing, that big white ship had everybody's imagination captured. I decided I might like to work for Project Hope, which was gearing up and there were a number of Hopkins' people who were shipping out with it. One of the very important people in Project Hope was a society physician, who has since become well-known nationally in Baltimore, by the name of Edgar Berman. He later was Hubert Humphrey's physician; and wrote several books about Humphrey. I read in the paper that Berman was very much involved with Dr. Walsh in founding Hope. I went to see him in the hope of getting on Hope. Turned out to be hopeless. He was not very encouraging because he didn't think young administrators were worth much in that situation. In fact, he didn't think young administrators could contribute much to international health. I found out later that that was not a unique bias. However, I had a very nice interview with Berman in his townhouse. It was quite a big event for me to sit there and talk with him for a couple of hours. But it didn't open the doors that I'd hoped it would open.

So, I had had at least that much interest in international health. The connection between health administration or hospital administration and international health at that time for me was a very weak one. I didn't see any clear channels, relationships, any career pattern, certainly no role models. There weren't any international or foreign administrators as there were foreign doctors working at Hopkins. We did get a lot of junketing administrators from Europe who came over, usually under the auspices of the International Hospital Federation. A couple of large tour groups came through and I helped with the hospitality. That might have had something to do with

my interest.

The significance of this is that, when I got back to Minnesota for the doctoral program, I elected to minor in political science--should be no surprise--and within political science to concentrate on Latin American government and public administration. I tentatively decided that I was in the doctoral program for international health. I had the idea of working with WHO or something like that. Also, it's not inconsequential that at that time the Kellogg Foundation, which was supporting the doctoral program, had set up a series of exchange relationships between specific hospital administration programs in the United States and programs in Latin America, which the Foundation was also assisting.

So I had developed some interest in international health and I pretty well decided that the reason I was in the doctoral program was that I wanted to go out into the field of international health and that there was this institutional connection between programs in the United States and programs in Latin America established by the Foundation. Minnesota was working with the program at the University of Chile, while I cannot identify the precise order in which it happened, it all converged: my interests, the Kellogg project in Chile, and the minor area available in political science. It was as if my interest was the right one at the right place at the right time. The Latin American program in political science at Minnesota was not a particularly strong one, but it was adequate. I was able to combine course work in Latin American history in the history department with political science courses having to do with Latin American government, but most of the political science work was in the general public administration sequence.

Through that in turn another very important contact was made in terms of

my present situation. I had a professor by the name of Harold Chase who was an expert on the Supreme Court. Chase was one of a select group of professors across the country who had an ongoing relationship with The Brookings Institution here in Washington. Brookings has a very interesting kind of extended academic family with "outfielders." They are experts who are based on their own university campuses but who have a relationship which permits them to move in and out of the Institution for various purposes. Hal Chase was one of those. I'd known him during my undergraduate days when he was adviser to the student government.

Ted Litman, my adviser in the doctoral program, was interested in geriatrics which, of course, relates back to my master's thesis. As I said earlier, this was a period in which medical care of the aged continued to come up in the public forum. Specifically, this was early in the Kennedy administration and there was a very strong move by organized labor to develop some kind of a Social Security based medical care of the aged program. Two prospective bills were circulating. One was called Kerr-Mills and the other was the Forand bill.

I was in my first year of the doctoral program, spending most of my time in the political science department, having some interest in medical care of the aged, and close contact with Hal Chase. At one point I began to look for a research project for a paper for a course. That brought me into discussions with Chase, who ultimately suggested doing some work in Washington, which he could arrange. I was in a good situation to do something like that because the Kellogg scholarships carried you through whatever activities you did, regardless of where you were, provided that they were integrated into your program and approved by the university. This meant that if I went somewhere

to do some research, I had support.

Chase was affiliated with the governmental studies division of Brookings. He arranged for me to talk with the director of that division and to find out if there was anything I could do at Brookings, combining research they were doing with my interests. Besides I was free. It turned out that they were conducting systematic studies of the politics of major urban issues. Although they had not considered health as one of the projects, they took the opportunity of my availability to say, "Let's do one on health. You can do it under our general guidance, and it might meet your needs."

I had to design a project and they had to approve it. I came to Washington that summer (1962) as what Brookings calls a "Guest Scholar." Most Guest Scholars come with their own project. I came with a project that was developed collaboratively with the Brookings staff to fit in with their overall project, but it was very much my own work. It was to do a case study of the evolution and current political activities surrounding the medical care of the aged bills. Very fortunately the three month period that I was at Brookings coincided with the culmination of that development, including the decisive vote. So, I was on the scene.

Several aspects of that experience have been important building blocks in both my development and to some extent the Association's development of the affiliation with Brookings. Today, AUPHA is housed largely in The Brookings Institution. That would never have happened if I had not had that familiarity with the organization. That's been a great asset to us to be at Brookings, in terms of image if not more practical aspects.

I developed a number of contacts in Washington, which in early days of the Association was an asset. I learned my way around town because I enjoyed the

license that goes with being at Brookings. Brookings has unmatched access in this city. It is best illustrated by the following story. A key actor in the health for the aged legislation was Rep. Wilbur Mills. Wilbur Mills was unquestionably the most powerful man in Congress on the issue and critical to John Kennedy in getting a compromise that he could put his name on. It was during this period that the National Council of Senior Citizens rented Madison Square Garden and Kennedy conducted a huge rally for medical care for the aged. The next night the AMA rented Madison Square Garden and had Dr. Annis, later their president, on national television addressing the Garden completely empty, refuting the Kennedy arguments. Quite dramatic. Well, the question in Washington was: What was Wilbur Mills going to do? Every newspaper column was speculating about it. He had the President over a barrel. He would talk with no one.

I called Mills' office in the middle of this thing, to get an appointment to interview him about some of the historical aspects of the legislation. I'd been told by the chief clerk of the Ways and Means Committee that I'd never get to see Mills. But it was in my research design and I had to try. Well, I never got past the second level receptionist. Three days later my phone rang. I picked it up and the voice said, "This is Mr. Mills, why did you want to see me?"

When I recovered... (I say this because every newspaper reporter in the city was trying to get an interview with Mills without success. He'd been invited to the White House and had refused to talk to the President). I told him very apologetically, I needed no more than a half hour of his time.

He said, "We couldn't possibly do it in a half an hour. Why don't you have breakfast with me tomorrow? We'll meet at 7 o'clock."

We met at 7 o'clock for breakfast and I sat with him 'til 11:30. Now, he didn't know me from Adam, but he knew I was with Brookings and therefore I had to be good. Secondly, I was "an expert." Third, whatever he told me would be held in confidence, and what he really wanted was to talk to somebody. The man had built himself into such a lonely corner that he didn't trust anybody except somebody from Brookings. I walked out of that interview knowing what everybody in town wanted to know, including the White House, and I couldn't talk to anybody. I eventually put it all in a manuscript, which is now available.* At any rate that illustrates why I had such an extraordinary experience for the summer, and that included access to the White House, interest groups of all kinds, people on the Hill and so on. It was all because of the timeliness of the issue and the credential of the Institution. Very useful experience, as it turned out.

The public administration faculty at Minnesota was, of course, quite impressed that one of their students had gone to Brookings. They were willing to accept that manuscript with only modest changes as a thesis. So I completed what they required and received a master's degree in political science. That was really a fringe benefit of the experience I had, but it too has been useful in later years, again, with the Association, as a nonprofessional academic credential. The doctoral program in Minnesota was a very difficult experience for everybody concerned. I was in the second cohort, the first cohort was still there. The third cohort was arriving or had arrived, and so the program had thrust upon it a group of about a dozen pretty bright, motivated people who came with a different set of expectations

---

*The Senate Rejects Health Insurance for the Aged. University Microfilms

bright, motivated people who came with a different set of expectations and experiences than did the master's students. I don't think that Mr. Hamilton was prepared for that difference. The question of style wasn't so important anymore to us.

When Mr. Hamilton said "This is the way it is." We said, "Why?" or "I don't think so," or even worse, "Where is your data?"

That led to a great deal of tension, which was not the same kind of tension as we had experienced as master's students. When we were master's students we were totally encapsulated in that program, its faculty, its traditions, its whole milieu. As doctoral students we were out across the campus and having experiences with many different faculty members and other doctoral students. So you came back to the program with something to compare it to. For me, at least, it was not always a pleasant comparison. Hamilton and I were at odds a good part of the time. A number of the students were at odds with him over the same issues.

The bridge builders were E. Gartley Jaco and Edith Lentz Hamilton who could see both sides of what was happening and devoted a lot of energy to translating both ways. Hamilton eventually married Edith Lentz, but I think she was very good at bridge building with students and so was Jaco. They played a very critical role. The place would have blown up except that he respected their academic credentials. They knew how to work with doctoral students and temporized that environment. But in trying to analyze Hamilton's role in the field it's fair to make my bias clear. I believe that Hamilton made a number of really quite remarkable and pivotal contributions by creating

---

International, 300 Zeeb Road, Ann Arbor, MI 48107

the master's program, by setting up the decision-making model and carrying it through so well, convincing a lot of people that they were part of the self-fulfilling prophecy of leadership. He also contributed a great deal by creating the doctoral program and by the vision of what a doctoral program could do for the field and what the critical mass of a faculty that dealt at the doctoral and the master's level could do. Where he reached the limits of his appropriate contribution was in attempting to put himself academically into the doctoral program. That's where the limit was. In later life I have learned to appreciate, if not to genuinely admire, a number of individuals in the field who have recognized and dealt with that in themselves and set up conditions through which they overcame that limit in themselves.

I ended up in Chile to do my Ph.D. thesis work. I often say that I picked it because it was as far away from Minnesota as I could get and still be on the face of the earth. That's not really true. Hamilton, in fact, made it possible for me to go there. I was able to develop a doctoral dissertation topic which combined the case study methodology that I had started at Brookings, the Latin American government course work in the political science department, the health sciences background, and, of course, with my interest of eventually going into international health.

Chile became the place to go because of the program's institutional relationship with the University of Chile and the fact that a number of Chileans were graduates of the Minnesota program. Most notably was a man by the name of Miguel Solar, the director of the program at the University of Chile and director of the University of Chile Hospital. He'd been at Minnesota a number of years before, and that was the principal reason for the eventual institutional tie supported by Kellogg. Several Minnesota faculty

members had been to Chile, including Edith Lentz and another Chilean faculty member, Gabriella-Venturini had been at Minnesota. So there was quite a cross-fertilization. The other Kellogg projects were between Columbia University and the University of Buenos Aires and between the University of Sao Paulo School of Public Health, which was headed by Dr. Odair Pedroso and one of the North American programs--I've forgotten which. At that point Kellogg was employing two strategies to develop the field in Latin America. One was the Paired Programs and the other their traditional pattern of awarding fellowships to Latin Americans to study hospital administration and many other fields in the United States and Canada.

We went to Chile, the family went, stopping along the way first in Venezuela to visit with a professor I'd come to know at Brookings, then in Colombia where we visited with a classmate from the Minnesota program. He was the associate director of the university hospital in Medellin which was headed by a Michigan graduate by the name of Bernardo Chica. It's interesting how many of these things come together. We then went on to Chile where I spent ten months studying the organization of the Chilean national health service, which is a very important model.

Chile is a very European country in its orientations. It's an immigrant country much like the United States. In fact, the Indians live on reservations, just like they do here. Chile was very strongly influenced particularly, by the Germans and Bismarck with his development of social security. He established a critical pattern for the whole western world which the Chileans imported on paper, but they went a step further, integrating it with the health services system. They took up the concept of regionalization which nowhere in the world at that time, to my knowledge, had been implemented

according to the basic tenets of the Dawson Report that had laid out regionalization in 1920. The Chileans then had developed the social security legislation and structure. They had developed a national health serivce with a completely integrated regional system reflecting the basic principles of the Dawson Report, which we began to talk about with the advent of Hill-Burton. Little had been written about the Chilean system other than that generalization and so I thought it would be very useful for me wanting to go into international health to have an indepth experience in that environment. I may have selected Chile had there not been the institutional connection with Minnesota. I can't say, but it seems such a logical choice in retrospect.

That thesis has had a lot of mileage. I never published even one article from it myself, but it continues to be cited quite a lot and copies of it continue to pop up in many places. I didn't finish my thesis when I came back. I didn't finish working on the thesis 'til 1970. At that point it was a race in getting my thesis done or social security so I needed to finish it up. It was an on-the-job thing.

While I was in Chile I began to look around for future remunerative employment. That was the time when the Peace Corps was in its greatest year of expansion and I made contact with the Peace Corps in Chile and began an application process for some kind of job. I also began to write to various schools here assuming I might want an academic position.

We came back for Chile in, I believe, November of 1964. I went back to Minneapolis and there continued looking around for jobs; my wife Jane was working as a nurse at University of Minnesota Hospitals. Kellogg support ended when I came back from Chile. For six months I took a job as acting director of the Minnesota Hospital Association when the director, Don Dunn,

was ill. Don Dunn was a highly respected former faculty member of the program at Minnesota who later was the first director of the program at Ohio State. During that time I continued to pursue the Peace Corps possibility and eventually was offered a job as Director of Peace Corps operations in Western Brazil, which I decided not to take because there was almost no health program involved. I was also afraid to end up speaking "Spaniguese" because my Spanish was still weak. I was fairly fluent but feeling very vulnerable, and my Portuguese was nonexistent. So, coming out with a hybrid under those circumstances is a very good possibility and professionally debilitating. The objective of the Peace Corps in those days was to get as many volunteers in the field as fast as possible. Most of them were liberal arts majors who were called Community Development Workers, which meant, they went into the field and then figured out what they could do. The closest thing to a health program that the Peace Corps had in that area of Brazil at the time was some water supply project, but that wasn't what I wanted to do.

I went out to UCLA and talked with Milt Roemer about a job as an instructor in the program in hospital administration. That was quite attractive. Eventually I might have taken that job.

But hanging around the Minnesota program I heard about a new position that was being created. This must be December of 1964, or January of 1965, right at that Christmas period. It was about that time that, around the program, one heard rumblings about the fact that AUPHA was looking for an executive director. We'd all heard about AUPHA, because periodically Mr. Hamilton would go off to one of the meetings to fight with his friends, and would come back and regale us with war stories. The rumor was that each program was putting up a candidate. I remember very distinctly having a long talk with Dr. Jaco

about the AUPHA job. He had been to some AUPHA meetings, so had Edith Lentz. He seemed to be much more approachable about that than Mr. Hamilton was. Hamilton was very much an insider in AUPHA and he had specific ideas about what kind of a person should be hired. Those ideas just did not include a recent graduate student, particularly one who didn't have his thesis done. Jaco, on the other hand, was a little more encouraging. He showed me a letter addressed to Hamilton from George Bugbee, who was the chairman of the search committee, asking for candidates. He had shown me another letter in which Bugbee was asking Jaco's help in finding a research director for the Chicago Hospital Council. Jaco thought that's the kind of job any one of his nestlings should be interested in, and more than one of them were, as a matter of fact. I wrote a letter to Chuck Goulet, whom I had known at Johns Hopkins. In the interim Goulet had gone to the University of Chicago as director of Billings Hospital. In addition to being the director of Billings Hospital Goulet wore two other hats. One was an associate director of the program at the University of Chicago; the second was as executive secretary of the AUPHA.

AUPHA's history administratively was tied up with the directorship of the University of Chicago Hospitals. In its earliest days Laura Jackson at Northwestern had been the secretary for the longest period of time, and before her, for a very short time, Mary Johnson, who became Mary Johnson Agnew. She married G. Harvey Agnew, the director at Toronto. But all of that had been in the formative period when Dr. MacEachern was the elder statesman of the group. Therefore, it quite naturally gravitated to his office at Northwestern to provide the leadership, going back to 1948.

About 1950 I believe it shifted administratively to the University of

Chicago. A succession of assistant administrators at the University of Chicago Hospitals had been "Executive Secretary of AUPHA" including Irv Wilmot, just before Chuck Goulet. Of course, Chuck Goulet was not an assistant administrator but he was the senior person following Ray Brown.

Goulet wrote back to me saying that he would talk with Bugbee, and encouraging me to apply. I did write a letter to Bugbee directly, which took some "chutzpah" because it bypassed Hamilton. Bugbee, reflecting the established job description, wrote back and said he'd be happy to talk to me about the Chicago Hospitals Council job, but in effect saying that I didn't fit the framework for AUPHA. Of course, I didn't realize it then, but I had put him in a kind of peculiar spot vis-a-vis Hamilton, who would have his own candidate. It was quite "ungentlemanly" for Bugbee to get involved directly with someone from the Minnesota program who didn't carry Hamilton's endorsement.

I don't think I thought about that in those days, but I realize now that Bugbee and Hamilton were very different people philosophically in those times, that Chicago and Minnesota were very different places, and that some of the gyrations that were eventually gone through before I was offered the job were probably more a matter of building a case for hiring me than would have been necessary had it not been for the politics of the situation.

Bugbee invited me to Chicago. I'd never met him. He was very gracious, and talked to me about the job at the Chicago Hospital Council. I had known Howard Cook who was the director of the Chicago Hospital Council at that time, still is, because Cook was a good friend of Glen Taylor's in the hospital association business and had come to Minneapolis a couple of times during the meetings of the Minnesota Hospital Association or the Upper Mid-West Hospital

Conference. So, actually it was not an unattractive job. I might have been interested in it had I not been able to promote the AUPHA situation. I very clearly remember shifting that conversation with Bugbee to the AUPHA job and he was just being polite in talking about it. He didn't quite see how I fit. But he was intrigued by the fact that I pushed him on it and was willing to give it some thought, at least, and not dismiss it out of hand. But, as I look back on the situation from what I know of it, at that point there were probably a lot more candidates to be heard from and it would be premature to have shifted gears as to what they were looking for. What they were looking for was a retired program director or a very senior person in the field. They had pegged the salary very high for those days, $25,000. The minutes of early meetings reveal that they would have settled for a practicing administrator who had some experience with education or some tie to the programs. I cannot find any record of any being nominated or being seriously considered. I believe though that Minnesota's "candidate" was an administrator, who at that time was working in Connecticut, by the name of Bright Dornblaser. He, of course, has gone on since to be the director of the Minnesota program, and even then had caught Hamilton's eye as someone of great intellectual force who would be good to bring into academia. Eventually the program did. I think Dornblaser was the Minnesota candidate. I don't know if he ever knew it. After I became a viable candidate, there was at least one other. That was Walter Burnett, who was with Gerry Hartman in Iowa at that time. I believe Burnett and I were the only two individuals (there may have been a third) who actually were sent out for interviews. Bugbee was very noncommittal during this process. I don't believe that I ever thought that he was supporting me. I believe that there just were not many other candidates for the job. After a

month or six weeks I was invited back to Chicago to talk with a broader group. This group included Fred Gibbs who was the president of AUPHA and the chairman of the program of the George Washington University. Goulet was there, and Bugbee and Ray Brown, who was at that time, I believe, at Duke. My impression is that they had other people in to talk with them. It was after that interview session that at least two of us, Walter and myself, were put on the train and sent around to be interviewed. I was interviewed by Larry Hill at Michigan and by John Thompson at Yale, neither of whom I'd ever met before. I'll never forget the interview with Hill because the University of Michigan was closed due to a snow storm. In fact, the whole Mid-West was closed. It took me fifteen hours to get from Ann Arbor to Chicago on the train station-to-station. The interview consisted of Hill walking through the snow drifts, meeting me somewhere in Ann Arbor, walking me to the railroad station and waiting three or four hours for an overdue train.

