ROBERT M. SIGMOND

In First Person: An Oral History

Lewis E. Weeks
Editor

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Robert M. Sigmond

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CHRONOLOGY

1920	Born, Seattle June 18
1941	Pennsylvania State University B.A.
1942-1945	Civilian wartime assignments with Air Force, War Department, War Labor Board
1945-1946	Governor's Commission on Hospital Facilities, Standards, Organization, (PA), Research Associate
1946-1950	Hospital Council of Philadelphia, Research Associate
1950-1955	Albert Einstein Medical Center, Assistant to Executive Vice President and Medical Director (Also Assistant Director, and Acting Director of the Center's Northern Division)
1952-1954	National Commission on Financing of Hospital Care, Director of Fiscal Studies (On leave from Einstein)
1955-1964	Hospital Council of Western Pennsylvania, Pittsburgh, Executive Director
1964-1968	Hospital Planning Association of Allegheny County, Pittsburgh, Executive Director
1968-1970	Albert Einstein Medical Center, Philadelphia, Executive Vice President for Planning

CHRONOLOGY

(continued)

1968-	Temple University, School of Business Administration, Adjunct Professor of Hospital Administration
1971-1975	Albert Einstein Medical Center, Philadelphia Executive Vice President
1975-	University of Pittsburgh, Graduate School of Public Health, Medical and Hospital Administration, Lecturer
1976-1977	Blue Cross Association, and Blue Cross of Greater Philadelphia, Consultant
1977-	Blue Cross and Blue Shield Associations, Special Adviser

MEMBERSHIPS AND AFFILIATIONS

(Past or Present)

Allegheny Seminar, Executive Committee, Member

American Association for Hospital Planning, Board of Directors, Member

American College of Hospital Administrators, Member

American Health Planning Association, Member

American Hospital Association, Member

American Hospital Association, Advisory Panels on Data Base Development and Research Policy, Member

American Hospital Association, Committee on Areawide Planning Agencies, Member

American Hospital Association, Council on Blue Cross, Financing, and Prepayment, Member

American Hospital Association, Council on Research and Development, Chairman

American Journal of Public Health, Editorial Board, Member

American Medical Association, Council of Medical Services, Committee on Community Health Care, Consultant

American Public Health Association, Fellow

American Public Health Association, Committee on Racial Discrimination, Member

MEMBERSHIPS AND AFFILIATIONS

(continued)

American Public Health Association, Subcommittee on Community Planning, Member

American Statistical Association, Member

Appalachian Regional Commission, Health Advisory Committee, Member

Association of American Medical Colleges, Member

Association of American Medical Colleges, General Assembly, Member

Association of Areawide Health Planning Agencies, Board of Directors, Member

Association of University Programs in Health Administration, Task Force on Health Planning, Member

Blue Cross of Western Pennsylvania, Board of Directors, Member

California State Department of Health, Hospital Utilization Research Project, Consultant

Congressional Office of Technology Assessment, Advisory Panel on Cost Effectiveness of Medical Technologies, Member

Dorothy Rider Pool Health Care Trust, Trustee

Forum of Delaware Valley Hospital Council, Executive Committee, Member

Governor's Hospital Study Commission (PA), Consultant

Group Health Planning, Inc., Board of Directors, Member

Health Services Research, Editorial Board, Member

MEMBERSHIPS AND AFFILIATIONS

(continued)

Health & Society (Milbank Memorial Fund Quarterly), Editorial Consultant

Health Systems Agency of Southeastern Pennsylvania, North Philadelphia Subarea Council, Member

Hospital Association of Pennsylvania, Member

Hospital Association of Pennsylvania, Council on Administrative Practice, Chairman

Hospital Association of Pennsylvania, Council on Planning, Member

Hospital Council of Western Pennsylvania, Public Representative

Hospital Research & Educational Trust of AHA, National Advisory Committee, Chairman

Hospital Utilization Project of Allegheny County Medical Society and the Hospital Council of Western Pennsylvania, Executive Committee, Member

International Hospital Federation, Member

Robert Wood Johnson Foundation, Community Hospital/Medical Staff Group Practice Program, Sponsor

Medical Care, Editorial Consultant

Michigan Study of Hospital and Medical Economics, Consultant

Milbank Memorial Fund, Technical Board, Member

National Center for Health Services Research, Consultant

MEMBERSHIPS AND AFFILIATIONS

(continued)

National Center for Health Statistics, Consultant

National Committee on Vital Statistics, Subcommittee on Epidemiological Uses of Hospital Data, Member

National Commission on Community Health Services, Advisory Committee on Community Activities Study, Member