I found later, after I'd been hired, that there had been another interview I didn't know about. When I was in Chile I had met a wandering professor by the name of Dr. Clement C. Clay, who was the director of the program at Columbia. Dr. Clay had come to Santiago on a WHO traveling fellowship and I had been his unofficial host, guide, and driver, because he spent most of his time at the hospital where I was doing my work. I learned later that he had written quite a lengthy letter to the committee based on that exposure when he found out that I was a candidate. So, I consider myself having been interviewed by Hill, Thompson, and Clay in addition to the group in Chicago. AUPHA obviously had to lower its sights considerably in hiring. After I had made the tour I was offered the job by Goulet and Bugbee, primarily by Bugbee.

I was to make my debut at the AUPHA meeting that spring, I think it was

April at Cornell, and to begin work officially on the first of July 1965. So, I went to Cornell and remember very little about that meeting; I played no role in it other than to be introduced by Fred Gibbs as the future executive director. It was a small group, not more than forty or fifty people and I felt quite at home. I remember coming away from that meeting being very conscious of how much there was to do with the organization--how little program content there was. I didn't think much of the meeting is what I'm saying. I'd been very nervous before I went but after being there I realized that one could do a little and look like you've done a great deal in that situation because there was so much to be done. I think that's exactly the way they all felt, that they were very anxious to have something of a programatic nature.

At this juncture it's worth while to review AUPHA in its role, as best as I can reconstruct it. Of course, I wasn't around for the early era, but I did have access, when I came in, to all the documents that existed--there weren't very many. Since then I've gone about collecting background materials as systematically as I know how, trying to establish an archive. So, I have read through what minutes and notes and correspondence exists from the period, collected from a lot of attics and basements and file cabinets of people who were active at that time.

Of course, the Kellogg role was critical at so many junctures. I've said a number of times in several places and, I firmly believe, that there's no professional role in this society which so clearly is the result of direct foundation intervention. The shaping of that role is very much Kellogg. The creation of the role predates Kellogg. The history of Michael M. Davis and the Rosenwald Fund is well known. Where people in our field lose sight of the

broader picture, I think, is when Kellogg enters the scene. We tend to view what they were doing in hospital administration in isolation from the general strategy of the foundation to impact on society in a number of arenas in which they were active. The Foundation virtually created the junior (now community) college movement. The Foundation plays a similar role with less discernible impact today, maybe with less success, in academic administration.

One of the key components of the Kellogg style or strategy of that era appears to me, in retrospect, to be the development of agencies which were central to the development of each of those fields. So, before there was an AUPHA there was an American Association of Junior Colleges that was well supported by the Foundation. There was also a group called something like the National Council for Academic Administration. It developed a secretariat that was based at the University of Indiana tying together programs that trained administrators for universities and colleges. It, too, received Kellogg support before AUPHA. So that the initial activity of the man that was Andy's mentor, Graham Davis, and Pattullo in '48 in bringing together the leadership of the field in Battle Creek has parallels in foundation activities in other fields. In 1948 when they brought the leadership of the programs together it was essentially a meeting of grant recipients. From that time until well after I had started Andy Pattullo was quite an active participant in the affairs of the Association. My guess is that Andy attended 90% of the meetings of the board (or the Biannual Review Committee as it was to be known before it was a Board). Through each of those iterations Andy probably attended 90% of the meetings and I would say that, that was the case until 1970. Undoubtedly part of that is due to the fact that he was so close personally, was contemporaneous with the group of people who were in

leadership positions, and came from our field. But it was also because the instrumentality was so central to the basic strategy of the Foundation and to the long-term viability of those investments that they made in the field. AUPHA was almost an operating extension of the Foundation particularly after the grant in 1964 that enabled it to bring on a full-time staff. The Foundation would probably not be comfortable with that characterization, but I think that it is historically accurate. Andy Pattullo is certainly among the sources of their ideas, which eventually were implemented. The Foundation properly has a place alongside the faculty and the staff, decreasing overtime.

There's no question in my mind that AUPHA was a "deans' club" in those early days. The program directors were men of great professional stature. They were, either currently or had been, in positions of major administrative responsibility running, in most cases, university hospitals. Most of them had been presidents of either the AHA or the ACHA or were going to be. They had very strong opinions about how you train hospital administrators and there was not much agreement among them on key points because a lot of that content was so personalistic and reflected their own training to a great extent. I don't find evidence of a significant split between the physicians and non-physicians. The real split was between the public health-oriented people and the business-oriented people. That eventually played itself out in the Olsen Report dispute which took place within AUPHA. The Olsen Report of 1954 was the second study of the field sponsored by the Foundation, the first having been the Prall Report 1948. The Olsen study was chaired by James A. Hamilton and the project director was Herluf Olsen, a Professor of Business at Dartmouth. Predictably, The Olsen Report seemed to favor the development of future health administration or hospital administration programs in a business

setting.

The study had been carried on under AUPHA's auspices with a Kellogg grant. When the recommendations came to the floor of the deans' club there was so much dissension about them that the Association would not put its stamp of approval on the publication. An independent publisher, the American Council on Education, had to be found. They brought out the book as being published by ACE for the commission with little recognition of the AUPHA role. That demonstrated the real substantive division of the house whereas the one that we might have thought more predictable between the Dr. Bachmeyers and the Dr. MacEacherns on one hand and the Jim Hamiltons and Ray Browns on the other, didn't seem as important.

The history of AUPHA In those early days is fascinating to read because so many of the elements of education for which we have "logical" explanations today, such as the residency, can be traced back to those early meetings. There it is discovered that many of those activities were developed for very different reasons. I pick the residency because very early in the Association's evolution there was a discussion of the field work component and what it should look like and what it should be called. The minutes quite clearly record that, in order to give professional status to the students, it was important to have them equated with the senior medical personnel in the hospital, the residents, and certainly not with the interns, or clerks or any thing of that variety. Those kinds of discussions were instrumental in the shaping of the field. It was during this time that the very strong commitment to the idea that classes should be small developed. This point is in dispute, particularly by George Bugbee, but I was told by Ray Brown that the reason why you couldn't have a successful program with more than twelve or fifteen

students was that so many people had been influenced by their experience at Chicago. The reason I was told that Chicago had adopted that number is that was the number of chairs around the board room table where Dr. Bachmeyer conducted most of his classes. I believe it. It fits with the style of the discussions in those days.

In the period roughly 1948 to '55, AUPHA felt that it needed to establish some standards for recognition of bona fide programs, again reflecting how influenced we've been by the medical model. Also there was a sense that a program had to have a certain substance, a certain critical mass of content and exposure, experience, integrated into it in order to professionalize the students. There was as much emphasis upon the socialization process as upon the content, and from that flowed sense of professional identity, mission, career and so on. It almost instinctively developed on the basis of the leadership's view of how other professions had evolved in our society. Instinctively and, I think, correctly. The problem was, of course, that the AUPHA members were all already "in the club." Given the wide variations of philosophy and educational approach, how could they develop anything you could call "standards" that everyone would agree on unless the standards were minimal or the most broadly acceptable? The first criterion for membership in AUPHA was that a program had to be organized in a university which belonged to the American Association of Universities, the AAU. I suspect that standard was dropped when the next program came along, whatever it was. Unless the AAU membership has changed over the years, I would guess that a substantial number of the early programs were not in AAU member schools. In any case, that's so irrelevant that the program directors probably didn't know whether they were or not and wouldn't care to ask. But that notion of having some minimal

framework was a persistent one and is one of the fundamental contributions of that era. Another fundamental contribution of that era was the nature of the relationship with the profession.

Very early the AHA and the ACHA played very important roles in AUPHA. Naturally, a group of people who had been leaders in those two organizations would see the interface and introduce it into the AUPHA proceedings. In practice that meant that the ACHA executive would talk at AUPHA meetings, that AUPHA meetings were held with AHA meetings and so on. There were many interfaces of that variety. When you look at the development of other professions you realize that through some good fortune, this field avoided having its educational agency subsumed by the profession. Even today, for example, much of the dental school educational activity, such as accreditation, is under the wing of the ADA. Nursing school education accreditation is under the NLN. In medicine there is the division between the Association of the American Medical Colleges and the AMA, but originally the AMA did the accrediting. Today the AMA and the AAMC share the accreditation responsibility. There are a number of other professions in which that pattern either still persists or was an important stage of evolution and was painful to terminate. There are great scars in a number of professions resulting from the educational community deciding that it had to come out from under the control, or at least implied control of the profession. That didn't happen here despite the overlap. A fortunate pattern I think.

Of course, I would be bound to have that point of view not only because I'm president of AUPHA but also because I believe that AUPHA has a role to play vis-a-vis the profession as a change agent. So that's another legacy of that era that's very important.

It came dangerously close to being the other way. There was a time in the early stages when AUPHA asked ACHA to accredit the programs. ACHA was short-sighted enough to turn it down. Had ACHA seized that opportunity, the field would have evolved quite differently than it has and perhaps ACHA itself would have evolved quite differently. I believe that some years later the college reconsidered and concluded that they would like to explore sponsoring a formal accrediting program. By then AUPHA had moved away from that idea and it was no longer acceptable. AUPHA had no resources in those early days and could have been courted and subsumed under either AHA or ACHA simply on the basis of being able to make resources available to facilitate the meeting of the group.

The need for and the process of developing more standards was central to AUPHA discussions for many years. It was not a topic that they could deal with and go away from and come back to three years later. There were certain elements always present in the discussion. It was partly due to the heterogeneity of the programs, partly to old rivalries among leaders, and the fact that you couldn't have a new program come in and tell how it was going about it's business without an argument starting about some aspect of it.

Before the Olsen Report there was little direct discussion of the AUPHA role in quality. Of course, that study was quite independent of AUPHA. There was debate about many elements of quality, but not consideration of the social need, possible approaches and directions. I trace this broader perspective to the debates over Olsen. The second stage of AUPHA growth came from this process, you can call the first stage "organizational" and the second "gatekeeper." The "gatekeeper" stage lasted until 1963, when the accrediting commission was launched.

In the late 1950s the principal function of the executive committee came to be the review of programs that sought access to association membership. Those that were already members were required to go through what was called a biannual review. The title of the board, or Executive Committee, changed to the Biannual Review Committee, thereby signifying its principal business.

I don't know who was responsible for introducing the idea in the middle fiftiess that there should be a uniform data collection instrument. That may appear on the surface a very small and bureaucratic step in an organization's history, but, in retrospect, it was a very important one in the evolution of educational standards in this field. As soon as there was a uniform data instrument there was a basis of comparison among programs. Regular data collection made it possible to generalize about their characteristics. The application of the instrument provided the vehicle by which program directors began to visit each other, which not only had an information function in paper sense, but a tremendously valuable educational function. The fact that the director of the program at Iowa spent a day with the Army program at Ft. Sam Houston and then had to write a report to the Biannual Review Committee describing it was about the most effective continuing education for everybody involved that you could envision. It chipped away at the isolation of the programs. It became a vehicle fo exchange beyond superficialities about style and the philosophy, and got right to the question of what was a program. You got right down to such details as whether the applicants, had to take the Miller Analogy Test or the Graduate Record Examination. You probed in a systematic way. A very important process was taking place. The Association had an impact on quality because it provided the vehicle under which this took place. It also meant that membership in the Association began to take on much

more meaning than it had before, which was appropriate because many agencies and individuals were beginning to use Association membership as if it reflected a measure of educational quality.

Again, we see the influence of the "medical model" where everybody in the health-related professions was credential conscious in talking about whether they came out of the accredited program or they were board certified, and all those various stripes on their sleeves. Well, here was a very handy one, AUPHA membership. It had started out being the club, looking around the room and deciding what they had in common, and now some programmatic substance was behind it. Not that there was any real enforcement, but the process gave status to membership.

The survey instrument got its most substantial boost when someone, I suspect it was George Bugbee, got the idea of hiring Peter Rosie of the National Opinion Research Center at the University of Chicago to design and field test it. It was field tested by a committee at the Medical College of Virginia and at Michigan. It then became the basic vehicle for biannual review. It was a good piece of work and in retrospect I guess that one of the things that Rosie did was look at accreditation survey instruments from other professions. Today, twenty years later the accrediting commission has a much more elaborate survey instrument but it really is an elaboration of that original format. It has definitely stood the test of time for efficacy in every respect.

The other thing that the survey process did was to begin systematically identifying needs and problems. It began to differentiate the content of the program from the status of the program director. A lot of mythology had developed, I think very naturally, about the quality of programs, how well

they trained people. But I use the word mythology advisedly because many times what people were looking at was the stature of the program director or the stature of the institution it was in or its ability to place it graduates, which had to do with a lot of other things than what the students received in the program. That's still the situation today, but much less so.

In the context of those developments: the fact that the Biannual Review had become institutionalized and was producing some good information; the fact that AUPHA membership had taken on wide recognition outside of the Association and the field; the fact that the number of programs had grown; and the very critical fact that in other fields in which Kellogg operated effective central agencies were developing through which the Foundation could make an investment and have a rippled effect. These facts led to the discussions, which took place in 1963, from which came the decision to hire a full-time staff. In 1963, there was an annual meeting and there were several meetings of the Biannual Review Committee, one of which included Andy Pattullo, George Bugbee and Chuck Goulet. Andy spoke, apparently with quite a bit of candor, about the differences in quality in programs, and the need for the quality issues to be addressed frontally. At the same time there was some discussion of the need to involve more than the program directors.

Again, and it is attributed to Andy, the programs themselves had grown, there were now more than one or two faculty in many and yet not any more than one or two people from a program were ever involved in these group activities. In fact, there are some famous stories about that. One of the things that AUPHA was well known for in its early days was executive sessions where a program director would stand up and say, "I ask for an executive session" and all the nonprogram directors in the room had to leave. Then the

business of the Association would be conducted. Apparently that was particularly irritating to a number of people at the Iowa meeting, which was, I believe, in 1963. After that a number of folks vowed they'd never go back to an AUPHA meeting, because they'd spent all their time outside of it. Chuck Goulet and George Bugbee drafted a proposal after the meeting with Pattullo. The proposal was to hire a full-time executive and to establish three task forces. The task forces were to deal with personnel, planning, and the hospital as an organization. From that original proposal comes one of our most important approaches, the concept of the task force, which today is the embodiment of everything that AUPHA is and can be. They needed to have something on paper that looked like a project. They fully expected what would develop might look very different from that. The idea of a task force on the hospital as an organization was particularly timely, they thought, because within the continuing debate about the role of management as the base that had grown out of the Olsen Report was the fundamental question of whether or not the hospital was different from other organizations. If so, how? If it was different and the "how" could be identified, then that obviously was the substance of a program in hospital administration. If a task force could be organized to examine that issue, it could then serve as a basis for curriculum development and evaluation. The task force on planning was envisioned as applied very specifically to deal with physical plant planning.

That reminds me. Among the files I inherited on July 1, 1965, was a set of mimeographed papers on curriculum in hospital administration. They were the product of another AUPHA project, which shouldn't be forgotten. That project was to enlist the help of many professional organizations in developing suggested curriculum for that part of the hospital administrator's

training with which those fields were concerned. The connection that reminded me of it was that one of the organizations which had developed a suggested outline was the American Institute of Architects. Their recommendations were for what a hospital adminstrator should know about the role of the architect in hospital planning. Others were done by Blue Cross, the social workers, the medical record librarians, and perhaps as many as a dozen or fifteen fields, including some of the specialties like the radiologists and the anesthesiologists. We didn't make any use of those materials, and I have no record of how they were used, but I retained them all and I have taken them out when I've been approached by those interest groups. Over the years I've been approached by all of them and a 100 more, each of them claiming the hospital administrators don't understand them, and it's the responsibility of the programs to either turn over a block of the curriculum to the field, or to develop curriculum materials that help them to be better understood. I have shown them these examples and to fend them off by saying if they want to produce something like that we'd be happy to distribute it to the programs. I don't think anybody's ever taken up my offer. So, there had been that curriculum development before the Kellogg grant.

Getting back to the Kellogg application. I, at this time, was in Chile doing my dissertation work and knew nothing of what was going on with AUPHA. In fact, if I was aware of AUPHA at all, it was very vague. After the grant was received, which was in the summer of 1964, the decision was made to separate the functions of the Biannual Review Committee from the search committee for an executive director. That may have represented some differences of opinion between the members of the Biannual Review Committee and other members of the Association who came up with a structural solution to

what they foresaw as a possibility that the Biannual Review Committee, left to its own devices, would hire an inappropriate person. So, that's how Bugbee, I believe, came to chair the search committee whereas Fred Gibbs of George Washington was the president of AUPHA. There was a set of job specifications developed. There had been some in the proposal which were elaborated on after the grant was received. Very clearly the ideal that the leadership had in mind was that of a either retired or soon to be retired program director. The salary was pegged quite high for those times, $25,000. The pattern of recruitment seem to have been that each program that wished to could came up with a candidate of choice, thereby narrowing the field and I suppose minimizing the politics. Sometime in the winter after I returned to Minneapolis from Chile (November of '64), I became aware of the opening for a director for the Association. My adviser at the time was E. Gartley Jaco of Minnesota, who had been to some of the AUPHA meetings. Jaco shared with me and perhaps all of the doctoral candidates, of whom there were between nine and twelve, a letter from George Bugbee to Jim Hamilton about the AUPHA job. Jaco also had a letter addressed to him from Bugbee asking for suggestions for another job for which Bugbee was responsible. That was seeking a research director for the Chicago Hospital Council. The connection there was that the Research Director was to be physically located in the Center for Health Administration Studies at the University of Chicago. So there was a link between the university and the Chicago Hospital Council, which accounts for Bugbee's role in filling the job. To bring it all together they had applied for the grant in '63, received it in '64, spent most of '64 and '65 looking for a director.

If you wanted to start an association in this field you couldn't find

anybody better to work with than George Bugbee. He'd been associated with every key association in the field and was the architect to many of them, so that he had a wealth of experience. Of course, he also had very strong ideas of his own. Many times in those early months George was torn between his own very strong ideas about the way things should be done and his belief in letting people do their own thing. I also had some ideas of my own because of all that organizational experience in youth activities as an undergraduate, which enabled me to really hit the ground running. One example was putting out a newsletter early as a way of signaling the field that we were in business, establishing visibility, providing a basis for communication of ideas and not insignificantly giving the membership a feeling that we were doing something with our salary and the money, that there some activity was taking place. Today we continue to publish it as Program Notes.

I knew that in organizations it is very easy for a sense of remoteness to develop between the members and the secretariat. One of the things that the secretariat had to do was to prove itself constantly to the membership in order to continue to have their confidence and, not insignificantly, their financial and other support. That was something I didn't have to be taught. I knew I had to do that immediately and that proved to be a very useful and important step. The Association had virtually no assets. Goulet turned over to me its records, which consisted of a very large pile of boxes of envelops that somebody made a good buy on years before and as near as I could calculate on the basis of our projected activity, would probably last fifteen years. The records of the association were literally stuffed in two of those envelop boxes and there was an envelop full of check stubs going way back to 1948, covering every penny they'd ever spent. There wasn't anything else. The

first several months were spent in renting office space at the Windermere Hotel because it was adjacent to the campus, and all the other minutia of organizing an ongoing activity.

One of the things that I did do very early, upon the advice of a number of people, was visit Iowa City. It was my first trip, and could not have been more that two months after I took the job. It was important because of two reasons. One was, that many people attribute the idea of an aggressively active AUPHA to Gerhart Hartman. In a speech at the Iowa meeting in '63, Hartman envisioned an organization of programs that would look very much like the Association of American Medical Colleges. Indeed, he was active in the teaching hospital group of the AAMC and was, therefore, probably more familiar with its structure than the others in the AUPHA. It's important to recognize now that he was right. The most significant organizational influence on me over the years, the most significant organizational model, has definitely been the AAMC.