National League for Nursing, Member

Pennsylvania Department of Health, Task Force on Pennsylvania Blue Shield Regulation, Consultant

Pennsylvania Mental Health Association, Committee on Development, Member

Pennsylvania Mental Health Association, Committee on Insurance, Member

Pennsylvania Public Health Association, Member

Pennsylvania Public Health Association, Medical Care Section, Executive Commitee, Member

Pennsylvania, University of, Leonard Davis Institute of Health Economics, National Advisory Committee, Member

Philadelphia Health Management Corp., Board of Directors, Member

Philadelphia Health Management Corp., Goals and Priorities Committee, Chairman

Philadelphia Health Management Corp., HMO Management Council, Member

Pittsburgh Foundation, Consultant

MEMBERSHIPS AND AFFILIATIONS

(continued)

Pittsburgh Public Schools, Health Advisory Committee, Member

Regional Comprehensive Planning Council, Philadelphia, Health Facilities Review and Study Committee, Chairman

Social Security Administration, Consultant

South Philadelphia Health Action, Vice Chairman

U.S. DHEW, Secretary's Committee on Hospital Efficiency, Consultant

U.S. Indian Health Service, Health Programs Systems Center Advisory Committee, Member

U.S. National Institutes of Health, Division of Medical Programs, Initial Review Committee, Member

U.S. Office of Economic Opportunity, Consultant

Urban League of Pittsburgh, Health Committee, Member

Western Pennsylvania Comprehensive Health Planning Group, Steering Committee Member

Western Pennsylvania Medical Programs, Steering Committee and Advisory Committee Member

AWARD AND HONORS

Albert Einstein Medical Center

The Trustees Medal, 1975

American College of Hospital Administrators

The Dean Conley Award, 1969

Nuffield Provincial Hospitals Trust

Edwin L. Crosby Fellow, 1976

BOOKS

Presidential Elections by Pennsylvania Counties, 1920-1940.

(with R. F. Alderfer) Pennsylvania State College, 1941

Methods of Making Experimental Inferences

(2nd Edition) 1945

Planning: Evolution and Development

University of Iowa, 1968

The Hospital-Blue Cross Plan Relationship (with Thomas Kinser)

Blue Cross Association, 1976

WEEKS:

I think the first question I'd like to ask you is: You were born in Seattle 1920 and I suppose your parents moved east to Philadelphia and you...?

SIGMOND:

Let me give you the details on that. Actually, my father came over with a typical Jewish immigrant family about the turn of the century and graduated from Penn law school in Philadelphia. The family had immigrated to Philadelphia, and was a typical Jewish sweatshop kind of family. My father worked his way through Penn law school and went out West to make his fortune. While he was out West he met my mother, who was a product of a more unusual immigrant Jewish family that went to the West Coast. So, instead of making his fortune he got married and had a couple of kids. When I was three years old and my brother was six, my mother died, so my father brought us back to his own family, then I grew up in Philadelphia. My contacts with the West Coast are something that I cannot bring back to memory. So I'm really an Eastern product. Grew up in Philadelphia, went to Philadelphia schools. I did spend three years - from five to eight in the Children's Seashore Home with osteomyelitis, which left me with an important hospitalization experience in my youth and left me in a condition where I wasn't able to get drafted into

the war and so on. But, no other effects that I know of.

WEEKS:

That's an interesting background. I was going to ask you too about your major at Penn State. I notice you have both your bachelor's and master's degree from there.

SIGMOND:

Yes, at Penn State, I had really two academic interests, that in a way ran through my life. One was in community affairs and that led me as an undergraduate to major in political science with an emphasis on local government. I did a lot of part-time work that helped me to finance my education, in an Institute of Local Government at Penn State pretty much under the influence of a Dr. Harold Alderfer. He organized the Institute of Local Government, not only as a framework for teaching young people about local government, but also an organizational framework through which Dr. Alderfer was, in effect, the executive secretary of the various statewide organizations of third-class cities, boroughs, townships and other municipal groups. This incidently, made him a very powerful person at the college because of the contact there with the legislature on behalf of those organizations. His students got involved in that. It gave me, early on, a very direct contact with the realities of organizing human services at the community level and a sense that Dr. Alderfer gave me of the richness of the variety of experience in people at the community level dealing with their own affairs. This was during the 1930s when most students were concentrating on New Deal programs, national programs, the general sense of the federal government being a source of all initiative. I wasn't unsympathetic to that, but my basic interest was in local community affairs.

The other side of my studies was in economics where I was getting involved in studying Social Security laws and learning about Keynesian theory. I had a kind of a dichotomy right from the beginning between my economic studies that tended to point me in the direction of major public policy issues at the national level and then my working with Dr. Alderfer at the local level and really feeling a lot more empathy with getting things done at the local level, but, certain parts of my intellect being attracted to macro solutions. The one person who kind of crossed over on that in my college life was my in professor public finance, Dr. Paul Weller, who was a great influence on me. His special interest was the relationship of national/local taxation policies and on grants in aid as the interaction linkage. I learned a great deal from him about that interface that has interested me. At that time I had no special interest in health, per se. The closest I came to that was in examining social insurance programs, and just slightly in terms of the involvement that I found in health on the part of local government.

I did my master's degree in economics. I did my thesis on industrial injury statistics and workman's compensation, which began to get a little closer to health. But, I had no real interest in health and I thought of myself increasingly as a technician in terms of handling data that bore on public policy issues with a special interest on interaction between local and national. My minor throughout was statistics. I became a member of the American Statistical Association long before I became a member of the American Hospital Association.

I have maintained my membership in the American Statistical Association but in recent years I find it harder and harder to read the journal and understand it.

WEEKS:

I noted that during the war you worked at some civilian jobs and then your first health job, as I could see, was when you became research associate for the Governor's Commission.

SIGMOND:

Yes.

WEEKS:

What was that...?

SIGMOND:

During the war, because of my physical handicap, I was not able to serve in the armed forces and I worked with various war agencies. First with the Air Force then with the War Labor Board. When the war ended I suddenly found myself out of a job.

I was looking for a job as a statistician, which was at that time what I thought I was. I was in Philadelphia and my wife who was getting her M.B.A. at Wharton School referred me to a professor at the University of Pennsylvania who was assembling a staff for a one-year study of hospital needs for a governor's commission that had been appointed, as I subsequently learned, in conformance with recently passed national Hill-Burton legislation. This required each state to survey its needs and to develop a state plan for hospital facility development as a requirement for getting Hill-Burton funds. I joined the staff then; they were looking for a statistician, I was looking for a job. Within a year, we had completed the required survey and the staff was asked to moved to the state capital, Harrisburg, and manage the Hill-Burton program.

I didn't want to leave Philadelphia, so, just at that time C. Rufus Rorem

was leaving the Blue Cross Commission of the AHA to become the executive director--first full-time executive director--of the hospital council in Philadelphia. We got together and he offered me a job, and that was my second job in the health field.

I might say that on that first job this Governor's Commission was headed by Thomas Gates, Sr. who had been the chairman of the Commission on Hospital Care that the AHA sponsored and which laid the foundation for Hill-Burton, as far as the hospital field is concerned. So, I became acquainted with Mr. Gates, who was head of Pennsylvania Railroad, and then through him became acquainted with the staff of the Commission on Hospital Care, which was in the process of dispanding. I came to meet Dr. Arthur Bachmeyer and Maurice Norby, who was the chief staff person then. They helped me a great deal in understanding the full import of the Commission's work and its relationship to Hill-Burton. And I got them involved in what I was doing. I got involved in what they were doing. That enabled me to make an early contact with the national scene that I found very, very valuable.

In that very first year, I think because of making those contacts, I was invited to speak at an American Hospital Association convention, which I think was either in Kansas City or St. Louis, in 1946, on our methodology that was a little different from what some of the other states were doing. That job also put me in touch with the federal officials, McGibony and Vane Hoge, because we were supposed to do our need-study in conformance with the federal requirements. I was able to deal with them on a fairly intelligent basis, I thought, and get a different sense of flexibility than some of the others who were doing these studies in other states, who were kind of assuming the Feds were turning out cookbooks that they had to follow. I got into that whole

issue of federal requirements and the kind of flexibility a state has and learned a lot of the folks at the state level didn't want any flexibility. I got to learn a lot more about that interface than I had known before. We were able, I thought, to turn out a very good state plan that did conform to all federal requirements, but it had a lot of Pennsylvania in it. We traveled all over the state and met all the hospital folks around the state. That was a valuable experience for me. The important thing in terms of my life is that during that year I got hooked on the hospitals.

WEEKS:

You've really got a tremendous background there that must have helped you all the rest of your professional life.

SIGMOND:

It really did. As it turned out the executive of that Governor's Commission staff was not full-time and I was the only full-time staff person above the secretary--everybody else was teaching courses at Penn or what not and it really didn't take you very long in the forties if you had the kind of energy that I had in those days, and intellectual curiosity and interest in people to become an "expert." I can remember getting out there in different parts of Pennsylvania--I can remember if you want me to go into this kind of detail--in particular, situations where we had to draw service areas and determine needs and there were two hospitals in this service area and we were meeting with them.

The one hospital said, "Well, you're not telling me the government expects us to plan together. We've never done that."