The other reason why it was important to go to Iowa City was that the other major candidate for the job had been Walt Burnett, who is today a close friend of mine, and has just finished a distinguished career as a director of the Tulane program. But there was some feeling that there might be some hard feelings on the part of the Iowa faculty having not had their candidate succeed to the job. When I got to Iowa, Dr. Hartman took me on a tour of the city and the campus and its environs, which must be one of the most extensive tours that anybody has ever received of Iowa City. Now, there isn't much to see in Iowa City and I wasn't sure as to the "why" I was getting such a thorough treatment. I discovered the reason when later in the day I commented I was renting an office in Chicago. Dr. Hartman had thought I was in Iowa

City to decide where to put AUPHA. He almost convinced me it was the center of the universe.

The other thing we did in those first few months was to develop an agenda for AUPHA. We established the Task Forces and that model has continued. I spent a great deal of time with Dean Conley at ACHA, but I was not successful in establishing any kind of working relationship with Dr. Crosby at AHA. Dr. Crosby had had his own uncomfortable experience with AUPHA several years before when he was director of the program at John Hopkins. John Hopkins had the privilege of being the only program to lose its membership in AUPHA up to that time and that took place while Dr. Crosby was its director. The reason for its loss was simply that it didn't meet certain minimum structural criteria.

In fact, the program had never been a very significant commitment on the part of Hopkins; it was always a marginal part-time activity. Nonetheless, I felt that there were vestiges of that earlier experience that crept in to our relationship. That was in addition to the basic philosophic question that Crosby seemed to represent, which was the appropriateness of hospital administration training as a non-physican-oriented activity. I do remember one meeting at which Ray Brown and I went to see Dr. Crosby. It was, in the first six months to introduce me to Dr. Crosby, and to suggest the possibility that AHA should give AUPHA some financial support. Ray raised the point, but didn't pursue it. Crosby responded with a quick and direct query as to what were the _quid pro quos._ What was in it for the AHA? Ray was quite adept at responding in a noncommittal way and I was unnerved by the whole thing. I thought that direct AHA underwriting was clearly logical without a _quid pro quo._

By then I'd absorbed enough of the lore of the field to know where the power lay. My sense of that contact was that I was not a very significant figure and that these powerful figures were in a position to pretty much call the shots and determine the destiny of AUPHA. There were many hospital forces at work about which I knew nothing and certainly over which I had no influence.

Later, within that same year, Crosby delegated the responsibility for liaison with AUPHA to Daniel Schechter who was his close associate. That was for me and for the programs a very fortunate development because Dan Schechter is a very thorough and competent individual, who is very approachable and genuinely interested in academic affairs.

He turned out to be more than a liaison between AHA and AUPHA. He became a liaison between Crosby and me, overcoming the difficulty I had communicating directly with Dr. Crosby. That was a significant contribution on Dan's part. He also opened up the resources of the AHA to me; he helped in many ways. He also was responsible for a number of AHA projects in the period roughly '65 to '70 which were related to universities. So it was useful for him to have AUPHA to deal with the universities and communicate with them in total. It worked very well on both sides, but that initial effort to establish effective liaison with AHA could have ended in a kind of standoff over my nervousness with having to somehow deliver the organization or some aspect of it to the control of AHA as embodied by Dr. Crosby, which was implied in that initial contact.

George Bugbee also played a very important role then in facilitating a more comfortable relationship with Crosby. However George was always very circumspect because he did not want Dr. Crosby or the field to feel that he was in any way impinging upon his successor at the AHA. His code of behavior

did not permit him to use his relationship with the AHA in that sense.

The most formal aspect of the relationship in those days with the two organizations, AHA and ACHA, was a three-way liaison committee that had pre-existed my appointment. Also two continual elements of the AUPHA annual meeting were presentations by the AHA and the ACHA. Schechter for the AHA, and Conley for ACHA would come to the AUPHA meeting and tell about activities of their organizations. These talks with the program directors about development in the professional activities were quite interesting to the program directors because almost all of them were themselves professional hospital administrators who were members of both of those organizations.

The liaison committee was chaired by James Stephan from Minnesota for several years. I don't recall who the ACHA and AHA representatives to it were, but it never did much after I came on board because I would communicate directly with Schechter and Conley and the once-removed liaison committee didn't have much to do. A couple of years later I succeeded in taking it back of the barn and shooting it, which was not appreciated by, particularly, the ACHA. They somehow felt that we were de-emphasizing the old close relationship. It was, in fact, a structure which probably was useful when there was no AUPHA secretariat, but with staff relationships it served no purpose.

The other part of the formal relationship was also to atrophy soon thereafter because AUPHA became very busy and jealous of the time at its annual meeting. We were less prone to want to give an hour to other organizations to tell their stories. The audience was changing to faculty members who were not so interested in what was happening in the AHA or the ACHA. An increasing number were not program graduates, or if they were

program graduates had never been practitioners and would really, if given their druthers, rather have heard from the health section of the American Sociological Association than from the AHA.

That was more difficult than putting the liaison committee out of business because that was a kind of an entitlement and, I think, Dan and Dean were personally hurt a little bit when they were disinvited from their annual appearance.

The whole pattern of relationships with those two organizations is appropriately an important and recurring theme at the interface between AUPHA and the field through all the years.

As I said, 1965 was the starting point and saw the first discussion in the executive committee, which dealt with priorities, in addition to these organizational relationships. Also that year there was the need for me to do some fence mending, like the Iowa and the AHA visits, like developing relations with ACHA, and getting out a newsletter.

The next question was, "What should we really do?"

So far the only thing we had on the ground running was an annual meeting. The one programmatic need that everybody agreed upon and which was not threatening to anybody's established ideas of how you educate administrators was to attract better students. AUPHA had done a couple of things before it had a full-time executive to try some student recruiting activities. For example, there had been a small pamphlet published which listed the programs. It was very soon agreed in that first year we should do something about student recruiting. It was an exciting area to get into, there was a lot to be done. It had all kinds of possibilities. Dr. Harald Graning at that time ran the Hill-Burton Agency in Washington, a major source of grants for the

field: research grants, development grants, and demonstration grants of one kind or another. I went to see Dr. Graning to see if there was any possibility of AUPHA getting some help for student recruitment activities. From that grew a proposal for a demonstration of student recruiting techniques. Nobody ever asked who we were demonstrating them to. The only organization you could really be demonstrating them to would be AUPHA.

We were successful in obtaining the grant from Hill-Burton for student recruitment and that--plus operating the three task forces--was the major programmatic thrust of the association in its first two or three years.

There was one side trip and it was a long distance side trip, because in August 1966 there was in Bogota, Colombia the meeting of the Pan-American Federation of Associations of Medical Schools. That's the federation of each of the national associations of medical schools an organization which had support from Milbank, Rockefeller, and Kellogg. It was really getting a lot of its leadership from AAMC, which at that time was also located in Chicago. When I had been in Chile in 1964, I had the good fortune to meet the Latin American director of the W.K. Kellogg Foundation, Ned Fahs, on one of his field trips. Ned Fahs is a very knowledgeable man about Latin American affairs and I mean knowledgeable in addition to his Kellogg experience. He'd been cultural attache at the U.S. Embassy in Chile in the '40s. Fahs and I had kept in contact and had become good friends. When I went to AUPHA it was with Kellogg support and Andy Pattullo's direct involvement. With my Latin American interest, it was natural to look for ways to build on that and, of course, the connection with Fahs facilitated that. Ned was involved in this major meeting of all the Latin American medical schools to be held in Bogota.

I suggested to Ned that AUPHA should invite all the Latin American

programs to meet in Bogota at the same time, as a way of helping them, of giving them visibility with the deans of medicine and maybe starting a Latin American association of which I would provide the secretariat as a service. Ned said that was a good idea but I would have to get the agreement of the treasurer of the Pan-American Federation. His name was John Cooper and he happened to be at Northwestern University in Chicago. The same John Cooper who is today the executive of AAMC. So I went to see Cooper and that's how I got to know John Cooper. He couldn't quite understand what I was doing there but he dutifully signed the proposal, which was about a page and a half long. The Foundation gave AUPHA a grant of eight or ten thousand dollars with which we brought together the directors of Latin American programs. I conducted this meeting where they met for the first time as a group. Totally a show-and-tell where each took time to talk about what they were doing in their country. The North American delegation consisted of Burns Roth from the University of Toronto, Larry Hill from the University of Michigan, John Thompson of Yale, and myself. It was one of the most memorable professional experiences we've all had because it really opened up everybody's horizons. So that, too, was a very early initiative, and a successful one. I look back now and wonder how we had the nerve to pull that off in the first year, but somehow it happened.

The recruiting project had a number of facets, but it confronted the fact that hospital administration was frequently an accidental career choice and that as the curricula became more organized, there also became more optimal ways to get there through one's undergraduate experience. For example, we knew that most programs required certain prerequisites. Accounting typically, but so many people arrived at the doorstep of hospital administration through

some last minute career switch, that they were almost always making accounting up the summer or a year before they went in. Only a very small minority had, as freshman or sophomore or even junior, come around to a program and said, "How can I best use my next year or two to prepare myself because this is what I want to do?"

So, infusing career information into the broad field would be a very important building block towards having better prepared students. Douglas Brown, from Cornell, had, as a project, been doing some studies of applicants in the programs, which he published in the ACHA's journal. He went so far as to suggest a national application system similar to the medical schools. Some people saw the eventual implementaton of that as a possible outcome of AUPHA's recruiting activity.

We also were very conscious of the fact that there were many health career materials published by various agencies like the AMA which left us out entirely. So one thing we did was to track down all those sources of career information and be sure hospital administration was included. There were many commerical publishers, educational agencies of one kind or another, religious agencies, all kinds of them, that were essentially pamphleteers. The only thing substantial was a book by Dick Kirk, of the American College of Hospital Administrators, one of a set of books on careers. It was called So You Want to be a Hospital Administrator.

If you didn't happen to know about that particular book, there was no way you could find out about the field. So we put out several pamphlets and we did a lot of mailing. We even did a little research on application and inquiry patterns among the programs. What that did was: a) it established AUPHA as a recruiting organization, and b) as an organization that did some

research inhouse. That was contrary to some people's view of what an association should be including George Bugbee, who felt that research was not appropriate function for an association, it conflicted with its service mission.

The other thing that project did was to get into the business of program level activities. By that I mean that one of the things we did, for example, was we set up The Campus Visitation Program. It was one of the best things we've ever done and we should be doing it now. We said to Berkeley, for example, "You pick out five or ten undergraduate institutions in your area that you would be willing (and it would be logical) to send a personal representative there. We will provide you with all the materials and a completely laid out process to carry out that visit, and, in fact, from the Hill-Burton grant we'll reimburse you for your travel."

So, if Berkeley was to visit ten schools, we sent them ten "Campus Visitation Kits," which included the letter that they sent out to the school in advance, the thank you letter afterward, and preprinted posters announcing the visit of the faculty member to interview people for hospital administration. The poster listed all of the programs in the field and the individual was to recruit for the whole field.

We served as a clearing house to make sure that UCLA and Berkeley didn't visit the same school, also to make sure that the activity was approved by organizations like the National Vocational Guidance Association and the American Personnel Guidance Association.

We provided in the kit twenty-five pamphlets to give one to each student that showed up for the seminar. A great program, and it put us in the business of being very activist in terms of program level involvement. The

response was wonderful. I think every program in the country participated. I don't think any one of them visited less than three or four neighboring schools. As recently as three or four years ago a couple of them were still carrying on.

I was fascinated to see that at a recent meeting of our board someone suggested that we ought to have a program that encouraged the programs to do that sort of thing. That's when you know you're old enough to participate in an oral history. But it was a good program, and the feedback from the member schools was very positive. They reported back consistently that they found new talent, that they had visited with counselors while they were on the campus and told them about the field, left material with them, and that two or three years later applicants were showing up who had actually wandered in off the street because they saw a poster at the visit to Carleton College, or wherever it was. That showed that AUPHA could have some effect.

Even today, all of those publishers of career materials, whenever they update, always send their materials to us to go over.

The other thing that happened in that process was that once again, AUPHA carved a role out for itself separate from the practitioners.

As part of the overall recruitment effort sponsored by the Hill-Burton grant, we provided hospital administrators with recruiting material, because they were a major source of referrals to programs. A young person interested in a career would go to a hospital administrator, so, therefore, it was important for hospital administrators to be able to pull out a pamphlet or be able to tell them where to go for information. We found that the best vehicle for getting to hospital administrators was the alumni associations of programs.

We could give those alumni associations a purpose, a programmatic activity

of their own. Many of the alumni associations felt the only reason they existed was to give money to the program.

The faculty didn't want them "mucking around" in the curriculum. Well, we could provide something that was an important function. Again, that's something in recent years that has lapsed into disuse but I continue to think it's a very relevant activity. In fact, AUPHA should once again, as it did in the past, undertake an effort to strengthen alumni associations and, therefore, help them to be a better resource to the programs.

The problem is in doing that you are not sure that a professional body such as the ACHA wants to see the alumni associations become the focus of a lot of the resistences we ran into the last time. It was a number of years ago and current perspectives might be different, but it was an unexpected source of resistence because one might assume that the College would like to see the alumni associations in the programs prosper.

In many professions the profession itself takes the responsibility for recruiting. The engineering societies pay for that kind of activity, and AMA invests a great deal in it, the dental association does, and so on. The ACHA, for many years, put out a pamphlet called "Your Career in Hospital Administration." I thought from the beginning that it was not a very appropriate piece of material. It was built around, for example, extensive quotations from people who mean something to the practicing administrator because they were leading administrators, but they were not part of the world of a college undergraduate or high school student who wouldn't be concerned with the advice of the former administrator of the Strong Memorial Hospital or the past president of the ACHA. It struck me that the thrust of the College's recruiting materials was more toward conveying to the adult world a good image

of the hospital administrator than to the young person aspiring to a career, which was quite a different thing. So, one of the reasons for AUPHA taking on the recruiting role was to convey our own idea to young people in terms which we thought were relevant to their frame of reference and their interests. In more recent years, that question has taken on a new dimension because as we evolved from hospital to health administration it became important for the academic community to convey to young people the broader concept of the career for which we are training, whereas the material published by each of the professional societies really pertains to the applied areas. So, again, perhaps serendipitously, our present self-concept has benefited by the accident of earlier history where we then took the initiative to put out recruiting materials. On a couple of occasions I can remember saying, either to Dean Conley or Dick Stull, instead of putting out or investing more money in recruiting material give us the money, and lets us put it toward our overall recruiting activities. I don't think they ever did, but that was my position.

THere was another very critical theme of development in that era. I'm now talking about the first two or three years of an active AUPHA 1965 to '68. That was the question of governmental support for education in this field. About half of the programs in that period were in schools of public health. Beginning in about 1965, schools of public health had received some federal support. They, in fact, were first of all the professional fields to get federal support for education. So we were in, as a field, the position that some of our programs were the beneficiaries of federal support and others were not. Early on, probably as early as 1960, there had been a number of inquiries about that question directed to the government, but no aggressive

follow up to the replies, which were essentially to the effect that this is support for schools of public health as entities and that programs in hospital administration were simply not in business for the same purpose as the schools of public health, and, therefore, didn't qualify.

Now there was an interesting twist to that even within certain schools of public health where the dean would say, "Yes, that's correct. Therefore the program in hospital administration within this school won't get any of this federal support."

So, we had really three varieties of the situation. There were programs like Iowa, that got nothing; programs like Minnesota where a hospital administration student might get a federal traineeship from the school; and a situation at Columbia where the dean told Dr. Clay, the director of the program, his students were not eligible because they were not involved in "community health."

Well, I investigated that situation, learned quite a lot about its dynamics, and journeyed to Washington several times in 1966 or '67, to meet with the people in the Public Health Service and to try to understand, if not change, the situation. There was no change in the situation. But in '67 when we countered the community health argument successfully and we pointed out the inconsistencies in the use of these funds, we were told by the people who ran the Public Health Service manpower section, that the reason why we couldn't have traineeships for our students, outside of schools of public health, was because we didn't have accreditation growing out of the equity question in federal support.

In 1968 there was a new health manpower bill being written. We had been told in '67 that it was not the intent of the Congress to provide money for

programs in health administration outside schools of public health because they were not community-oriented. In 1967 or '68 Mr. Bugbee and I spoke on the phone to an old friend of his, Senator Lister Hill. As a result of that discussion, we were asked by Senator Hill to suggest specific language to be included in the report which would accompany the appropriation for health manpower that year. That specific language was to say that it is the intent of Congress that these funds were to be made available to programs in hospital administration because they were commuunmity health. That's what happened. Then we were told by the bureaucracy, "Well, that's all very nice, but you don't have accreditation." That's when I began to get a reputation of being anti-school of public health because the schools were opposed to opening up the funds to anybody else. Some of the deans were still arguing that hospital administration within their own schools wasn't community health.

From that time to the present I've been deeply involved in the process of securing federal support for programs in health administration. At that time there was about $300,000 at stake. Yesterday I read a draft of the new bill by Senator Schweiker, which in 1982 would authorize $27 million for programs in health administration. We've come a long way.

The legislative issue preoccupied us for quite awhile in those months. In 1968 the Surgeon General convened a conference to review the status of public health manpower and a number of important people in the field participated. It was the third Surgeon General's conference. They made recommendations and we were able to get enough input into the conference, to which I was not invited, to have the conference recommend a broad interpretation. That took quite a lot of work behind the scenes, whereas, at the time of the Surgeon General's earlier conferences there'd been no AUPHA to organize such lobbying.

The other issue which occupied us in those days was accreditation. I guess it's fair to say that wasn't very long after I started with AUPHA, certainly within the first year, that I had established the goal of a formal accreditation program as central to my own agenda. I was motivated primarily by the wrong reasons, in retrospect that is, the status that accreditation brings to a field. I don't think that accreditation as it's currently carried out in every field and every situation is a socially desirable thing to do. It needs to be very closely scrutinized.

At that time I had an agenda. It was basically three things: to put AUPHA on its feet organizationally; to put AUPHA on its feet financially; and to establish accreditation. I expected to accomplish that agenda in about seven years and be on my way. Where I don't know. As I mentioned earlier, there had been some discussions of accreditation in AUPHA some years previous when it was suggested that it might be done by the College. The reason it had come up at that point was the Veterans Act of 1952. It was because the Veterans Act of 1952 specifies that in order for a veteran to be able to apply benefits for an educational program, the program or school must be accredited by an agency or agencies recognized for that purpose by the U.S. Commissioner of Education. Quite a number of veterans had come out with medical training after World War II and been a big factor in the growth of programs in the mid-forties. The situation in the fifties following Korea repeated that. But you had the Veterans Benefit Act language, which in operation meant that some questions had come up in particular individual cases of students who had applied to the programs, had been accepted, and then applied to the VA for benefits and had them questioned because the program was not specifically accredited. Upon appeal that had always been resolved because there was no

accreditation program, and, or, the programs were in institutions which were regionally accredited. But the response of programs in AUPHA to that problem was to say that maybe we should have the AUPHA accredit us and that would solve the problem for the VA.

When I came on the scene that problem still existed but to a much lesser extent because the bulge was over. But I did have that question raised in Washington relative to the availability of traineeships. I knew perfectly well that it was just one more roadblock being thrown in our paths by the Public Health Service people who had a very close clientele relationship with the schools of public health. They didn't want to see the money dissipated over a wider clientele group. There were considerable philosophical issues, too. They really did feel, I think, in many cases, that programs in hospital administration were not community-oriented, that they trained people to serve the fee-for-service curative system, and that was not public health. We're still arguing that today.

The question of accreditation came up in the executive committee of AUPHA again in '67. I came to Washington to talk with the U.S. Office of Education about what was required to be recognized as an accrediting agency. They had some minimal criteria. There was another agency in Washington that was concerned with accreditation called The National Commission on Accreditating. It represented the nation's colleges and universities, through their presidents, and had essentially been organized as a defense agency against which was then seen as the needless proliferation of accrediting agencies. In effect, then, NCA and OE were the "accreditors of accreditors" and it would be necessary to gain their recognition in order to have an acceptable program. Of the two, NCA's recognition process had more teeth, but, in either case, one

stood a better chance of being gummed to death than being bitten. So, armed with that information I came back to the board and laid out what appeared to be necessary to have AUPHA recognized as an accredited organization.

Mr. Bugbee, and, I think, Mr. Brown suggested a different model based on their own experience, and that was the Joint Commission model, with which I had no experience. Among the leadership group in AUPHA that idea quickly caught on, was received enthusiastically, was a natural model to gravitate to. It also came closer to meeting sort of roughly drawn criteria of NCA which was that the accrediting mechanism ought to somehow represent the community of interests in the field.

So, we decided to pursue it by forming an exploratory committee which was headed by John Summerskill, who at that time was the director of the program at Cornell, later the president of San Francisco State College. To that committee were invited representatives of ACHA and AHA. From that committee, which I staffed and Mr. Bugbee was an active member and Mr. Brown and others, came the model, the first model of a kind of joint commission based accrediting body. We moved very quickly. This was done within a period of less than a year. My contribution to that committee was to suggest the addition to the group of the American Public Health Association. My idea being that by coopting the APHA into that structure we would deflate the argument that programs in hospital administration were not concerned with community health and that APHA couldn't refuse to participate because half the programs were in schools of public health, which they already accredited. That further added to the logic of their participating because it would be an overlapping accrediting program. Politically it was a timely maneuver. I could then go to Washington and say, not only do we have an accrediting

organization but the American Public Health Association is one of the sponsors, the primary clientele group of the Public Health Service. So that's what we did. So, we'd gone through phases. One was the initial membership in AUPHA, serving as an approval mechanism; the second was the still-born idea that AUPHA should be the formal accreditation body; the third was that ACHA do it; and finally the one that flowered, was the independent joint commission model to include the American Public Health Association, AHA and ACHA. That Commission became operational before it gained national approval, because one of the criteria for national approval by either OE or NCA was that the accrediting machinery must be established, which in retrospect was a peculiar way of playing a gatekeeping function because it encouraged agencies to present themselves de facto on the doorstep of the approval agency which then supposedly was to protect society from the proliferation of accrediting agencies. The other thing that was decided was that, again, copying from the Joint Commission, there should be an advisory committee composed of the CEOs of the sponsoring organizations.

WEEKS:

I think you can begin from where you left off in talking about the Joint Commission.

FILERMAN:

I pointed out that the Joint Commission on Accreditation of Hospitals was an important influence on the model that finally evolved. One aspect of the Joint Commission structure that was transferred to our structure was an advisory committee composed of the CEOs of the participating organizations. Like so many ideas which were critical in the development of these organizational structures, AUPHA and the Commission, the source was George

Bugbee. He felt that the organizations which participated in this kind of a commission had to have a commitment at two levels.

One was the elected representative who participated in the commission's actions. But at the CEO level there is an obligation to understand what the commission is all about, to promote its work and make sure that its policies are integrated with it into their own policy structure. The way to accomplish that, George felt, was to set up an advisory committee. The original advisory committee, was Ed Crosby of the AHA and Berwyn Madison, the head of the American Public Health Association, Dick Stull of ACHA and myself. I was chairman.

It met once in late 1968 (the commission started January 1, 1968) and did not meet again for over a decade. The second meeting of the advisory committee of the commission was in 1979. By that time, the membership of the accrediting commission had changed--as had its name. It had become the Accrediting Commission on Education for Health Services Administration. The participating organization list had been expanded to include the American College of Nursing Home Administrators, the American College of Medical Group Administrators, the American Health Planning Association, and the Association of Mental Health Administrators. When this advisory committee reconvened it brought together a much broader perspective of the world health administration practice than had the founders of the accrediting commission a decade before. As such it was a good reflection of the field as educators see it now. Not always as practitioners see it and not always as the practitioner organizations see it, and therein lies an important tale of the evolution of the field and the evolution of AUPHA.

The Accrediting Commission, when it changed its name from hospital to

health, was really behind the programs. By the time the commission changed its neame, there were only two on their accredited programs which called themselves "hospital administration". The others had modified their label to reflect a broader scope. Some had dropped the word hospital completely, others had added "and medical care", "and health" and so on. So the commission was catching up with the evolution of the programs rather than leading it.

That was a political necessity because when the commission decided to change its name, it ran into the active opposition of the agency which accredited schools of public health. They felt that by changing our name, the commission was broadening its turf and challenging the Council on Education for Public Health in schools of public health. By that time, health administration had grown to be the dominant section of many of the schools. In several schools of public health, as much as 50% of the enrollment was in health administration, not hospital administration, but in some health administration related activity.

So the commission didn't move until it was on very firm ground in justifying the change. That was essentially that the programs we dealt with had themselves already broadened their mission. Furthermore, new programs created in the late sixties and early seventies all came in with a broader mission. There were no new programs in hospital administration being created.

The commission also made a shift in composition. It devoted some time to considering where delivery organizations were going and where graduates were going. That's when they concluded that the College of Nursing Home Administrations, the Medical Group Administrators, and so on had a legitimate role in the activities of this commission.

It's interesting that those organizations, when invited, were not all enamoured at the idea of becoming a part of the commission. The number of program graduates amongst their membership is a distinct minority even though it may be increasing. Furthermore, participation in the commission isn't free. The organizations each contribute a modest amount of money based on the number of seats they have on the commission. Each of them has one, except AUPHA which has four. So there was a transitory period during which they were invited to be consulting members of the Commission. When they felt they wanted to become full voting members, they could exercise the option of coming in and paying dues.

It's now several years after that process was initiated and two of the organizations, the Association of Mental Health Administrators and the American Health Planning Association, have not exercised the option to become full members. They are very limited financially and reflect the still weak professionalism in those two areas as far as professional health administration is concerned. They are both fields in which the flow of funds is dependent upon public financing, federal financing in particular, fields in which career identity of the program graduates is not strong.

As you look at where health administration practice is going, one may see other configurations emerging which perhaps are as appropriate potential participants in the accrediting process. Home health agencies, for example, or HMOs as distinct from group practices, might legitimately claim a seat on this accrediting body as graduates begin to move into those fields.

There are two organizational sidelights relative to the Commission that are worthy to note. One is that the AMA has approached me on two occasions, since 1968, with a very quiet "flirtation" or investigation as to whether they

should be on the commission. In both cases they have communicated a desire to be invited, but did not press the case for fear of appearing to be aggressive in their designs. On both occasions, the commission has felt that the AMA would not contribute appropriately to the role of that body.

The other relationship that has been interesting has to do with the role of the profession in Canada. When the commission was started in 1968, all the hospital administrators in Canada who belonged in anything of a professional organization, belonged to the American College of Hospital Administrators. Today a new organization, the Canadian College of Health Services Executives, has developed and the ACHA has reduced its profile, if not its membership, in Canada. Since the Accrediting Commission deals with Canadian schools it would be logical to ask whether the Canadian College should be a participant.

The Commission has put that question to the Canadian schools on several occasions, giving them the option of designating their appropriate professional representative body. On each occasion the Canadian programs have declined. They have felt either that the Canadian College does not represent their interests appropriately, or that their interests are adequately served by the professional representation in groups such as the AHA and the ACHA. I think that has to change. The Canadian College has an appropriate role to play and is the appropriate representative organization of practice in Canada, although graduates are a distinct minority of its members.

The Accrediting Commission has developed into an extraordinary body. I believe that it is one of the most consequential activities in the field in the sense that it has had a profound effect on the quality of the educational process. Furthermore, it is the one working body in the field where all of those interests sit around the table as equals and share philosophies of

delivery of health services, share perspectives on success and failure, and talk about their aspirations for the field. The evidence of the success is borne out by the very high priority which participants in the commission place upon it.

Two or three years ago one member of the commission was told that he was going to be taken off the commission by his organization and moved to another assignment which would start him up the ladder to the presidency of that organization. He responded that as much as he would like to be president, if it meant giving up the seat on the commission, it wasn't worth it.

That doesn't surprise me. The commissioners have the unique opportunity of actually visiting campuses, talking with faculty members, talking with students, looking at what's happening in the classroom and then coming together and, with colleagues from different perspectives, talking about the implications for the field, five, ten years hence. That's a very enriching and satisfying contribution.

The commission's role is a little clouded by its relationship with AUPHA. My role clouds the commission's role in a way. The commission, to be optimally effective, not in an operational sense but in a political sense or image sense, should be totally and unequivocally independent. At first, it was necessary, for the two organizations to have an overlapping director, to protect the interests of professional education. Now mechanisms are built into the structure which protect the prerogatives of the universities and now there are traditions of operation that are established which would have to be very closely and objectively examined before they could be modified.

What is necessary now is the adequate financing of the Commission. AUPHA underwrites it overwhelmingly. The Commission pays me or my colleagues no

salary and it pays only a fraction of the true overhead. If the Commission were to become independent, it could not carry on anywhere near the quality of the program it carries on at the present time. But a way must be found eventually for the accrediting process to become independent.

That doesn't mean that AUPHA should then become a trade association. That needs to be underscored. AUPHA has never behaved as a trade association and the fact that the gatekeeping function is clearly shifted to another body doesn't mean that the association of universities should then attempt to develop the largest possible membership and maintain the highest level of member satisfaction by catering to the lowest common denominator of interests. I think those are characteristics of many trade associations.

The Accrediting Commission had also played an important role in leadership development by giving an opportunity to a number of practitioner leaders to have this experience with colleagues from other associations. It is an education which had broadened their prespectives of the field and given them a set of personal relationships which have enhanced their effectiveness as they moved up within their own organizations. It's introduced a different kind of leadership development experience to the field, a field-wide experience rather than a nursing home or a hospital experience. It bodes well for the future of the field to have a group of people that have shared that experience.

The commission has also, with the support of Kellogg, provided for a fellowship experience for people who are moving toward leadership at the program level. By giving them a year of work with the commission, as fellows, the commission has been able to share the wonderful experience of systematically looking at several programs, critically evaluating them and participating in the kind of conversations that I have just outlined. It is

invaluable to share that with young leadership in academia who have gone on to be program directors in many cases. I feel that has been the most cost-effective development experience available in academia and the best investment in leadership development that we've made.

So the commission has had quite a broad effect, much broader than some people realize. An interesting footnote is that at this moment the commission is beginning to have an impact on the European situation. Not that it would hold itself out as providing service but it is being looked at by the Europeans as a model.

In Europe, the notion of peer review of higher education is very foreign. There is almost no peer review of anything, be it peer review of the surgeons' practice or peer review of teaching geography. But we obtained a grant from the Kellogg Foundation through which a representative of the European Association of Programs in Health Services is looking at the accrediting process in terms of the applicability of its general principles, that is peer review, to the European scene. That has had the very positive effect of illuminating what the process really is to many people who have absolutely no experience with it, and secondly, suggesting to European leadership that there is a substantive activity of exchange of indepth review that could give the European Association a real programmatic foundation.

If we succeed in doing that, it will be a very good contribution of the Accrediting Commission.

If the Accrediting Commission plays that role in quality, what is the AUPHA role? Having created this Commission and spun if off, to a degree, there is a certain pressure for AUPHA to be a trade association. As money gets tight in universities we have to face the reality that despite our

sometimes idealistic view of higher education and its values, higher education is a very heterogeneous community. It consists of many kinds of institutions with different charters, different value systems, and different admissions objectives. Right now, because of the changes in the economic environment, there are a number of institutions of higher education which are beginning to look at the world with a marketing perspective. They are, not inappropriately, asking what are the growth areas in this society which are going to generate new jobs to which they should be responsive.

Some of them are identifying health administration as where the action will be over the next decade or two.

Being a resource limited environment, they look for the least expensive way to get into the business. that's where their model of education may clash with the dominant model among the AUPHA universities today. For example, we are seeing a resurgence of what Northwestern was offering the field in the 1940s. It was part-time education based largely upon part-time practitioner faculty and the university didn't really have a lot invested. In fact, both then and now, many of these programs are revenue producers.

There is nothing inherently wrong with that approach to education. It represents a valid service to the community and meets the needs of many people and the system. But it is a variation from the traditional model which dominates AUPHA and which is focused on entry level education at the master's level, rather than on master's degrees for people who are already working in the field. So that development represents a challenge to AUPHA's view of the world.

Another challenge comes from so-called nontraditional education. By nontraditional, I do not mean education which is delivered at nontraditional

times, but in a traditional way. A weekend program or an evening program is a traditional program because it is still basically a classroom experience, the compilation of credits and all the same processes. Nontraditional education, on the other hand, refers to programs which attempt to assess the accumulated experience and learning of an individual and give him credit for that toward the degree.

Then they establish a learning process, as opposed to a teaching process, which is highly individualistic and focuses on the outcome of the process, by measuring what the person has learned. That's when you get to self-study at home, working with mentors, doing case studies at their places of work and many other varieties of educational experience.

Some of those programs are of excellent quality. Some of them, in my view, are of poor quality. In fact, they are dangerous to the survival of nontraditional education because they, in effect, undermine professional and public confidence in nontraditional approaches.

Those two developments press AUPHA's sense of what it's in business for. I believe that it has an obligation to the field forthrightly to do the best job it can of distinguishing between educational programs which honestly attempt to offer the student an optimal experience and those educational methods which offer a credential in response to the minimum exertion by the participant and investment by the institution.

Therefore, AUPHA needs to recommit itself periodically to supporting a tough Accrediting Commission but one which is openminded toward educational variety. At the same time AUPHA needs to protect itself, fending off efforts by those among its members and those outside of its membership who would have AUPHA become an agent for reducing the potency of the Accrediting Commission

and use its seats on the commission as instructed representatives of the regulated, as we see in many regulatory agencies.

Up to this time, no one has come to the Accrediting Commission table instructed. They have always left their representation credentials at the door and dealt with the issues at hand as individuals. AUPHA has never asked its representatives to report back on the commission's position or work. That is as it should be. But in a changing economic environment where the survival of programs and indeed the economic interests of faculty members are at stake, I see mounting pressures for AUPHA to serve as a vehicle to constrain the commission or to have it be more responsive to the interests of a broad spectrum of programs, and itself to open its doors to all kinds of programs.

Now in a social perspective, one could argue that as long as there is a student anywhere in Canada or the United States who thinks he is studying health administration, AUPHA has an obligation to take that program into its fold, no matter how poor it might be, because that's the only way we are going to improve it. There is a conflict between the philosophy that you influence quality by embracing everyone and the philosophy that you influence quality by excluding.

We have elected the latter course. I think it's the proper course. It means that there are now and there will continue to be programs that are in AUPHA and programs that are out of AUPHA. In the last year, AUPHA dropped John Hopkins, the University of Kansas, and Florida International University, on the grounds that those schools failed to achieve accreditation with in a reasonable amount of time. In one case, it was after being an AUPHA affiliate for six years. As a historical footnote in the case of John Hopkins, they now have been dropped twice from AUPHA, the only program to have that honor.

Clearly, not having a university as prestigious as John Hopkins as a member of AUPHA is sometimes a disadvantage. There are times when I have appeared before a Congressional committee or before an academic body and wished that I could list John Hopkins as a member of AUPHA, but that's a small price to pay for maintaining the integrity of this organization.

The other development which confronts the role of AUPHA with potentially dramatic change is the rise of undergraduate education. I have not been an enthusiastic supporter of the development of undergraduate education for health administrators. Many of my colleagues in undergraduate education have been aware of that. My reservations are two. The first has to do with the needs of individuals, and the second has to do with the needs of the field.

I'm not so idealistic that I believe that everybody that has a liberal education is an educated person and is going to perform successfully in society. But I am idealistic enough to believe that unless we produce people who have a liberal education, our hope of finding such individuals is severely reduced. I believe that we do a disservice to people's potential by enticing them into vocational training before they have the wisdom or the perspective of realizing the enduring value of being well-educated. By steering them early to vocationalism, we take away that opportunity.

From the field's perspective, when I look at the job of a health administrator, I am convinced that what a health administrator can contribute most significantly to an organization or community is good judgment. The question is, what goes into the judgment process? Is it a process based on a totally technical perspective with understanding of people, institutions, and communities? Only in the case of the later will we get the kind of institutional and programmatic leadership that a complex society needs and

deserves.

Given the choice, I would rather have a well-educated person running a complex social institution, than a technically well-trained person. In reality we do not have to make that choice. But I would not subscribe to technical education and I am afraid that some undergraduate education for health administration is skewed in that direction. If someone has a graduate degree in health administration, there is a chance that they had an adequate undergraduate education. So my reservations about the role of undergraduate education have to do with both a value system about education and a concept of what is needed by the field.

In contrast to that, I understand that there are many young people who are not going to go for graduate education, need a job and expect their undergraduate education to give them entree into the world of work. There are also a lot of jobs in health management which do not require a graduate education. I suppose that much of what we call graduate education for health administrators is in fact not any different in rigor or in depth from what is taught at the undergraduate level, it's just taught later in one's academic career.

We still have an opportunity to mold and influence the direction of undergraduate education in the field. I for one want to promote attention to the quality of general education as much as I would promote attention to the quality of the technical education that comprises the undergraduate field. I hope AUPHA will do that. So far it seems to be moving in that way. As a result, there is a very good chance, looking ahead, that at the undergraduate level AUPHA member schools may be for some time a minority of the programs.

AUPHA just did a survey, within 1981 and identified exactly 100 institutions which purport to offer undergraduate training in health administration. Only fifteen are AUPHA members. The ratio will change, but not overwhelmingly. And as it changes, the internal structure and politics of AUPHA will change because graduate faculty members will no longer control the priority setting process of AUPHA. They will increasingly share their organization with individuals from undergraduate schools.

The development is no different than that in social work, engineering, nursing and many other fields, but it is a change for us. If there are some general values that permeate the work of the association, if there's a solid understanding of what it believes and what it stands for, I don't believe that we will see major change of a disruptive nature or friction between the two, or friction between traditional educators and nontraditional educators, be they graduate or undergraduate.

I think my responsibility as the spokesman for the association is to try to create that image, to keep in front of the membership some of these broader goals. It is to keep bringing before them the question of how responsive education is to the needs of society and our graduates' place in it as opposed to the needs of teachers to teach their courses and do the things that they feel they need to do, because the two are not always the same.

We come back to the differentiation between teaching and learning. If we can keep our eye on learning and not only on teaching, we will achieve and maintain that consensus. If we just focus on teaching, then the diffuse interests which the organization now is embracing will be very divisive.

WEEKS:

Going back to the undergraduate courses. Is there any tendency for a

ladder there from undergraduate into the master's?

FILERMAN:

There is some. But remember that much of what we teach at the graduate level is not very different from what is taught at the undergraudate level. There are some graduate programs that do not want undergraduate program products because they feel that they have covered much of the same ground. There are some educators at schools which have both graduate and undergraduate education who feel that their undergraduates should go to a different school if they want to proceed on. There are educators at both levels who feel that if a student comes out of an undergraduate program and continues to graduate school, he or she is in a way, a loss, because the mission of undergraduate education is not to recruit graduate students. And there are others who are very concerned about the articulation question as indeed there are educational generalists who are concerned about that in every field.

There are two programs which offer a combined bachelor's and master's in five years. The idea, incidently, was pioneered by Marvin Cohen of Wagner College in Staten Island, New York. Cohen sent me a paper, five or six years ago, proposing that Wagner College (which at that time offered a master's degree but was having trouble supporting it) integrate that master's degree into a five year combined program. Later, and independently, the University of Iowa developed an identical model and obtained Kellogg Foundation support to implement it. That's the ultimate integration model. For selected students, given today's environment including factors of cost of higher education, it certainly has validity. For select students, I would underscore.