I said, "I think they do." I can remember saying, "I don't think they necessarily mean sleep together but you ought to be able to talk together and

tell each other what you're doing. Maybe you ought to do that because it's in your best interests."

I remember having some of those kind of conversations...

WEEKS:

You were a relatively young man then too.

SIGMOND:

Yea, and brash, but the experience that I had with Dr. Alderfer, having watched him deal with these second-class township commissioners, was very, very helpful at that time. I probably was better at it then than I am now because I've got much less patience.

WEEKS:

Well, did you meet Bugbee about this time?

SIGMOND:

Yes, I met George Bugbee at that time, but I really got to know him much better later on.

WEEKS:

I was wondering because he was so strong on Hill-Burton--working for Hill-Burton or the passage of Hill-Burton at least.

SIGMOND:

You see, Maurice Norby was the key staff person on the Commission on Hospital Care under Dr. Bachmeyer who was continuing at the University of Chicago. When Maurice Norby left the commission, he became George Bugbee's deputy. I had a lot of contacts with Maurice Norby and that continued for many years after I went to work for Dr. Rorem because Maurice Norby started with Dr. Rorem. I can remember visiting the American Hospital Association back in the forties frequently, when it was located in a converted private

residence and the whole staff essentially consisted of George Bugbee and Maurice Norby and a gal named Ann Friend in personnel work, and maybe two or three secretaries. I did get to know George Bugbee, but, to me at that stage of my career, he was the guy that ran the Association. I was dealing with Norby. Later on when George Bugbee got involved with the so-called Bugbee Report--and this would be in the late fifties--then we became very actively involved. I think by the time I got into it in the forties, George had done his main work with Hill-Burton; he got the bill through, he'd gotten the commission set up. He moved on to other things. At least that was my image of it. As I say, he was a figure that didn't mean a whole lot to me until a little later on.

WEEKS:

Yes, you wouldn't in contact with him very much. How about Rufus? What kind of a man is he to work with?

SIGMOND:

I went to work for Rufus at the Hospital Council of Philadelphia. Rufus had just left the Blue Cross Commission. He decided that that job had gotten beyond the promotional stage, it was a management job. He wanted to work at the community level and thought the Philadelphia position might be a good opportunity. Rufus has been the single strongest influence in the health field in my life--still is. I talk to him at least twice a week and I think I probably have all my life from the time I went to work for him. If you're interested in some anecdotes, I could probably give you an hour or two of anecdotes and my wife could do better because she loves Rufus and she treasures anecdotes involving him.

Matter-of-fact, just yesterday I was talking to him and he says "You know,

when it comes to this HMO idea it looks like all these folks are rediscovering the wheel." He said, "You know, if they lost it, there's nothing wrong with them rediscovering it." That's kind of a typical Roremism.

I think that I've come to appreciate the impact that Rufus had on me in those early days more as I've thought about it. I mean, it wasn't something I was glorying in, I was just doing my job. As a matter-of-fact, I'll never forget an event that happened the second or third week I was working for him. Some issue had come up: The organization was very new and they were forming a retirement plan. As it was getting developed it looked like the secretaries were going to be left out. I thought that was wrong. We were having a little staff meeting--there were only four of us--and I spoke up pretty vigorously. Rufus was obviously upset about how aggressive I was being on this point. So, a couple of weeks later he called me into his office and he said, "You know, I really want to sit down and talk to you because I was surprised at your behavior in that discussion the other day. I always thought I'd like to have an organization that was a nice big happy family. Let's talk about that. It didn't seem to me you were behaving like a member of a happy family."

I said to Rufus, "I don't know very much about your family but I was behaving just like I do with my happy family. If there's some kind of issue, we're screaming and shouting."

Then he sat back and laughed. "You're right," he said, "you're right. In a Quaker family you don't do things that way."

I said, "Well, in a Jewish family that's the way you do things." We were both agreeing that we ought to be a good happy family, it's just a whole different cultural background.

Working for Rufus, I think, gave me maybe two or three or four things.