I don't believe that articulation can be accomplished in the sense of the pre-med/med model or the pre-law/law model because these are not pre-health

administration programs. They are both terminal professional programs. The problem has been faced in psychology, in social work, and in some other fields. In those fields it has never been successfully resolved and I don't think we can do it either. It's less resolvable in health administration because we don't have the homogeneity of educational setting and model that some of these other fields have. We've got fourteen different degrees. Any hope of regularizing the process of vertical mobility through education in such a heterogeneous environemnt, I think is beyond the pale. But there are those, particularly undergraduate educators, who continue to hope that will be the case and hold that out to their students as an educational path. I think, unrealistically.

WEEKS:

How is the field accepting the undergraduates who come out with a health administration degree? Are they accepting them on a professional level?

FILERMAN:

We don't really have a well-documented answer to that. At this particular time, in 1981, AUPHA is just concluding a direct mail survey of every identifiable undergraduate alumnus in Canada and the United States.

A vast majority are employed in the field. The problem in answering the question as to how the field is responding to them is complicated because the students are a very heterogeneous group and so are the programs, in terms of what they are training their students for. That means, for example, that there are programs which train people to be middle-managers. It's not fair to compare their employment success with the graduates of a graduate program which is oriented toward producing CEOs.

Some of the undergraduate programs feel they are competing directly with

the graduate programs and have given the students that set of expectations. Most of those programs are so new, and their graduates have been out so short a time, that you can't really assess their impact. Certainly there is a point in one's career where track record overtakes academic background and inevitably one expects that graduates of the two kinds of programs to compete for the same positions.

WEEKS:

Let us return to the Canadian relationship. Can you add to your earlier comments about the role of AUPHA in Canada, accreditation in Canada, and related issues?

FILERMAN:

AUPHA has always involved both Canadian and U.S. programs as equals and a number of Canadians have been presidents or now Chairmen of AUPHA. When the Accrediting Commission was created, Burns Roth of the University of Toronto, was one of its founding members. An early question was: What would be the effect of accreditation on Canadian programs? Accreditation in higher education is an American phenomenon. There is no accreditation of the total university such as we have here by the regionals. Institutions and their programs are chartered by the provinces.

The question was whether Canadian universities would accept accreditation and if it would be used by potential students, donors, faculty and all of the third parties who are the consumers of accreditation action in the United States. The Canadian programs turned out to be very supportive of the process and so were their universities. I an not aware of a situation where a Canadian university has questioned the appropriateness of a program being involved in the accrediting process. We must admit that there is a carrot.

The carrot is AUPHA membership and the benefits thereof, financial and otherwise.

AUPHA should become more involved in Canada. About four years ago, I initiated discussions toward becoming a Canadian corporation. We did not do it because of the cost, for one thing. Another reason was the fear by one of our officers that a Canadian corporation would set the stage for the eventual splitting-off of a Canadian AUPHA. My conclusion was the opposite. I don't believe that the factors which caused Canadian hospitals or Canadian administrators to create their own associations are the same as they are in academia. In fact, Canadian universities have more in common with individual subsets of universities in the United States than they do with each other. Toronto is more like Yale than it is like Ottawa or Alberta. Alberta is more like Michigan or Minnesota than it is like Montreal or Toronto. They are more land grant or more research than they are Canadian or U.S.

WEEKS:

Let me interrupt you. I can't understand your motive in forming a Canadian corporation.

FILERMAN:

My motive is to strengthen AUPHA's identity as an international organization, and to enhance our ability to raise money in Canada. Also to strengthen our hand in those situations in which we are representing the Canadian programs in Canadian affairs.

WEEKS:

This would be a subsidiary of the American corporation?

FILERMAN:

Not a subsidiary, another incorporation of the same organization. I look

upon AUPHA as an international consortium which is incorporated in the United States. In my view of internationalism, this corporation would have legal status in several other countries, to enhance its international image and give it certain operational advantages.

For example, it would be advantageous to be a Canadian corporation because we could operate financially in Canada and not incur the cost of transferring funds. We have also, in recent months, been talking to the Deputy Minister of Health in Alberta, on behalf of the program. We have made representations in Ottawa, on behalf of the interests of the programs for student bursaries.

WEEKS:

You are also taking advantage of the nationalistic feeling in these different countries, too, aren't you? I mean, if you had a Canadian corporation...

FILERMAN:

Yes. I don't think the Canadians resent the fact that AUPHA is an American corporation, but they would feel even stronger in their affiliation with AUPHA if it was also a Canadian corporation. But when some member of the organization walks into a government office in Ottawa and can say we are a Canadian organization, our credibility and influence is increased.

Also there is a fund raising aspect. AUPHA needs to raise money in the corporate community. There is a limited tradition of corporate giving in Canada. There is no tax incentive in Canada for corporate giving. Yet, we've had some small success there and we must have more success there because we need the support for our Canadian activities. It is more attractive to a Canadian company to say that we have corporate identity in Canada than to give the impression that they are contributing to an organization in the states.

The AUPHA role internationally is beyond the U.S. and Canada. U.S. and Canada is the domestic operation. I mentioned earlier, that in the early stages of our development in the mid-sixties, AUPHA participated in an important conference in Bogota which brought together the Latin American programs. That was our first venture into aggressive international programming. There has been a great deal since.

Up until a few months ago, AUPHA was the only organization in the world which had a full-time professional staff devoted to helping institutions create health management training activities. As such, we have had many opportunities to become involved in helping other countries and schools develop programs. Initially the interest came because of the Kellogg Foundation's interest. Kellogg had invested extensively in the development of health administration in Latin America and more recently in Australia and looked to AUPHA as a complementary communications vehicle, relative to those investments of the Foundations.

I mentioned earlier my own Latin American interests. Eventually, through the late sixties, the World Health Organization, represented in this hemisphere by the Pan-American Health Organization (PAHO) developed a commitment to health administration education. That commitment is also traceable to Kellogg. Kellogg has invested in PAHO for many years, in many fields of health, but the Organization was not interested in the delivery of medical care services. It was a public health agency. In the late sixties, PAHO began to change. It began to change because of pressure from many countries, to bring together their public health activities which are based in central governments and their medical care activities which are based in social security systems. In fact, in countries like Mexico and Peru, social

security is stronger than the central government, because they have more money.

So PAHO began to accommodate to that interest in medical care delivery. Through a very fortuitous decision, they hired a young physician by the name of Dr. Manuel Bobenrieth, a Chilean, who had graduated the Minnesota program, and installed him in a division headed by Dr. Alfredo Leonardo Bravo, who once had headed the Chilean National Health Service. That division set out with Kellogg support to undertake some modest developmental activities in health administration education.

In 1967, one year after our Bogota conference, PAHO held a similar meeting in Medellin, Colombia, and began to launch an initiative. At that meeting in Medellin, I brought together the Latin American programs and attempted to create a Latin American association of programs in health administration. They are separated by immense distances and have very limited resources, but I hoped that if our organization could serve as the secretariat, and thus the glue that would hold them together, that an indigenous Latin American movement toward some of things we were experiencing would take place.

Following traditional Latin American patterns, they elected the oldest, most esteemed member of their group, Dr. Odair Pedroso, the Director of the program in Sao Paulo, Brazil, the School of Public Health, as president. And nothing happened. There was no followup, other than that which I did. I was unable to shift the responsibility to them that would create some internal momentum. The effort disappeared.

Late in the 1960s, we extended membership to programs outside of North America. The use of the word membership, was purposely fuzzy. We wanted to say that a program in England or Ghana is a member just as Yale is a member, but they got there by different routes. One went through accreditation, one

didn't. In more recent years, I've had to go along with clarification of that and we now refer to programs outside the U.S. and Canada as international affiliates, rather than members. Nonetheless, I have attempted to involve them in every way possible to fulfill the notion of a consortium.

Bobenrieth did a remarkable job of developing health administration education in Latin America. Today there are about fifty programs in Latin America. Several of them would be accreditable by our commission and are stronger than some in Canada and the United States. I attribute that development largely to PAHO under Bobenrieth's leadership. AUPHA played a minor supportive role during the peak of PAHO activity. That was not by choice, we were kind of pushed out primarily by Kellogg, interestingly enough.

From 1965 to 1971 or 1972, AUPHA had been a central vehicle for Latin American program development. In the early 1970s there was a change when a new Latin American director came to the Kellogg Foundation, Dr. Mario Chavez. The foundation adopted the position that it would only operate through indigenous organizations. It would no longer fund extranational organizations or international organizations or American organizations to provide services in Latin America.

PAHO reduced AUPHA's profile substantially in response to what it felt was a policy directive from Kellogg. I believed then it was serious error and now I believe it more. After a decade PAHO's priorities are changing and Kellogg's priorities are changing and the question is what infrastructure remains? AUPHA is not now particularily active in Latin America. PAHO is reducing its role in health services administration education. There are now fifty programs and many of them are looking to AUPHA to provide communication among them, when PAHO no longer provides that medium.

So here is a case where voluntary organization and its momentum, independent of the vicissitudes of the priorities of PAHO and financing by Kellogg, could have maintained its infrastructure in more of a collaborative way looking toward the day when it might be all that's left operational in the field.

In the meantime, AUPHA's activities shifted much more to Europe and more recently to Africa and Asia.

About two years ago, Kellogg made a grant to the European Association of Programs which has provided them with a full-time executive.

WEEKS:

Is this the Irish set up?

FILERMAN:

Yes, it's based at the Irish Institute of Public Administration in Dublin. I believe that has an unclear future because of the immense problems of support in Europe.

I see AUPHA continuing for some time as the stable international resource for health management education development. The mission is to support those leaders, pioneers, educators who introduce formal management training into their respective systems. Many of them work in isolation. Not only geographically, but professionally within their countries. People who see the need are positioned to do something about it, have some ideas and are doing something. Some in universities, some in ministries, some are in free-standing training institutes of public administration, some are in professional associations like the Hospital Association of Sao Paulo, Brazil, or the Indian Hospital Association in New Delhi. What they need is backup, they need communication, they need to have a source of ideas and exchange,

which AUPHA can provide.

Furthermore, they need legitimazation that they are in fact part of an international development, that the field of health services administration is a bona fide professional activity.

Thirty or forty years ago, there wasn't any backup available that could give them that legitimazation. Today we can. I've seen it work. I've seen a program receive resources because it became a part of AUPHA. The head of the program was able to point to what he learned about through our literature to justify a broader role for the program of immense value to his country, Ghana. When I visted Africa a couple of years ago I found a program in Kenya that nobody in this country knew about. It also happened that nobody in Africa knew about it. So I was able to introduce the program in Kenya to the program in Ghana. Eventually the heads of the two programs became external examiners of each other's program and traveled across the ontinent to work with each other. Demonstration of how we can move the state of the art more rapidly then it would in the absence of such an organization.

The alternatives to AUPHA playing that role really are two. One is the International Hospital Federation, and the other is the World Health Organization.

During the late sixties, when our international role was in that formative period, I approached the International Hospital Federation asking them to provide a focal point for international development in this field. One suggestion was that an educator be appointed to their board as educator. Several program directors had been on their board, particularly from Europe, but with charge to provide leadership in creating a worldwide health administration field. The second request I made of them was that the

IHF's network of meetings, their world congress and regional jamborees of one kind or another, be expanded to include health administration education activities. The IHF was not enthusiastic.

More recently, the IHF has been more amenable to being supportive but not to a leadership role. In about 1975, the IHF held a regional congress in Mexico City. I organized sessions for program faculty from Latin America, which were really quite successful. But IHF's role was to give us a room and put it in the program.

There was an IHF world congress in Tokyo, about 1979. AUPHA organized educational sessions there built around the Japanese, Australian, Philippine, and other Far-Eastern programs. Our affiliate at Keio University in Tokyo acted as Chairman. We wrote to all the programs in the world asking who would be in Tokyo and from that grew a program that was reported to be quite productive. The association was not, itself, directly represented. It demonstrated what we could accomplish at long distance by taking some initiative and it underscored the potential of IHF.

The second element is the World Health Organization. I mentioned the Pan-American Health Organization which represents WHO in the western hemisphere, but WHO internationally has not had a substantial interest in the health administration field until very recently.

About 1977, WHO appointed a Colombian, Dr. Alphonso Mejia, to its staff in Geneva. Dr. Mejia was given the charge of assisting in the development of worldwide health management education. He had other responsibilities, and his worldwide resources consisted,then as now, of whatever PAHO does in the western hemisphere plus part-time of one staff person in the European office, part-time of a staff member in the Western-Pacific office Manila,

and a place somewhere down the priority list of the other regional offices. In fact, WHO doesn't have much to work with.

On the other hand, WHO is very potent in a policy sense, because, unlike the United States and Canada, many countries take WHO policy seriously. That is, our governments do not set priorities according to the World Health Assembly in Geneva. That's not true of the rest of the world, particularly the developing countries. So when WHO assembles an expert committee on health management and they conclude that only physicians should be in charge of health organizations, that has a profound effect on many, many countries. Furthermore, when they conclude that schools of public health are the logical training site for managers, that has an important effect.

WHO has published a number of books on hospital management and on health services organization, almost all of which relegate the manager to a narrow hotel-service role. AUPHA obviously represents quite a different philosophy of training and management than does the World Health Organization. As a result, our relationship has been friendly, but somewhat competitive, both for ideas and for leadership.

The big problem in sustaining an active role in international development of the field is lack of resources. The problem at this moment AUPHA is in poor financial situation. Under these conditions, it's hard to justify to the University of Cincinnati spending the resources to underwrite sending material or providing service to a university in England or South Africa. The leadership has to some extent shared my sense of the mission of the organiazation and if not, at least they've indulged my interest in doing these sort of things. But I'm not certain, given tightness of resources, that would be always carried on with quite the same commitment.

On the other had, in a time of tight resources, one of the competitive advantages of AUPHA is its international role. Not competing with WHO or IHF, but when I go to Procter and Gamble asking for corporate support one of the characteristics of AUPHA which they find most appealing is that we operate in the same countries that they do. By making a contribution to AUPHA they are able then to point to their operations in India and other places and say, "Look, we are contributing to an organization that serves your country."

I've been building on that idea in the fund-raising process. For example, the Bechtel Power Corporation has a number of important contracts in the Middle East. I have specifically based our appeal for support upon the work that we are doing with the American University of Beirut and the fact that most of the health leadership of Saudi Arabia and the Gulf States are graduates of AUB.

In this country, the largest source for support for international health activity has been the Agency for International Development, AID. I have maintained contact with AID for at least ten years. During all that time, my contact was almost entirely with the health division, I was totally unsuccessful in interesting them in investing in AUPHA as a development resource. Yet AID was frequently involved in projects in which there was a health management training dimension, or should have been. At the same time, AID made very substantial investments in public health. The American Public Health Association has for a decade had an international division totally supported by AID which in turn supports a big part of APHA. Similarly there's a whole network of voluntary organizations in this country which are really AID contract extensions. Some are focusing their

activities in the health management development area.

In AID, I encountered the same kind of traditional loyalty pattern that I found originally in the Department of Health, Education and Welfare. A close clientele relationship between public health school graduates running the division of health services development and the public health intrastructure and a great hesitancy to go beyond that. Also, there is as in WHO, a physician/nonphysician split. AID's rationale for the physician/nonphysician split is that it's important to send someone to developing country who fits with their image of what an expert should look like. So their criteria for experts are--grey-haired, physician, male. Our position was that we have access to an extraordinary array of talent, well trained in relevant disciplines but many of whom were not either grey-haired or male or physicians. If AID turned to us as a resource we would put skills and the disciplinary and language ability factors ahead of those other traditional characteristics.

Furthermore, we are seen by those folks as being more management than epidemiologically oriented; more curatively than preventively oriented; more institutionally than system oriented. Therefore, you see that traditional divisions found on some campuses, in some health departments, among the national health organizations in this country and in Canada, also appear in the Agency for International Development.

In 1977, I found a man sitting behind my desk who introduced himself as an AID employee. He had come to ask our help with a major AID problem. He was from the rural development division of AID, and his field was public administration. The rural development folks had decided that AID's fundamental problem in making large investments in health development was

their lack of systematic assessments of the management capacities of the systems in which they were investing. That has led to many embarrassing situations for AID. They characterized these as building expensive hospitals or health clinics in the jungle only to return fifteen years later and find them resembling Mayan ruins. He pointed out that they made many of these large investments at the request of the country and with the endorsement of the ambassador. What the countries inevitably requested were hospitals, or the medical schools or health centers, but they didn't request help with the accounting, or purchasing, or the personnel systems needed if those investments were going to be maintained.

Furthermore, he said, "We don't know how to assess that. We've talked to many organizations and they agree that we ought to turn to AUPHA for help."

I pointed out that we did not have the resources to prepare an appropriate bid and he responded that AID had assigned him to AUPHA, if we wanted him to help prepare a bid. That's an unusual route to competitive bidding, but we did. AID subsequently provided $1,200,000 from 1977 to 1981 which supported our office of international development. During that period it was AUPHA's largest staffed group and budgeted operation.

We were at last in a position to hire a professional international development staff and to produce materials which could give us an image of productivity in the international service area. We proceeded to produce management assessment materials which are in the process of publication at this time--pretty good, too, I think.

There is no real future in AID support. Just as our contract was reaching its end in 1981, the government of the United States was changing

its priorities and substantially reducing its investment in AID. The rural people had to get out of the health area. The health people continue their original view of the world and so they are not about to follow up on the investment.

The highlight of recent international development activities was the June-July 1981 international course in Portugal. It was the fourth major international seminar in which AUPHA has been involved. I'm not counting the meetings of international programs such as the ones in Bogota, Mexico, and Tokyo. These four were intense study seminars designed for faculty members. The first one was in England in 1971, the second in Canada, and the third in Finland in 1975.

When I begin to explore the possibility of a seminar which would focus on the needs of developing countries, several ideas began to converge leading to Portugal in '81.

One idea was the notion of cosponsoring an activity with the European association. Frankly it was a way of demonstrating to the Europeans what their potential is. The second factor, and a very important one, was to respond in some cost-effective way to the increasing demand from the developing world for help in assessing the need for a program, designing a program, helping determine its content and so on. Those requests and the potential service opportunities far outran AUPHA's resources. Just the cost of correspondence with as many as ten or twelve countries at a time, was more time and more money than we had.

The notion developed that perhaps there was a cost-effective way to get all these folks together and have a sharing experience. Portugal looked good because it was their turn to host the European association revolving

meeting. They are a relatively low cost country, as far south and as far west as you can get and still be in Europe, which means they are optimally located from the standpoint of travel costs for most of the developing world.

The planning for the course was delegated by the Europeans to Dr. Donald MacMillan, Director of the Nuffield Center at the University of Leeds. MacMillan and I set out to put together a course in collaboration with Dr. Jose Caldenia DeSilva, who heads the program at the National School of Public Health in Lisbon. The most difficult problem we encountered was the lack of sources of support to bring people to Portugal who, by every measure, should have been there for the benefit of their national interest. For example, we were unable to bring anybody from India, yet there are a half-dozen institutions in India involved in health administration training. There is apparently little, if any, communication among them and virtually no contact with the outside world.

I was able to identify two individuals who could add substantially to the content of a course but I was unable to find money to bring them. Similarly there is a program in hospital administration in the Thai national school of public health headed by a Harvard School of Public Health graduate and in a school which has received substantial support from Rockefeller, AID, and other agencies. I went to the company which buys most Thai pineapples for import into the United States and was unable to get support. The support finally assembled for the Portugal course demonstrated the scope of our field at this time. Kellogg once again played a privotal role without which there would not have been a course. They provided about twenty fellowships for Latin America, Canada, and Australia which gave us the necessary critical mess. Other support came from WHO for the USSR

and Somalis, the Aga Kahn for Kenya, American Hospital Supply for Mexico, AID for four U.S. faculty, the Gulbenrian Foundation for Mozambique, the French government for Tanzania, etc.