Number 1, he gave me appreciation of the potential of the hospital as a community institution. (I might want to come back to what I mean by that.) I want to emphasize potential. He didn't believe that everything that hospitals did was right, but he gave me a sense of the importance of the organizational form that the hospital represents in American society. Secondly, he gave me a sense of the importance of keeping the financing as close to the management as possible at the community level. And third, he really hooked me on Blue Cross. I've been a Blue Cross junkie ever since. Lately the product has become so impure that recently I've actually gone to work for the national Blue Cross Association, so I can be as close to the source as possible to get my kicks. But he really hooked me on Blue Cross from the early days. It's important to recognize that when Rufus left the Blue Cross Commission there was no strong leadership at the Blue Cross Commission or its successor groups, until Walt McNerney came along fifteen years later. Immediately after Rufus left the Blue Cross Commission, if there was an individual running one of the plans who wanted to talk to somebody about a basic issue, a basic problem, he had always called Rufus and so he still did. Of course, Rufus helped most of those folks, not only to get their job but to get organized. I would say, in the early days when I went to work for Rufus--I guess that would be '47, '46, whatever--Rufus was quite free in giving advice to Blue Cross people and I mean literally free. He didn't set up a consulting business, and the office was involved with whatever Rufus was doing. So, I got involved. In effect, we were running an unofficial, informal Blue Cross Commission. So I got to know a lot of those Blue Cross folks and the problems. Rufus wasn't doing anything that could be interpreted as undermining the Blue Cross Commission. He just tried to help people. So, issues came along. (Running the Hospital

Council of Philadelphia, wasn't that onerous a task--if you did too much you'd get in trouble.) So, I really did get quite actively involved, in a very informal but most productive way in what Blue Cross was about.

As a matter of fact, at that time Louis Reed was doing a first study of Blue Cross for the Public Health Methods Division of the Public Health Service. A very controversial study. It was controversial because the Blue Cross people weren't sure they wanted to be studied by a government that was headed by Harry Truman who was for national health insurance. They thought the study would discredit them. There were a lot of Feds who didn't want the study to go on because they thought it would call attention to a development that might undermine the move towards national health insurance. Well, of course, any of those people that were worried didn't know Louis Reed--unfortunately he's gone and you can't interview him--but he was one of the straightest, most honest people, an exstaff member of the Committee on Cost of Medical Care. He did do that study and spent a lot of time in Philadelphia on it. That's a study that's well-worth reading. It's the best study ever done on Blue Cross and raises many questions about the composition of the board, community responsibilities, rating...everything is in there.

WEEKS:

I haven't read that. I'll pick up a copy at the Blue Cross library.

SIGMOND:

Yes, you can get it. Now, it never was published by the government printing office, but a lot of copies were circulated and there are copies there in some kind of multilith form. It was such a controversial thing that it was never printed by the GPO. But you really should look at it.

So, a lot of things were going on that involved the Blue Cross. So, to go

back--Rufus got me interested in the potential of hospitals in Blue Cross, and in financing. I think he helped me to develop a skepticism about the national government entering all of this. I think maybe three other things. He helped me to understand that you cannot deal realistically with policy issues without thinking through the management implications of those folks who are involved in day-to-day work and have to make decisions. That has been very helpful to me all my life. I think it also helped me to be a manager when I was a manager, but I never was a very good manager.

I've always been much more interested in the interfaces: interface between the hospital and the community; interface between the hospital and the Blue Cross Plan; the interface with state government and national government.

As I say, I don't know if Rufus has ever managed anything of any size, but he had a management sense. He had a sense that public policy has got to reflect and understand there are people out there making decisions and they have their problems and public policy is just one aspect of it. So, he helped me on that.

I think two other things. He helped me to be much more patient than I am, in terms of dealing with people. I guess he encouraged me not to be afraid to deal with people in a light-hearted way about serious matters.

Probably more than anything else was his sense of ethics. He had an unusual standard of personal ethics, respect for people and a sense of public purpose. It always bothered him when people would talk about the public sector and the private sector. Whenever he heard people say that if you're in government, you're in the public sector, if you're not in government, you're in the private sector, and that bothered him. Also when people would talk about the health care <u>industry</u>. He certainly planted all those thoughts in me

or reinforced those kinds of thinking in me. Just an unusual person. I would get irritated with him once in a while and he would get irritated with me because sometimes I didn't think he would confront people as explicitly as he should. He often was confronting people but they didn't know it. But, as I look back on it, I wouldn't want to see Rufus change in anything he ever did.

WEEKS:

For your information, one time he was talking with me he said...he referred to you as "my dear friend Robert Sigmond." He thinks a great deal of you, I'm sure.

Was there anything about the Hospital Council different from any other city or metropolitan area hospital council?

SIGMOND:

Yes, there was. There were differences between that hospital council and other hospital associations at that time, as well as great differences between that council then and what it represents today and what hospital associations represent today. Let me see if I can outline that briefly. Dr. Rorem took a great interest in hospital associations and the role of hospital associations and made a strong distinction between the role of a national association like the American Hospital Association, state hospital associations, and metropolitan hospital associations of which the Hospital Council of Philadelphia was one. I think some of those distinctions are being lost. But let me outline the unique characteristics of the Philadelphia Council, which at that time wasn't much different from the Cleveland Hospital Council, which was the daddy of them all under a guy named Guy Clark. Both Councils had--when I say both, Cleveland and Philadelphia--had their genesis in the Community Chest. Community Chests in those days, in many of the metropolitan

areas, were putting a lot of money into hospitals as sources of philanthropy...