One of the highlights of the course was the participation of Andy Pattullo of the Kellogg Foundation. Andy was about to begin his last year with the Foundation. Since he had been personally responsible for much of the world-wide development of the field, to say nothing of AUPHA itself, it was gratifying to have him see the fruit of his efforts and to enjoy the extraordinary fellowship of the event.

In the process of putting together this course, we found a new world of health administration education which extended far beyond what I had known. Through such organizations as the Asia Foundation, the China Medical Board, and the Rockefeller Foundation, we discovered educators in institutions who are operating or planning hospital or health administration programs in as far-flung places as New Zealand, Indonesia, Bolivia, the Middle East. The field, clearly, is on the verge of immense international growth.

Portugal saw fifty-five people from thirty-one countries work together for three weeks. Even the Russians sent two senior people. It was, in a way, the culmination of all the years of AUPHA effort in the international arena. Because in the end, WHO came in as a cosponsor along with the European Association. So it was an activity in which AUPHA and WHO collaborated, finally.

A number of foundations provided sponsorship, hopefully leading to longer term relationships with them. A very good example is the Aga Khan Foundation. I just spoke with their office in Paris on Friday. They called

about information on health administration training in Bangladesh. The conversation led to the possibility that we will work with them to develop a seminar for administrators in their institutions in Kenya, Tanzania and Uganda.

That's illustrative of a much broader spectrum of relationships that Portugal moved ahead. It also underscores the paucity of support for responding to this tremendous opportunity to help countries use resources better through management. It underscores the frustration of being positioned so that I see the need and the opportunities and not the wherewithal to respond. That's a source of great personal frustration.

Kellogg has put emphasis on the development of the European association. I am afraid that ultimately there is a competitive situation developing because of limited resources. It is inevitable that the European association will see the same advantage as I do, positioning itself as an international resource to attract resources.

WEEKS:

I wonder how much of this is Bob DeVries' interest in the European association? Didn't he go to Australia with the IHF? Maybe he'll come back with a little broader viewpoint, I mean, want to extend this European thing to other parts of the world.

FILERMAN:

He may very well. You can already see some of the tensions that are developing. For example, in the United Kingdom the Department of Health and Social Security has told the institutions which participate in the national health management training scheme that they are limited to 250 pounds a year in payments to external organizations. For the European association to

survive it has to raise dues to a high level compared to ours. They are now asking for a dues increase that will put them at the 200 pound level. The English schools that belong to the AUPHA will either have to find other funds to pay our dues or make a choice.

The problem for the English schools is that it makes sense for their highest priority to be a part of the European association. But we also need a world-wide network and they need to be a part of it. Unless they pay their part of the bill, we can't succeed. AUPHA is the only organization that is positioned to be the nucleus of such a network. I believe strongly that AUPHA should expand and nurture that world-wide network.

Next year when we launch our new journal of health administration education, I know that some leaders in the European association will be angry. They will feel that it is inappropriate for AUPHA to publish the international journal. I'm afraid that it is exacerbated by Kellogg's view at least informally, that the world should be somehow divided between the European association and AUPHA, that the European association should become a parallel to AUPHA. But I see little prospect of that.

WEEKS:

It this a fear of all the eggs in one basket, do you think?

FILERMAN:

There was a period a few years ago when it was popular to try to develop indigenous organizations everywhere in the world and to remove Westernized or American initiatives from leadership roles. That is an appropriate kind of rethinking. But, I think in this case, it's confused, because of lack of options, among other things. There may be a future for a European association or a Latin American association, but I think it has to come as a

spinoff or from some kind of a confederation rather than replicating this model.

In Europe there is a small number of programs. They are very heterogeneous. Many of them are part-time, night school operations with little in common with Louven or Leeds with their full-time faculty and master's degrees. It will be very difficult for the European association to develop a series of projects which serve all of those kinds of institutions. Furthermore, they are building in, by necessity, the realities of working in a multinational environment where the French insist they operate in French, the Spanish insist they operate in Spanish, etc. The Flemish Belgians and the French Belgians are acting out four hundred years of cultural battles which exist between two programs in health administration. That, too, comes into the association.

It isn't to say it cannot survive and doesn't have a necessary function but its horizons are limited. Until more realistic horizons are reached that take it beyond those kinds of considerations, I believe, at least, that AUPHA can make a useful contribution to Europe within our world-wide function; in addition to what the European Association does and not necessarily in competition. One of the issues for AUPHA as for other organizations that have enjoyed the largesse of the great foundations is the question of how responsive is one to the views of the other?

WEEKS:

This is the difficult position you're in when you have to depend on soft money to operate and to do the things that you know need to be done.

FILERMAN:

That's right, in spite of AUPHA's financial difficulties, my highest

priority is to develop a million dollar endowment. It would not meet all of its operating costs but would give AUPHA the venture capital to start activities independently of the availability of funds from an outside source.

We have received a modest amount of support from industry since 1965. Ray Brown, George Bugbee and I, very early, worked on a system of going to the health industry and asking companies to contribute a modest amount each year to operational support. The amount has stayed the same and some companies have dropped out and others have come in, but of course, it's decreased as a porportion of our overall operating budget.

One of the people I met in the process of fund raising was Foster McGaw, the man who founded the American Hospital Supply Corporation. In 1966 or '67 I went to the American Hospital Supply Corporation for what for us was a large grant, $5,000. They had been giving us $1,000 a year, for a couple of years. To my pleasant surprise the response I got was $150,000 in stock in the company from Mr. McGaw. That lead to a personal and very pleasant relationship. And it also was the first of a number of gifts which have exceeded a million dollars. The funds have been divided between general support of which $250,000 is committed to the endowment effort, $550,000 for a Mary and Foster McGaw Scholarship Fund and a more modest amount which the corporation now maintains annually, which provides fellowships for faculty members from our international affiliates to come to North America. We have built the $250,000 up to $400,000 in the development fund. I am spending half of my time in the corporate community attempting to raise money for health administration education through AUPHA.

I'm discovering some interesting things. First, there is among corporate contributions leadership little appreciation of the role that

management plays in health services. Corporations make large contributions to train doctors, cure diseases, and build buildings. They do not ask themselves whether the resources are being used well or whether the health services system uses the same management skills which these corporations epitomize and so value in their own activities. That's changing slowly as corporate leadership realizes that health costs as a total and as a proportion of benefits are increasing and will continue to increase and perhaps they could do something about it. That's the grounds upon which I appeal to them.

I tell them that they can contribute to the effort to contain costs by helping us strengthen the management of health care delivery organizations. In doing so, I take a position which my colleagues in practice might find some objection to, which is basically that the health system is not very well managed. I say to them that they should not mistake the management they see in the large urban medical centers as being typical of the management competence of the system as a whole. That substantial number of institutions, maybe more than half, do not have adequately trained managers either in depth or in breadth.

It is probably particularly true of the small towns in which they have plants. In many of those communities, we're talking about the two largest employers--company x's factory and the hospital. Every time the hospital needs more money, it naturally turns to the company. Every time somebody in the company misses a day's work they are in that hospital. Yet company X has probably never directed its attention to the quality of management of that institution. I contend that if they did look at it, in many cases they would not be pleased with what they would find.

Secondly, I point out to them that the discussion about competition, which is current, is in a way hypothetical because there is limited management competence which can create effective competition in alternative delivery systems. For example, in home health agencies, which can keep people out of the hospital, or get them out faster, there is very little trained management. The HMO field is stymied in its growth, in part, by the lack of qualified management. Preventive initiatives will be thwarted by the constant drain on resources for curative activities until a new generation of managers is trained who also have a commitment to prevention. Further we must train management for preventive services with the same entrepreneural skills which have paid off for the large community hospitals. They then have a stake in AUPHA's effectiveness, and should invest in us.

So far it's not going very well. But as I go along I'm learning more about the process and, I hope, increasing the effectiveness of the appeal. We have been able to attract a certain degree of support from the insurance industry which readily sees the direct relationship to their interests. It is an appeal which should make sense to the labor intense industries. But, in any case, we are on a path which is somewhat independent of our industry, pointing to its weaknesses rather than to its strengths.

We are also going to expand our personal membership base. We know from previous experience that many management people are interested enough in education to want to be on our mailing list, keep informed of educational development, have an opportunity to participate in international institutes, annual meetings, and so on. We have lacked the appropriate materials and internal systems to handle an expanded personal membership. We now have a

booklet about AUPHA, which was produced as a contribution by the Equitable Life Insurance Society and the American Hospital Supply Corporation. We will upgrade our informal journal called Program Notes to a more professional international journal of health management education. When that is implemented, we plan to pursue, aggressively, personal membership in AUPHA.

That, in turn, creates still another potentially competitive interface because AUPHA is going to the individual administrator in competition with his or her alumni association, in competition with the College of Hospital Administrators or Nursing Home Administrators, and making an appeal for membership dollars.

Up to this time, the ACHA has discouraged us from doing that. That was when Dick Stull was there. Whether Dr. Wesbury, a former chairman of our board, will feel that way or not, I don't know. History will tell whether AUPHA was constrained in any way by pressures from the membership organizations not to compete with them. If AUPHA is constrained, it will be up to the membership organizations to provide the support that otherwise would have been forthcoming.

WEEKS:

Do you want to start to talk about the Kellogg study?

FILERMAN:

The Kellogg study was one of a series of systematic looks at the needs of the field that the foundation has sponsored. The first was the Prall Report in the 1940s, followed by the Olsen Report in the 1950s. In the late 1960s the dramatic changes in the field led to the conclusion that some guidance to the foundation, if not to the public was again needed. The

major reasons were those which we have discussed. The proliferation of programs, the change from hospital to health, the growth of undergraduate and non traditional education, all contributed to an environment ripe for a leadership commission to address the desired future.

Once again, it was Andy Pattullo who sensed the need and the potential for the Commission. He approached Jim Dixon, the President of Antioch College, to serve as Chairman. Dixon, a physician and program graduate, former Health Commissioner of Philadelphia and Denver, is an individual for whom the Foundation has respect, and a man who has a reputation as an educational innovator and entreprèneur, par excellence.

Pattullo and Dixon, approached me early in the discussions about the organization of the commission. They suggested that I resign from AUPHA and become the Director of the Commission, envisioned as a two to three year assignment. I was interested, but troubled. I didn't feel that it was a good time to leave AUPHA and further, more pragmatically, I didn't know where you went from being a commission director. It had to be some sort of a transitional step toward something, and I couldn't see something specific.

In one of the early discussions about what the commission should do and how it should be organized, I put forward the position that the most fundamental need for any commission was a data base. The pace of change was such that the commission's effectiveness depended to a great extent on its ability to base its recommendations in hard data, much of which was lacking.

I developed then, two conditions for my own participation. One was that the first job of the commission be the development of a data base and the second, that I have some voice in selecting the members of the commission. The model that I put forward was that the commission should, under a small

steering committee, devote its entire first year to data collection and only when the product of that process was in hand should it begin to address the questions facing the field. That idea was rejected. Jim Dixon's idea was to move much more quickly into debate about the issues and alternatives. I saw that debate as being essentially a political one in the absence of a data base, or an ideological one, at best. I felt that the prospects for the commission to have real impact would be severely limited under those conditions, and on that issue, withdrew.

I suggested that they talk to Charles Austin, who was at the University of Colorado. In doing so, I made the biggest contribution I could possibly have made. Chuck Austin is an eminently qualified and sensible individual, who managed that commission with statesmanship and furthermore has gone on to provide real leadership in pursuing the objectives of the Commission, if not its recommendations. He has made a number of important contributions to the field, building on that experience.

However, the Commission itself didn't contribute as much as I hoped it would. The foundation did not develop an explicit program around the product of the Commission. There is some tendency to take foundation investments in retrospect and to rationalize them into a related series of events. It takes some effort to do so, when attention to the principal recommendations has been left out, particularly the recommendation that there be established centers of excellence that could focus upon the faculty needs of the field.

There is no issue more generic to the development of health administration education than the lack of appropriately trained faculty. Besides the problem of faculty depth, all others pale. Little has been done

in recent years about the question. Even after two follow-up task forces were created by the foundation to advise it on implementation strategies--one on nontraditional education and one on centers of excellence--there has been no follow-up.

So what I consider to be the most pivotal recommendation in potential impact and identifiable strategy for investment has been ignored. And that, in turn, weakens the ability of the field to respond to the other recommendations of the commission. On the other hand, the commission developed an important body of literature. It conducted a series of informational and fact-finding activities which produced a body of knowledge and made it available in a way which was an important contribution.

The commission had no impact on federal policy. AUPHA was able, in making our case for federal support of health administration education, to make extensive use of a single "finding" of the commission. But it is not well based in data, namely, that 75% of the occupants of managerial jobs in the system do not have appropriate training for their responsibilities. I attribute that to the Kellogg Commission, but I am always hopeful that I am not questioned about its authenticity.

Other than that, my conclusion about the Austin report, is that it was not as instrumental in influencing the field as were its predecessors. Is that a self-fulfilling prophecy? The critic could say "yes," because, if any organization had an obligation to respond to the commission, it is AUPHA. If I had a limited view of the commission's impact, potential, or wisdom, which I convey to my constituents, that would predispose the environment of receptiveness.

WEEKS:

I came away from a meeting of the commission with the impression that the people in this commission were so diverse that there was no way of reaching a consensus and that many of the people who were there didn't understand the problems of education, they were there representing some faction of the population without any ability to enter into the discussion of an educational policy. It seemed to me that the outcome of the publication itself very plainly showed they couldn't agree on recommendations except the innocuous kind that everybody would agree to.

FILERMAN:

That's a fair observation. I mentioned that my second reservation was the composition of the commission.

WEEKS:

By the way, I talked with John Millis, who has made many studies. One of the questions I asked him was, "How do you get together a commission and make a study and have a final report in the short time that you have taken? How do you do this? How do you get these prople to agree to work together?"

He said, "Well, the first thing is, I select my own commission."

He got people who could work and people who were capable of evaluating the situation, whatever it might be.

FILERMAN:

I think Jim Dixon would say that he got people together who reflected his idea of a commission. Jim has a very egalitarian view of the world. He reflected in the commission the conventional wisdom of the period about the importance and value of a broadly representative body. But the question is how appropriately representative that composition is to a given situation.

For example, the commission became locked in early to a definition of health administration which included environmental services. That may be appropriate in a total worldly view, but it was not an appropriate definition for the range of activities with which the commission was concerned. It was the result of including on the commission an individual who represented that persuasion, and had no exposure to health services administration education or health services administration having to do with physicians in medical care delivery. So that diluted the effect of the commisson and expanded the generalizability of its statements.

WEEKS:

So nothing really has come of it more than a review of the situation?

FILERMAN:

Not very much has come of it given the size of the investment. But the story isn't over. We may see more work in the nontraditional area. I don't know what's an appropriate time frame for implementation for that kind of a commission's recommendations.

WEEKS:

But, it's been six or seven years and things are changing all the time.

FILERMAN:

That's, of course, true, but the conclusion relative to the need for a few centers of resource concentration at a sophisticated level has borne up.

WEEKS:

Yes. Well, maybe this goes back to George Bugbee's idea of the institute of hospital administration.

FILERMAN:

Yes, as one type center. I think HRET, from time to time has been

viewed as potentially the nucleus of that. In fact, there was a center, combining Northwestern-AHA-HRET, some years ago. It's hard to conceive of that kind of a center succeeding outside of an academic environment. But the way things are going now, it's hard to conceive of it succeeding inside an academic environment. The resources just aren't there. Only a foundation could make it possible.

WEEKS:

It would seem that it's a possibility that Kellogg would someday consider this as a necessary result of this commission if they agree with the idea.

FILERMAN:

I hope so. I hold out the hope that the period of judgment as to the commission's impact is not over and that we still may see some fulfillment of that idea in particular.

In the late sixties when Larry Hill was the president of AUPHA, and we were in Chicago...Larry and I approached the Brookings Institution in Washington with the notion that AUPHA establish an interuniversity center for research and doctoral training, in collaboration with Brookings. I had been at Brookings in '61 and I knew that Brookings owned some real estate nearby that might serve as such a center. But Brookings was not interested in that much commitment to an applied field.

I think there is merit in universities sharing a research center. There are some very good examples in the United States of such centers. Mount Palomar was established because of an expensive piece of equipment and the Brookhaven Laboratories were established because of the necessity of sharing a federal contract. They demonstrate that a consortium among the

institutions of higher education, properly managed, has viability.

There is a need to create access to such centers for scholars from institutions which are not directly involved in these issues. For example, I am contacted periodically by faculty and graduate students in fields like economics or sociology from universities which have no health delivery related activities.

These individuals have research interests, either pre- or postdoctoral which demand work in such a setting. They are looking for advise on where to go and how to make it possible to do it--sometimes looking for introductions, sometimes asking for support.

What I've become aware of is that there is a group of talented young people at the pre-doctoral level who are turned away from applying their discipline to health-related problems because they are unable to find a thesis writing situation in which they will have supervision and work with people who know the environment. If there was such a multi-university center, it would provide a place for those people to go, and thus not lose their talents to the field.

There is now a problem in Canada and the U.S. of an oversupply of faculty members trained in the social sciences. At the same time, I have just described a shortage of faculty in the health applications of those same social sciences. Therefore, we have a kind of production imbalance.

It would be much less expensive to provide a year of postdoctoral orientation to health services delivery than to provide complete training for a young person to develop a Ph.D. in medical sociology or health economics, or political aspects of health care. The lack of such centers, or at least, of a center, either multi-university or single university,

forecloses a number of options for important developmental efforts in field.

I have often encountered the lack of an appropriate place for a foreign scholar to work, for example. It's the same problem. So the commission was on target. The field, the institutions, the donors, the governments, AUPHA, we have all failed to respond. Now with federal financing for health services research being collapsed at such a rapid rate and a number of the federally supported centers for health services research closing, the outlook is even dimmer.

WEEKS:

Well, you need outside money, there's no question about it.

FILERMAN:

It's interesting to reflect on the mission that Hill and I undertook to Brookings, because it was a forerunner of AUPHA's move to Washington. We were originally housed at the University of Chicago. At one time I explored the possibility of moving to the AHA. Dr. Crosby thought that was a good idea, but what he offered was a desk in a large room with secretaries, which was not exactly what we had in mind. It was fortunate that there wasn't a meeting of the minds then, because it would not have been good for AUPHA to be seen as an appendage of the AHA. But, for a short time, that looked like an attractive possibility. I also explored with Dr. Crosby the possibility of opening a multi-university center within the AHA. It was then that I learned, for the first time, that he had already made an agreement with Northwestern that the AHA and HRET would develop a research center at Northwestern which would serve the interests of the field as a whole.

It was a shock to the people at the University of Chicago when they learned about the AHA plan, because they had not been aware of any desire on

the part of AHA to do something of that variety. Mr. Bugbee, with some justification, felt that as a former director of the AHA, it might have been appropriate for the Center for Health Studies at Chicago to at least have had the opportunity to bid on the special relationship with the AHA. But they were not given that opportunity on the ground, Crosby later explained, that the AHA sits on Northwestern University land and therefore has an obligation to develop a special relationship with the university.

In outlining his plans for Northwestern, Dr. Crosby rejected any notion of AUPHA establishing a center in that building along the lines of the multi-university center that Hill and I eventually talked about in Washington.

In 1968 I learned that the American Council on Education was about to build a building in Washington as a national center for higher education. I found the idea of moving to that building very appealing. By that time I was spending a considerable amount of time in Washington lobbying for traineeship support for health administration students. The Accrediting Commission had begun to operate and was part of the higher education accrediting machinery. Our international activities were bringing us into contact with PanAmerican Health Organization and other Washington organizations. In general, we were establishing, for the first time, a pattern of working relationships with other organizations in the higher education community, most of which were based in Washington.

I approached both ACHA and AHA with the notion of making a bid to get into the new building. I don't remember any response from ACHA, but Dr. Crosby was angry at the suggestion. He told me that the voluntary health sector needed to maintain its power base in Chicago, as a counter balance to

government. He said that the AHA was the focal point for those activities and that the AHA family of organizations should be close enough to collaborate actively and the last place they should be was in Washington.

To underscore his concern, he told me that if we insisted on pursuing the idea that he would terminate the $5,000 a year annual support to AUPHA which started in 1966. $5,000 was a big chunk of our budget. I went to Walter McNerney, who I felt had a broader view of AUPHA's role and potential and would be sympathetic and told him about the conversation with Crosby which had disturbed me deeply. Crosby had laid down the law and, for the first time, had in effect said that he was calling the shots. McNerney told me to go back to Crosby and tell him that if he cancelled the $5,000, it would be the most widely publicized event in AHA history. And furthermore, he, McNerney, agreed to talk to Crosby and to strongly tell him that where AUPHA was was not his business.

That is typical of the help that McNerney gave me at a number of turning points. Well, I didn't go back and tell Crosby what McNerney had suggested but I did simply go ahead, with my board's approval, and arrange to move to the building in Washington. Crosby didn't cut off the $5,000. I am sure that McNerney talked with him.

Being in One Dupont Circle has been of great value to the field. Ironically, I expect that within a year we will be out of One Dupont Circle. They have made plans to reallocate their space, have set new priorities. We need more space and we're a low priority to them and we need to save money. So for a variety of reasons, AUPHA will relocate.

But the decade in One Dupont Circle has been good for health administration. It has brought a recognition to the field by the higher

education community and opened innumerable opportunities for us to participate along with the more well-known professions. It has given us a seat at the table in activities relative to Congress, in higher education policy committees, even in discussing such issues as the role of the National Intercollegiate Athletic Association in setting academic standards. AUPHA has been represented, I believe, because we've been part of the National Center. By moving away we don't lose a lot of that because we've established ourselves. But at a critical time in the history of our evolution as a well-established educational endeavor it was a positive factor. On several occasions, important people have dropped into our office only because they saw it on the list downstairs. At least once a foundation officer dropped in, who had not known there was an organization in our field and it led to an eventual grant to one of the programs. So it was worth the stress in making the move out of the AHA family arena in Chicago. The prestige of being in the building has been an asset, no question about it.

I mention McNerney in relation to the Crosby decision. I should say that behind the scenes, McNerney was a consistant contributor to the effort to develop AUPHA as a strong independent organization. In the early period, when I first came on board, he made available the considerable technical skills of the staff of Blue Cross Association. They helped us with publications, printing, consulting on our bookkeeping system and anything else I needed. They also contributed financially.

In later years, McNerney has helped by providing fund-raising leads, by opening doors behind the scenes to potential donors, and most of all, by being a very good role model. Many times I have pointed to Walter as a graduate of one of our programs and as an example of the kind of leadership

which we hope we are producing more of. Also, I have used him as a sounding-board for both personal decision making and organizational policy formation. He, early on, established the principle that he had a direct phone number and would always be responsive when I called. I didn't do it often, but he was always responsive. Frequently critical, even occasionally angry because, in my free-wheeling style, I crossed him more than once. But always supportive. Clearly, one of the individuals like Pattullo, Bugbee, others who are the builders of AUPHA.

I have often felt that the programs, electively, have not done for Blue Cross or the prepayment field what they could and should be doing, either in steering graduates to careers in those areas or helping with the management of those organizations.

Generally, they have tended to look at prepayment as money machines, not seeing them as a partner in the delivery system. Maybe AUPHA hasn't done the job it should in opening up those horizons.

WEEKS:

We were going to talk about minorities, too.

FILERMAN:

In 1970, Haynes Rice and his colleagues in the National Association of Health Services Executives, NAHSE, a black group, became concerned about the lack of sufficient minority, really black, participation in the programs.

It was an era of militancy and that group, which was primarily New Yorkers were being militant on a number of fronts. They were pushing for more black administrators in the New York City system. They were trying to protect the role of the hospitals that were serving a primarily black constituency. They were knocking on the doors of the programs, around New

York and others nearby, pressing them to take black students. And then they started knocking on my door and saying, "What are you doing about the lack of minority students in the field?" Their diagnosis was correct. The number of black students in programs in the late '60s was infinitesimal. The explanations were the typical ones: no applicants, they can't pass the tests, whatever.

I remember more than one confrontation in my office. Haynes Rice would call from New York City and say, "I'm going to come down and see you on Tuesday, at four o'clock," and he would walk in with thirty people, all black and would they give it to me! They wanted action. I'm unclear as to exactly what the genesis of the idea was but Haynes, Robert Detore and I responded to that pressure by putting together a program which would offer minority students summer jobs in hospitals and start them toward careers in health administration. Detore had joined our staff just before that as director of our student recruitment program. He was the perfect man for the job, an aggressive, creative activist and a genuine humanitarian. He got along very well with the black leadership. He became the spearhead of this effort.

We began in New York and Baltimore because that's where NAHSE had a cadre of individuals who could help. They helped by setting up a local selection committee and also by putting pressure on local administrators to take students for the summer. I was to set out to find money for stipends. I started out by going to the Commonwealth Fund, because the fund had helped AAMC with minority activities. I obtained a quick $5,000 grant from Quigg Newton, who was the director of Commonwealth. That was quickly followed by a grant of $15,000 a year for three years from the Weir Family Foundation.

Building on those two grants, and on the experimental program in Baltimore and New York in the summer of 1970, we developed a program which is today still operating, 1981. At its peak, it operated one year in twenty-six cities and it has provided summer opportunities for over 1,400 young people.

That program became the nucleus of a broad minority effort. But the interesting thing, politically, is the way that it fell to us to do it on behalf of the field as a whole. The real issue has not for several years been admission to graduate school. The issue is placement of graduates and advancement in practice. Those are issues with which AUPHA has very little influence.

The summer program was eventually well-supported by Kellogg, Johnson, the federal government, Blue Cross, AHA, the Veterans Administration and innumerable local foundations. At least 50% or more of the stipend money had to be raised in each community. In Chicago, for example, the Wiebold Foundation was a major source of support. In San Francisco the program has been successfully run for several years by the Association of Young Health Administrators, and they raise all the money. The Veterans Administration continues to give us two places, fully funded, in every city where we operate and in which VA has a hospital.

Outgrowths of that are a retention program funded by Robert Wood Johnson, which sees students through more advanced study and a minority student loan and scholarship program which has partially financed the education of over 100 students. The enrollment of minority students has gone from something like 5% in 1967 to 13%-15% now. The situation has changed remarkably, although there are clouds on the horizon, for many

reasons.

The weak aspect of this activity has been really in terms of interorganizational relations and support. The week that Dr. Crosby passed away he decided that the AHA should take over those programs. And, in fact, Dan Schechter was in my office as an emissary from Dr. Crosby to tell me that when he was called about Dr. Crosby's death.

NAHSE at no time picked up on its opportunity to be a full partner in the operation of that program. The future of that orgnization is very uncertain. I believe that the summer program is a solid accomplishment, but I believe that could have been a better accomplishment had NAHSE contributed energy and money to making it work. It never contributed any money, and its energy contribution was limited to two or three cities in which there were active chapters.

As a national project that would have engaged the energies of black leadership. I don't think it could have been matched. We always held out the opportunity and kept NAHSE's name on the programs, as if they are in fact a viable cosponsor. It's a source of disappointment that they have not been.

Another issue has to do with the involvement of other minorities beyond blacks. For a time there was an active group of Puerto Rican administrators in New York City. When we reached out to involve them in the management of the program, NAHSE objected. That highlights the tensions between the Latino community and the black community in New York City for jobs, power, and prestige.

We also directed the attention of the program a few years ago to the chicano population in the Southwest and to the American Indian population,

we had been relatively successful in opening up enrollment for blacks and needed to concentrate on other under-represented minorities. So we took the program aggressively into Los Angeles, San Antonio, Oklahoma City, and some other communities.

During the early seventies when there were the vestiges of the OEO programs, there were community organizations to work with that could find us students, and sometimes find some support. All has disappeared, that whole infrastructure has gone. AUPHA has to carry the ball alone, with the help of our programs. We always try to put the summer program where there is a member program of AUPHA that provides an organizational base.

We've not been notably successful in the chicano and Indian communities. Part of that has to do with the sociology of those groups. Part of it has to do with operational problems of the program. Its first staff leaders were white, its last two staff leaders have been black. White leaders and black leaders don't have the necessary rapport with chicanos. But on the other hand we can't have a leader from every group we are trying to serve. We will be lucky under current financing if we have any leader in our office to carry on this work.

But, the field generally had failed to come to grips with what to do with the influx of talented young minority graduates. Many of them are finding good jobs in public systems or in organizations that provide services to the industry. A disproportionate number of minority students have found high paying jobs in the consulting field, for example. The big eight and the management consulting firms have bid successfully for the outstanding minority talent. The foundations have also hired minority program graduates. There has been some discernible improvement in the

breadth of positions which they are occupying, but not enough.

It has been discernible enough so that it has taken the wind out of NAHSE. That is, when black leadership can make it on equal terms in ACHA and AHA, MGMA and other organizations, the motivation to devote a lot of attention to a black administrators group is low. The black administrators as an independently identifiable group pressuring for change has been diluted. Perhaps now, in the Reagan area, with the collapse of many social institutions, job opportunities and services for the poor and so on, the militancy will resurface. It does have a way of getting things done.

But, as a field, we have not a very good track record. The fruits of AUPHA's recruiting efforts are only beginning to be felt in practice. The summer program started eleven years ago, so the maximum that a graduate could be out who was recruited through that means would be nine years. The overwhelming majority have been out five years, or less. They have not yet begun to surface as competitive for top jobs. But they represent a strong group of young people who are going to do well.

WEEKS:

You've had a noticeable increase in women, too, haven't you?

FILERMAN:

Yes, there are programs which are more than 50% women and I have been told by program directors that if they were totally blind in their admissions and ranked people only by academic promise, they could have 75% women.

The biggest placement problem is women. Most boards of trustees have a difficult time envisioning a woman in a position of authority vis-a-vis a medical staff or a community power structure. There is no evidence of an

increase in women participating in the leadership of the professional colleges, with the exception of the College of Nursing Home Administrators, because women have managed so many nursing homes.

I'm not sure how the field leadership can get a handle on these problems. In the sixties, when there was the militant black leadership group to respond to, I couldn't see clear avenues for action by the AHA or the American Nursing Home Association or other groups, and I don't see them now. The one thing that such organizations can do is to promote women's roles in their own activities and thus give visibility to leadership, who then by implication would be seen by boards as having the respect of their peers. But that's not many opportunities. I don't see the options clearly.

On the other hand, I have not been a party to much serious talk about this issue. In other words, maybe we've pointed to the summer program as action, as evidence that we are doing something or that we're doing all we can. So in a way it has let us off the hook and we haven't had to go a lot further looking for ways to have impact.

WEEKS:

Then you have the problem of striking a balance between graduates and job placements. You'd be in a very embarrassing situation if you were graduating a lot of people you couldn't place.

FILERMAN:

There was a time when it was accepted that the obligation of a program was to place its graduates. Today, there is a different view, that is at least as influential. As programs have matured, their new leadership has not had the placement network of personal contact that the old leadership depended on. Secondly, there are programs imbedded in schools or

universities which have an institutional policy against accepting the responsibility for the placement. They do not consider that to be an appropriate role on the part of the university.

WEEKS:

Well, most disciplines don't place graduates necessarily. They may make arrangements for interviews and things of this sort, but that's about the most they do.

FILERMAN:

That's right. And of course, we are the inheritors of the tradition of the early days of this field. It would be inappropriate in today's academic and professional environment to expect universities to relate their placement policies to their admission policies.

WEEKS:

I suppose you could take a long view of this and say, well, by giving a placement service or at least having some kind of placement ability, you are building a stronger alumni association, a stronger loyalty to the school, and in time it might help your endowment fund, you see? That's a roundabout way of looking at it.

FILERMAN:

That's one way of looking at it. There are schools and faculties that would strongly endorse that and it's a high priority on resources. But the opposite persuasion exists as well.

There is another perspective and that is, what's good for the field? That may lead us to a different conclusion, namely, the more open the field, the broader the market place, the more likely it is that an optimal match of job and individual will take place.

WEEKS:

At the present time approximately how many graduates are there from master's degree programs?

FILERMAN:

A couple of thousand.

I've always felt that for a single university to have an inside track to a particular institution is a disservice to the public served by that institution. I remember giving a talk to a group of administrators after which I was assaulted by the audience for taking the position that there was not an oversupply of graduates. Their evidence for oversupply was the number of applicants for job openings.

WEEKS:

Looking at the number of hospitals, thinking in terms of hospitals?

FILERMAN:

That's one dimension of it. They were saying that when they made a job opening public, they received a hundred or two hundred applications. They would prefer, they said, the system some of them still had of not publicizing the opening and just calling up their alma mater or one or two schools and having them send two or three names. They have their values turned around. When they have two or three hundred applications they are given the optimum choice and the institution has a better chance of finding the best talent. The public is better served by the open competitive model. Through the closed system, university "x" makes sure that everybody who graduates has a job no matter how marginally competent. On the open market, individuals are going around looking for jobs who are far more qualified than some of those individuals universities are protecting by

handing them off to their friends.

There are many people in this field who ought to be doing other things. An open, more competitive environment, with less closed systems controlled by individual university/employer relationships will inevitably work to the benefit of the public.

WEEKS:

You reminded me of the "old boy" network that was present back in the Hamilton/Bugbee/Mannix days when they would just get on the phone and call the other boys and say, "I have an opening down here, do you know someone?" This is a little more personal than calling up the university....

FILERMAN:

It's an extension of the same period and the same process.

WEEKS:

So you were nearly assaulted?

FILERMAN:

Yes, they were furious! They were indignant that I could take the position that there might even be a shortage of graduates, which I would still argue is the case.

WEEKS:

If you expanded the field to cover all the facets that could and should be covered by trained people? Has the field begun to accept this idea yet? Are they still assaulting you?

FILERMAN:

It continues to be troublesome. It's one thing to accept it intellectually but it's another for an individual administrator to be looking for a job or to feel that it's time to make a change in his or her

career and find the market "flooded." At that point, they feel that they're not advancing because we're producing too many people, not because they're not competitive.

WEEKS:

Maybe they are just overwhelmed by two hundred applicants, just to process two hundred applicants might be frightening to them.

FILERMAN:

It is, but it's not frightening to General Motors when they are looking for a division manager.

WEEKS:

But you see, most of our people haven't begun to think like Mr. Sloan and all of those.

FILERMAN:

They have to. The organization of services is moving very rapidly in that direction. It doesn't only affect the market place for managerial talent in the numbers sense, but it has profound effects in the skills sense.

WEEKS:

Well, what do you think about going through an intermediary, going to an agency or a head-hunter? It this a better way of doing it than screening all the applicants yourself, or having your personnel department screen all the applicants?

FILERMAN:

It's not an important distinction. It's another service that management can buy to extend its abilities to cope with a need. Certainly there's a place for those kinds of activities and services. They can be quite helpful, although I have a disagreement with the firm which is the most

visible in the field, in Oak Park, Illinois. The president of that firm frequently has written and spoken about his view of the overproduction of graduates and, I think, performs a disservice because he is referring to the market in which his firm operates, which is not the whole field of health administration. That reflects the problem that I am talking about.

We have the same problem in our relationships with the American College of Hospital Administrators. As we sit here, it is only two months after the meeting in Philadelphia where the effort of ACHA to change their name from hospital to health was defeated. That would have been an appropriate change in terms of the direction they are moving in, but even by changing their name, it does not accomplish the fact that they represent the health field.

AUPHA must relate to all of the professional organizations that represent places in which graduates work, and particularly to those places where graudates will work more in the future. ACHA's view of the market is different than that of a field like group practice which is looking for program graduates, in which the leadership says to us, we aspire to further professionalize management in the group practice environment. How can we encourage more of your graduates to look this way? Now there are obviously two very different views of the market place.

AUPHA must relate effectively to the leadership of both of those components and to others if we are going to produce and place a graduate who can relate to the broader health care systems that are developing.

By 1990, there are going to be very few free-standing hospitals in the United States. Furthermore, the multihospital systems that we see so many of today, will also have faded. I think they are a transitional form of organization.

WEEKS:

What's going to happen?

FILERMAN"

What we will have will be comprehensive health plans which will resemble organizationally the Kaiser model. I'm not sure they will be HMOs, because a) they will have far more emphasis on prevention and on supportive services outside of the health care institution, such as counseling in nutrition, fitness, aging, and offer more home health and supportive services in the workplace, in the home, and in the school.

WEEKS:

Would we still have fee-for-service?

FILERMAN:

Yes, I think there still will be a place for fee-for-service. But there will also be a greatly expanded contract for service.

What will move organizations in that direction will be employers, unions and governments, which will come to realize more than they do today that cost is the result of the health status of the community. Health benefit costs are only part of the picture. Another part is sickness days lost. That part of the picture includes the thousands of work hours that are lost because of dental needs, or the hours that are lost because a parent is concerned about an old person at home, or a child with a drug problem. These employer or union groups are going to start buying their health care from organizations which offer the best track record in terms of reducing illness days lost and supportive services that in turn improve productivity. These are nuts and bolts, dollars and cents, productivity issues.

WEEKS:

Well, something has got to happen because the costs can't be contained, insurance costs must be a terrific part of the fringe benefit of every large employer.

FILERMAN:

I visited a corporation which has had its health insurance costs go from 53 to 102 million dollars in a twelve month period. That company has become sophisticated very quickly about health costs. It has hired two health economists to analyze its problem. As they get into that analysis, they cannot help but conclude that they've got a direct stake in the system and that they better start buying their services from the organization which prevents the most illness and keeps people out of the hospital.

WEEKS:

If these people buy this care wholesale it will mean that the physicians won't be practicing so much defensive medicine, won't be ordering more tests than they really need. Or do we have to find an answer to malpractice insurance premiums first?

FILERMAN:

I don't know the answer to that. Controls on practice and on expenditure generation will have to increase markedly in order to keep those delivery organizations competitive with each other. The internal controls generated by that environment will make any controls that the government ever imposed look very loose, by comparison.

WEEKS:

This had to be done, or maybe the health system will be nationalized. I'm not offering that as a solution, but as a result that might happen.

Nelson Cruikshank, the labor man, told me that he had never been in a hospital until just recently and he was in for nine days and the bill was $12,000. This just can't go on. Our society can't support this kind of expense. Something has to give, as they used to say.

FILERMAN:

For the employer, the present situation is a no-win situation. One company I know believes that the availability of appropriate health service can be a competitive advantage in attracting and holding employees. That's another element of potential employer interest. Under these circumstances systems that take total responsibility for health status, rather than responsibility for a four day illness, are going to require a much different kind of management perspective than we are producing now.

WEEKS:

What are we going to do about the social ills that cause us to be ill such as smoking too much, drinking too much, eating too much, among other things? Alcohol and automobile accidents, that kind of thing?

FILERMAN:

That's part of what I was talking about in terms of the broader preventive role. In New York City a group of employers are working to set up a counseling service for their employees whose children have drug problems. They realize that the company bears the brunt for every day a mother goes home to look after the child, or the stress that the parent feels on the job.

It's interesting that firms are getting together to work on that problem. It means that the problem has escalated to the point where it has their attention. It is claiming some resources in competition with

everything else, including profit.

That's our business. That's health administration instead of hospital administration. Hospitals have the opportunity to respond to that demand because they have the resources, they have the access to the expertise and they have the management. If they don't through, alternative systems will develop that will isolate the hospital as a service to the larger health system, not as the focus.