WEEKS:

Making up deficits?

SIGMOND:

Making up deficits, etc. and where they didn't do that they ran great risks of a United Hospital Fund being set up and competing. So, the hospitals had a lot of power in the Community Chest. Generally speaking they were absorbing as much as a third of the Community Chest money, which represented just a few percentage points of the hospitals' money, so the leverage that the Community Chest had in the hospitals was nothing like the leverage in other agencies where they would underwrite the deficit and that would amount to maybe 90%. So, in a number of places, Cleveland, Philadelphia, Boston, Detroit, the Community Chest set up the hospital council figuring, "Let's take some of this money and put it into coordination. Now, in Boston, actually, the hospital council was just a suboffice of the Chest. It was like the hospital division of the Chest. But in Philadelphia and Cleveland they created organizations; gave those organizations autonomy--they had their own boards. Then they made a grant to them, which I think, turned out to be a better approach than Boston. But, as a result, the Philadelphia Hospital Council and a number of others were what we call 501(C)3 organizations, which the American Hospital Association is not, which no state hospital association is because of the issue of legislation.

WEEKS:

I didn't realize you could do that now.

SIGMOND:

Yes. Furthermore, it was organized so that ... (almost everything I'm

saying was similar for Cleveland and some others, but let's stay with Philadelphia). Half our money came from grants from the Community Chest and half from dues. Eventually we developed some fee-for-service type program and it got to be about 1/3, 1/3, 1/3. The board consisted of trustees--no administrators on the board. There was an administrators' advisory board that was elected by the administrators and the chairman of the advisory board sat with the board of directors. So, we had trustee involvement. That was number one. Number two, we had community sponsorship and financing so that we didn't have to be quite that responsive to the day-to-day pressures of the membership, though obviously, we had to be responsive because they were a source of half our funds and you couldn't very well have a hospital council that wasn't responsive. But, it was a special kind of organization that was a community organization at the same time it had trade association characteristics. The only organization that exists today that is similar is the Greater Detroit Area Hospital Council which gets half of its money from nonhospital sources and its board is mixed. I think that's terribly important. Now, the Hospital Council of Philadelphia since that time has given up--voluntarily given up--its 501(C)3, has voluntarily given up its Community Chest grant and operates pure and simple as a trade association, as has the Cleveland Council. The interesting thing is, in the Cleveland Council some of the people don't know that and they try to operate like in the old days. They don't realize they don't have the structure either financial or otherwise. So, there's a lot of tension in the Cleveland Council.

WEEKS:

That's one point I'm not clear about is, back in the old days when the Council was formed by the Community Chest, how did the Community Chest help

make up deficits of hospitals? Did they go through the Council?

SIGMOND:

Yes. One of the functions of the hospital council staff--and that was one of the excuses for the grant--was that the hospital council staff served as the staff to the Community Chest committee that made those hospital allocations. Now, they made those allocations essentially on a formula basis so it didn't get up into quite the kind of tensions that it might have but, nevertheless, it did get us into tensions with our membership.

WEEKS:

There had to be some judgment made and it was your judgment that was followed probably.

SIGMOND:

Well, it was our input as against the individual hospital. And, of course, Dr. Rorem handled that with sensitivity and with character. Now, the same thing in terms of our dealings with Blue Cross, a lot of the hospital membership felt that we should take Blue Cross on and get as much money as we could from them. Of course, the Community Chest was also interested in Blue Cross primarily--and the Community Chest, by the way, set up the Blue Cross plan.

WEEKS:

Oh, did they?

SIGMOND:

Yes, and that's a long story. Rufus was involved in that because that was back in the thirties when he was helping all the Blue Cross plans to get started. The Community Chest, as in many other areas, helped to set up the Blue Cross plan because they saw that as a way to get the hospitals off their

back in terms of the share of the philanthropic dollar.

WEEKS:

Make them pay their way a little bit.

SIGMOND:

Right. So, the Community Chest was not interested in the hospital council doing anything to raise the Blue Cross premiums excessively that would keep marginal income-type people from buying Blue Cross. So, we were in the middle of that. And, Dr. Rorem, of course, was a very, very close friend of Mr. van Steenwyk, who was the head of the Blue Cross. So, he had to play some very sensitive roles in dealing with Blue Cross and dealing with the membership.

WEEKS:

At that time did van Steenwyk succeed Rufus at the Commission or...