WEEKS:

Howard Berman, in a speech made at the Michigan Alumni Association meeting the other night, was talking about some young administrator in Brooklyn, I think it was, who took over a factory and made a hospital. He even has been concerned about housing and made arrangements so that some of the housing in the area could be renovated so that people would have a decent place to live and be less likely to need his health services.

FILERMAN:

AUPHA made a student recruiting film of that hospital, Lutheran Hospital. It's called "The Fixing Business."

WEEKS:

I think I've seen that. Is that the same man?

FILERMAN:

That's the same man and the same institution and the way that the film got its title was when he was asked what business he was in, he said, "We fix communities, we're in the fixing business. We don't just cure sick people, we prevent illness and we use the resources of this institution as a community resource."

WEEKS:

That's a good example of a practical application of what you're saying.

FILERMAN:

That's right.

There's an irony to this and that's how much it brings us back to what the leadership in public health was trying to teach hospital administrators thirty years ago, but they didn't know how to get their message across.

Our problem in developing curriculum today, is to find people and teaching materials that alert future generations of administrators to these forces and to the directions that these scenarios may go in so that they can capitalize on them and provide leadership in moving there rather than protecting the status quo.

WEEKS:

I think there is a great deal in that last statement.

Did you want to say more on that subject? I wanted to ask you about alumni associations, since they are on outgrowth of your program in the sense that graduates of your program start and maintain alumni associations. Have you any thoughts on it? Have you noted any experiences that would make you want to say something about alumni associations? I'm saying this in the sense that George Bugbee once made the statement that Ray Brown really wasn't very much in favor of having a strong alumni association. I don't know whether he feared that they might interfere in the program and make too many suggestions about curriculum and that kind of thing. On the other hand, some of the programs have very strong alumni associations. I think they do at Michigan.

FILERMAN:

Unquestionably the strongest alumni association is Minnesota's. They

are the most involved in every aspect of the program and they have raised $1 million and are working at the second million dollars. They have a part-time employee who handles both their placement service and their fund raising activity. On the other hand some programs do not feel that it is a useful investment, and some universities do not want individual programs to develop alumni associations. They want one central or a school-wide association or one for the school of business or the school of public health. By and large alumni associations are critically important at this juncture and, I must admit, it's for the money.

The alumni of programs in health administration do not contribute nearly what they should. There is no question that the reputation of the program has an effect on the credibility of the graduate long after they have graduated. So they have a stake in the quality of the program, and they ought to invest in it. Secondly, what the fund raising efforts of Chicago and Minnesota have demonstrated is that alumni are willing and able to contribute at a significant scale. I believe that the average contribution to the Minnesota campaign was over $500. They raised over $250,000 from the alumni.

The potential is there, and the motivation should be there, and the need is there, programs are being hit very hard now by the cutbacks, not just in federal funding, but in all support. A modest amount of additional support can make a great deal of difference in the ability of a program to attract top faculty or to expose students to leadership in the field. There really is a qualitative difference possible with a few thousand unencumbered dollars. Alumni make the critical difference.

AUPHA has a high priority now on helping develop alumni activities. We

are seeking a grant to finance an alumni development program which would assist the programs in strengthening their alumni associations. The alumni are the most important undeveloped resource for strengthening education in the field. However, the American College of Hospital Administrators and potentially the other colleges need to understand that and encourage it and not be threatned by it as a competitive venture.

WEEKS:

Well, it would seem to me that the ACHA has the appeal that other associations don't have in the sense that a man can advance to fellowship and that he has the prestige of being a Fellow which he probably would hate to relinquish and probably wouldn't relinquish even though he had to contribute some money to his alumni association.

FILERMAN:

I think that's probably true.

WEEKS:

You know there's a lot of magic in the word "Fellow."

FILERMAN:

There are radical strategies that could be adopted. One could foresee a group like the ACHA offering to be the unbrella for alumni associations.

WEEKS:

Is there any central organization of alumni associations?

FILERMAN:

No, there isn't. We attempted to establish a coordinating council some years ago, but the turnover in alumni association leadership is quite rapid. We would have to have ended up providing the continuity and leadership. They could not agree, at that point, on an agenda of common

interest because they are so heterogeneous in their idea of what is appropriate alumni activity.

We did, a number of years ago, have a two day leadership institute for the alumni leaders which was very useful. We plan to do that again, as part of the new effort. But, the commitment varies a great deal among programs and I really don't see a future for such a coordinating activity, except on an _ad hoc_ basis.

WEEKS:

Seems like there's a potential there for a lot of good, if in some way it could be harnessed and used.

FILERMAN:

It needs to be within the framework of each program. AUPHA can make important contribution by developing case studies of success which all programs can consider, also by developing materials which they can repackage and use in their own publications. That's what we intend to do.

WEEKS:

I think that's wise. You could be hosting a number of things and helping without being involved in the actual management of all these associations.

FILERMAN:

The objective of AUPHA, remember, is to help each of the participating programs realize its own objectives. AUPHA's objectives, separate from those of the programs, are limited. We only realize our objectives, ultimately, through the strengths of the programs. That's what a consortium is all about.

WEEKS:

That would be a worthy objective, to help them help themselves, in other words.

We were talking about licensure and continuing education as a part of maintaining that license.

FILERMAN:

My view of the potential for licensure of administrators, particularly hospital administrators, has changed. Five years ago my prognosis was that licensure would expand as an outgrowth of the licensure of nursing home administrators.

Now, however, it's virtually a dead issue, for two reasons. One is the decrease in a regulatory environment. Second, though, is the disillusionment with educational requirements to maintain credentials and competence.

I see a tendency to discount the effect of continuing education requirements, because nobody has brought in any evidence that they accomplish very much. I am one of those with much faith in the educational process, but no evidence from educational outcomes.

WEEKS:

I've noticed it in several of the fields. The first I remember, years ago, in Michigan where we have a lot of osteopaths , and the osteopaths had a requirement for continuing education long before anybody else did, at least in Michigan. I had several friends who were osteopaths. They would go up to Grand Rapids or Traverse City, places away from the metropolitan area, and spend three days and have a good time. They would to into a meeting and sit down for a minute and leave. They would joke about it later. Yet they would get their credits. Maybe the meetings weren't

worthwhile, or they might have stayed.

FILERMAN:

Yes, and that's an important question.

WEEKS:

Yes, these men were pretty sharp and I think that if it were pretty low grade, they would just get up and walk out. If it were interesting, I'm sure they would stay. But they went through this process and took their golf clubs along and took their wives and had three or four days at some resort and enjoyed it. It was a vacation. They complied with the regulations of their profession, their licensing. That, to me, was a waste of time as far as the educational effort was concerned. Maybe not for the vacation.

FILERMAN:

I think that's a fair statement. The other factor that has taken away some of the impetus from this movement is that the malpractice problem is eased somewhat.

At the height of the malpractice problem , there was a groping for answers to the problem of obsolescence and inappropriateness of professional behavior. There were few options identifiable, of which continuing education was one. It is a way of screening out people at the extreme, anyway. Now that the pressure is not as acute, there is not the interest.

WEEKS:

If it doesn't just remain a vestige of something that happened yesterday, it will all right. If they have the courage to face the issue and do something about it. Either make continuing education worthwhile and make it something that everybody wants whether he has to have it or not, if

it's available.

FILERMAN:

We need a lot of research into the learning process. The AHA some years ago undertook some research and had quite a sophisticated project to look at all the evidence. It was to lead to a book, but it never produced anything. Research into the learning process, particularly of adults, of professional behavior change is essential. Such research as it affects health professionals is a legitimate dimension of health services research. Few health services researchers agree.

WEEKS:

Unfortunately, the very fact that you outline your needs of research is something many researchers would rebel from. Many researchers feel you can't be a good scientist unless you can see the idea you want researched. To do contract research, which this would be in a sense, is beneath the dignity of a good researcher. Maybe that's carrying it to the extreme.

FILERMAN:

In the pure sense, yes.

WEEKS:

I think we need some wild spirits like you to suggest these things even though they are not acceptable to everyone.

FILERMAN:

I find that a lot of the things that I suggested aren't acceptable to everyone, or even to anyone.

Interviews in McLean, VA

December 28, 1979

October 27, 1981

INDEX

Accrediting Commission on Education for Health Services Administration 64-68,70,79,110

Africa 85

AgaKahn Foundation 94

Agency for International Development (AID) 89-90,93

Agnew, G. Harvey 28

Agnew, Mary Johnson 28

Alberta, Canada 81

Alumni Associations see AUPHA

Amberg, Ray 9

American Association of Junior Colleges 33

American Association of Universities 36

American College of Hospital Administrators (ACHA) 34,37,38,47,49,50, 53,56,60,62,63,67,101,110,124

American College of Medical Group Administrators 64,65

American College of Nursing Home Administrators 64,65,101,119

American Council on Education 35

American Dental Association (ADA) 37,56

American Health Planning Association 64,66

American Hospital Association 11,34,37,38,47,49,50,62,63,64,109,110,111,
112,115,116,119

American Hospital Supply Corporation 94,98,101

American Indians 116

American Institute of Architects 43

American Medical Association 21,37,56,64

American Nursing Home Association 119

American Personnel Guidance Association 54

American Public Health Association (APHA) 62-63,64,89

American Sociological Association 50

American University, Beirut 89

Amos Tuck School, Dartmouth 16

Ann Arbor, MI 31

Annis, Edward 21

Asia 85

Asia Foundation 94

Association of American Medical Colleges (AAMC) 37,51,52,114

Council of Teaching Hospitals 46

Association of Mental Health Administrators 64,66

Association of Young Health Administrators 115

AUPHA (Association of University Programs in Health Administration) 13,
21,22,27-28,89,131

Accreditation 38-41,60-61,64-65

Agenda 61

AUPHA (con't)

Alumni associations 55-56,129-133

Annual meetings 49

Biannual Review Committee 33,39,41,43-44

Campus Visitation Program 54-55

Canadian role 79-82

Curriculum development 43

European efforts 85,97

Executive Committee 39,50

Executive session 41-42

Financial situation 98-99

Government support of education 57-59

International role 89-94

Interuniversity center 107-109

Iowa meeting (1963) 42,46

Journal of health administration 96

Liaison committee (AHA,ACHA) 48-50

Location of office 46-47

Meeting of Latin American directors 52

Minority aid 113-120

Program Notes 45,101

Program placement policies 120

Recruiting students 36,50-57,128

Relationships with other organizations 124

Secretariat 44-46

AUPHA (con't)

Task forces 42,47

Undergraduate education 74-79

Women students 118-119

World congress, Tokyo 87

Austin, Charles 103

Austin Report 104

Australia 87,93,95

AZA 2

Bachmeyer, Arthur C. 35,36

Baltimore 16,115

Bangladesh 95

Battle Creek, MI 33

Bechtel Power Corporation 89

Beirut, Lebanon 89

Belgians 97

Berman, Edgar 17

Berman, Howard J. 128

Biannual Review Committee see AUPHA

Bismarck, Otto von 25

Blue Cross 43,115

Blue Cross Association 113

B'nai B'rith 2

Bogota, Colombia 51,52,92

Bolivia 94

Boynton, Ruth 4

Brazil 27,85

Brookhaven Laboratories 107

Brookings Institution 19-22,24,25,107,109

Brown, Douglas 53

Brown, Ray 29,31,35,47,62,98,129

Buenos Aires, University of 25

Bugbee, George 28-30,31,40,41,42,44,45,48,54,59,62,64,98,106,110,
113,122,129

Burnett, Walter 30,46

California, University of, Berkeley 54

California, University of, Los Angeles 27

Canada 25,67,73,79-82,88,90,92,93

Canadian College of Health Services Executives 67

Canberra, University of, Australia 15

Catholics 9

Chase, Harold 19-20

Chavez, Mario 84

Chica, Bernardo 25

Chicago 9,30,31,46,51,107,110,115

Chicago Hospital Council 28-29,44

Chicago, University of 29,109

Billings Hospital 28

Center for Health Administration Studies 44

Hospitals 28-29

National Opinion Research Center (NORC) 40

Program in Hospital Administration 28,36,130

Law School 14

Chicanos 116,117

Chief executive officer (CEO) 63,65

Chile 25-26,31,43,44

National health service 25

U.S. embassy 51

University of 18

University of, Hospital 24

China Medical Board 94

Cincinnati, University of 88

Clay, Clement C. 31,58

Cohen, Marvin 77

Colorado, University of 103

Columbia University 25,31,58

Doctoral program in hospital administration 15

Commission on Education in Health Administration 101-106

Commonwealth Fund 14

Community health 58

Comprehensive health plans 125

Congress 21,58,59,74

Conley, Dean 47,49

Connecticut 30

Continuing education 133

Cook, Howard 29

Cooper, John 52

Cornell University 32,53,63

Council on Education for Public Health 65

Crosby, Edwin 5,47,64,109,110,111,116

Cruikshank, Nelson 127

Dartmouth College 16

Davis, Graham 33

Davis, Michael M. 32

Dawson Report 26

Defensive medicine 126

DeMolay 2

Denver 102

DeSilva, Jose Caldenia 93

Detmer, Mac 11

DeVries, Robert A. 95

Dixon, James 102,103,105

Dornblaser, Bright 30

Dublin, Ireland 85

Duke University 31

Dunn, Donald 26-27

Dupont Circle 11

Eisenhower, Milton 16

Eisenhower, Ruth 16

England 88

Equitable Life Insurance Society 101

Europe 70,85,86,97

European Association of Programs in Health Services 70,85,94,95-96,97

Fahs, Ned 51

Filerman, Jane 26

Filerman, Lee 2

Finland 92

Flagle, Charles 13-14

Florida International University 73

Forand bill 19

Fort Sam Houston 39

Gabriella-Venturini 25

General Motors Corp. 123

Geneva, Switzerland 87,88

George Washington University 31,44

Germans 25

Ghana 86

Gibbs, Fred 31,44

Gilbenrian Foundation 94

Goulet, Charles 11,13,28-31,41,42,45

Grand Rapids, MI 133

Graduate Record Examination 39

Graning, Harald 50-51

Gulf States (Middle East) 89

Hamilton, James A. 4,8,9,10,15,16,23,24,27,28,29,30,34,35,44,122

Hartman, Gerhard 46

Harvard School of Public Health 93

Health administration 1,59

Health insurance 126

Health manpower bill 59

Hill, Lawrence 31,52,107,109

Hill, Lister 59

Hill-Burton 50-51,54,55

HMO (Health Maintenance Organization) 66,100,124

Home health agencies 66

Hospital Association of San Paulo 85

HRET (Hospital Research & Educational Trust) 107,109

Humphrey, Hubert H. 17

Hungarian revolution 8

India 93

Indian Hospital Association 85

Indiana University 33

Indonesia 94

Institute of Hospital Administration 106

International Hospital Federation 17,86,87,89,95

Iowa, University of 30

  Doctoral program 15

  Program in Hospital Administration 39,51

Iowa City, IA 46

Irish Institute of Public Administration 85

Jackson, Laura 28

Jaco, E. Gartley 23,27-28,44

Japan 87

Jews 9

Johns Hopkins University 16,73-74

International Club 16

Operations Research Division 13

Program in Hospital Administration 47

Johns Hopkins University Hospital 11-13,28

Johnson, Robert Wood, Foundation 115

Joint Commission on Accreditation of Hospitals 62,63

Kaiser-Permanente 125

Kefauver, Estes 7

Keio University, Japan 87

Kellogg, W. K., Foundation 15,18,19,24,25,26,32-35,41,43,51,52,69,
70,82-85,93,94,95,101,107,115

Kennedy, John F. 21

Kenya 86,95

Kerr-Mills 19

Kirk, Richard 53

Korea 60

Latin America 18,24,51,82

Leeds, University of 93,97

Lentz, Edith (Hamilton) 23,25

Licensure 133-135

Lisbon, Portugal 93

Litman, Ted 19

Los Angeles 93,117

Louven University 97

Lutheran Hospital 128

MacEachern, Malcolm T. 28,35

McGaw, Mary & Foster, Scholarship Fund 98

MacMillan, Donald 93

McNerney, Walter J. 111,112-113

Madison, Berwyn 64

Madison Square Garden, NYC 21

Malpractice 127,134

Mandelstam, Ben 7

Manila 87

Mannix, John R. 123

Medellin, Colombia 25

Medical College of Virginia 40

Mejia, Alphonso 87

Mexico 82,94

Michigan 133

Michigan, University of 25,31

Program in Hospital Administration 40,128

Middle East 89,94

Milbank Foundation 51

Miller Analogy Test 39

Millis, John 105

Mills, Wilbur 21-22

Minneapolis 26,44

Minnesota Hospital Association 3,4,26,29

Minnesota, University of 6,18,24,27,29

Doctoral program 14,15,22

Program in Hospital Administration 4,8,9,10,11,24,27,52,130

Student government 4

Student health service 3,4,7

Minnesota University Hospitals 9,26

Mount Palomar 107

Mount Sinai Hospital, Minneapolis 6,8

Mozambique 94

Multihospital system 124

National Association of Health Services Executives 113,116

National Commission on Accreditating 61-62,63

National Council for Academic Administration 33

National Council of Senior Citizens 21

National Intercollegiate Athletic Association 112

National League for Nursing 37

National Opinion Research Center 40

National School of Public Health, Lisbon 93

National Vocational Guidance Association 54

Nelson, Russell 11-12

New Delhi, India 85

New York City 113,115,127

New Zealand 94

Newton, Quigg 115

Northwestern University 9,28,52,71,109

Northwestern-American Hospital Association-HRET 107

Nuffield Center 93

Oak Park, IL 124

Ohio State University 27

Oklahoma City 117

Old boy network 122

Olsen, Herluf 34

Olsen Report 34,38,42,101

Osteopaths 133

Ottawa, Canada 81

Pan-American Federation of Associations of Medical Schools 51,52

Pan-American Health Organization 82-85,87

Paris, France 94

Pattullo, Andrew 33-34,41,42,51,94,102,113

Peace Corps 26-27

Pedroso, Odair 25

Peru 82

Philadelphia 102

Philippines 87

Portugal 92,94

Prall Report 34,101

Preventive medicine 127

Procter & Gamble 89

Program Notes see AUPHA

Project Hope 17

Puerto Ricans 116

Regionalization 25-26

Residency 35

Rice, Haynes 113

Rockefeller Foundation 51,93,94

Roemer, Milton 27

Rosenwald Fund 32

Rosie, Peter 40

Roth, Burns 52

San Antonio 117

San Francisco 115

San Francisco State College 62

Santiago, Chile 31

Sao Paulo, University of 25

Saudi Arabia 89

Schechter, Daniel 48,49

Schweiker, Richard 59

Social Security 19

Solar, Miguel 24

Somalia 94

South Africa 88

Staples, Eugene 9

Staten Island 77

Stephan, James W. 49

Strong Memorial Hospital 11

Stull, Richard 101

Summerskill, John 102

Surgeon General 59

Swanson, Ray 5

Swedish Hospital, Minneapolis 1

Tanzania 94,95

Taylor, Glen 3-5,29

Thompson, John 31,52

Tokyo 87

Toronto, University of 52

Traverse City, MI 133

Uganda 95

Upper Mid-West Hospital Conference 3,4,29-30

U.S. Commissioner of Education 60

U.S. Department of Health, Education and Welfare 90

  Ways and Means Committee 21

U.S. Office of Education 61

U.S. Public Health Service 58,61,63

U.S. Supreme Court 19

USSR 93

Venezuela 25

Veterans Administration 61,115

Veterans Benefit Act (1952) 60

Wagner College 77

Washington, DC 19,58,61,63,109,111

Wesbury, Stuart 101

West Virginia, University of, Hospital 9

Wiebold Foundation 115

Windemere Hotel, Chicago 46

World Health Organization 31,86,87,88,89,90,93,94

Yale University 31,52