SIGMOND:

No, no.

WEEKS:

No, van Steenwyk was here in Philadelphia.

SIGMOND:

In Philadelphia. Ten years before Rufus came to Philly, van Steenwyk left Minnesota and became the first head of the Philly Plan on Rufus's recommendation.

WEEKS:

I can remember hearing that, yes. It's difficult to keep everything straight because a lot of these people are moving about quite a great deal, aren't they?

SIGMOND:

That's correct.

WEEKS

You know, we were talking here about the forties, I'm wondering, in thinking back to the forties how impressed were you...Let me say this first: Historically when you read something years later, it's very difficult for a person to know how much impact that event had on people in general at that time. Later on we begin to see the significance of it and we say, "Oh, this was a very significant fact or factor." Yet, at the time, people might not realize it because...So, that prefaces my question. At that time the Wagner-Murray-Dingell bills were being brought forward every Congress, were you aware, I mean, did this have any importance to you? Thinking back, how were you affected by it, let us say?

SIGMOND:

In the forties one kept up with those national debates, you know. I guess I would have kept up with them even if I wasn't in the health field, just as somebody interested in politics. But, the sense of national health insurance as a reality, that maybe something very important was right around the corner just wasn't there. I didn't have that feeling at all.

WEEKS:

Well, of course, I think another thing that we forget, is that the Wagner-Murray-Dingell bills were not only bills for national health insurance or health insurance for the elderly, but were also workman's compensation and to increase the benefits for the Social Security people. There are a lot of other things in there besides the health insurance item. But now we look back at it and say "Well, every two years Wagner, Murray and Dingell were in there introducing another bill."

SIGMOND:

It seems to me that when I got into the field, the national political thrust was toward national health insurance for everybody. For those of us who were working in the vineyards I would say that was so removed from the reality that we were dealing with that it wasn't taken seriously in terms of something that was going to happen. It was a serious thing to debate but I don't think the matter ever began to achieve a sense of reality, as I say, other than debating, until those who were interested in that approach decided to focus on the aged.

WEEKS:

Can you pinpoint that? That's a question that's been in my mind and I was going to ask Cruikshank that same question on Monday. When did we stop thinking about health insurance for everyone? Was it after the war, was it after Blue Cross came? This was the argument the Republicans were using that most of the people are covered by some kind of health insurance. Was that the reason?

SIGMOND:

Now this is very much off the top of my head, I don't know if anybody's ever asked me that question before or that I ever thought about it. But, I think, on deeper reflection, I would give you the same answer. I think that those who were speaking in terms of federal initiatives in financing of that type, to build on the Hill-Burton, which was the major initiative of the forties, I think those folks--let me say Ig Falk, Michael Davis, and other people who would be associated with them--all of whom I have great respect for--I think basically made a shift in their assessment of the national scene after Eisenhower won the election. So, I would date it from '52. You see, Truman, as long as he was President, was for national health insurance, for

everyone not just for the aged. Now, Forand came along with his legislation which focused on the aged. My recollection on history and I may be wrong...

WEEKS:

I think you're right, because the Republicans under Eisenhower were saying it isn't necessary to have health insurance for everybody because so many of the Americans are already covered under Blue Cross and under commercial insurance and they began talking about subsidies for insurance for people who couldn't afford it. And that was their argument right down until King-Anderson bill, until Medicare came in. Maybe that was the break. I hadn't...

SIGMOND:

I think the Ig Falks said there's only one way we're going to get to national health insurance given the political climate we're in, and that is to appeal to the public in terms of a specific problem that there is no other reasonable solution to and a problem that bothers everybody. First of all, everybody gets old, and secondly, everybody has parents. I mean, the problem of the aged isn't just the problem of the aged, it's a problem of your children, and it's a problem that private health insurance just can't solve. And so, I think they latched on to that. I think that was translated into support for the first Forand legislation, which was introduced, if my memory serves me right, early on in the Eisenhower...

WEEKS:

Certainly during Eisenhower, it was in the fifties and...

SIGMOND:

And right on through. It actually passed one or other of the Houses at one time and because it was really written as a bill to focus issues. It

didn't have any lead time built into it. I can remember once when it passed, I think, the Senate or the House, and Eisenhower had a predilection against vetoing. So, it might have been enacted into law. I can remember just a little incident on that; right after HEW was created, which was in the Eisenhower administration. They created a small office to follow the Forand legislation from an administrative point-of-view, just in case, and the guy that headed that up was Irv Wolkstein. I met Irv Wolkstein early on, I would say this would be maybe as early '55. He came to see me; I think Harry Becker told him to come and see me.

He said, "I understand you know something about hospitals and how they work. My job is, if this law passes, how would we work with hospitals?"

He was asking me those elementary questions about how a hospital bill is produced. Irv Wolkstein stayed on that job from that time until the Medicare legislation was passed. Sometimes he had a staff of one, sometimes he had a staff of 100, depending on what was goin on...

WEEKS:

His name certainly became familiar a few years later, but I had no idea he began that way. What was his background?

SIGMOND:

He was one of these guys--if I recall and if the record doesn't fit I just recalled wrong--he was one of these bright young men who was brought into government out of university public administration programs. Then he learned the realities of health from there. But, I can remember all kinds of sessions with Irv Wolkstein long before Medicare, when he was trying out different ideas and just always kind of both worried and excited that some legislation might pass. Excited because he was genuinely interested in this problem and

worried because he knew the government was totally unprepared. I think national health insurance was a debating, consciousness-raising thing until it got translated into the problems of the aged, which I think was a conscious decision of I. S. Falk, and Nelson Cruikshank.

Then the Republicans had to react to that. They might have picked children, you see,...

WEEKS:

That was the next thing wasn't it?

SIGMOND:

That would have been the next thing. The aged issue gave some reality to the health insurance debate. And then Walt reacted to that when he came into BCA, as you know, and introduced a management sense of reality. I got involved then with the development of Medicare legislation when I was in Pittsburgh. That's jumping ahead and I don't know if you want to go back or...

WEEKS:

I don't know, you went to...

SIGMOND:

Going back to the 1940s I worked on the government Hill-Burton commission for a year, then I went to work for Rufus at the hospital council where, among other things--we're talking about the hospital council--we would represent the hospitals in dealing with Blue Cross and dealing with the Community Chest. We were also charged to do anything that would help the hospitals serve the public more effectively by coordinated activities. So, we got involved in setting up a group purchasing program. I was especially responsible for developing interchange of information, which was not very well developed at all, and personnel programs--more effective personnel programs--also

developing ambulatory services. Simultaneously, Rufus got involved with a group of corporate leaders; in 1949 we set up a separate corporation, that didn't last very long, it was called the Hospital Planning Association of Philadelphia--a voluntary group--very much like we later set up in Pittsburgh. Rufus thought maybe he would head that up as well as the Council, but that wasn't possible. He was given a choice to be head of the planning association or of the council. For reasons that I don't understand, he decided to stay with the council. We brought somebody else in to head up the planning association whose name I won't mention unless you insist, and that didn't work out very well. But, we got deeply involved in the internal management problems of many of the hospitals. We had two other staff members and we had about sixty hospitals. Essentially, we were trying to help those hospitals to develop an external focus at the same time we helped them deal with their internal problems. It eventually got me to the point where I felt that's what I wanted to do for a living and to do it well I ought to spend a couple of years in a hospital. I remember saying to somebody at the time, jokingly, "I think I'd better go to work for a hospital for credibility. The way a union leader had to spend a year or two in jail." Where today you have to have an M.H.A., we didn't have those kind of programs in the forties, --except at Chicago and Northwestern.

So, I left Rufus--reluctantly--and, of course, we never did leave. He thought I didn't have to go to work for a hospital--he'd never gone to work for a hospital, but, I wanted to. So, I went to work as the assistant director of the Jewish Hospital in Philadelphia and just got actively involved in day-to-day hospital management and working with the medical staff. That's the experience I hadn't had before. But most important, I got involved in

efforts to merge the three community general hospitals in Philadelphia that were associated with the Federation of Jewish Agencies. That's a long story in itself. Those hospitals all came out of World War II with tremendous capital requirements and the Federation of Jewish Agencies had put on a postwar building drive and raised quite a bit of money, but it turned out that the amount of money each of these three hospitals wanted was exactly the sum of money the Federation had raised. So, the Federation brought in a consultant who advised the Jewish Federation that if the Jewish community was going to be consistent with other Jewish communities it would want to sponsor first-class hospitals, outstanding hospitals, quality institutions. There was no way Philadelphia Jews had the resources to sponsor three outstanding places; therefore, merge. That report came out in '49, just about the time I went to work there. All three hospitals resisted that, including ours. We all essentially took the same point of view. I can remember attending meetings with Federation people, explaining to the Federation that our hospital would support merger in principle; that we knew it would take them some time to convince the other two hospitals, but, we would support the idea in principle if they would just give us half their money right now. Of course, the other two hospitals were doing exactly the same thing.

The Federation had a very strong businessman in charge of the committee on this question. He explained to all these delegations coming in that he was not used to paying for things in advance. He said he once paid for something in advance when he was a very young man. He said it was an interesting experience but it wasn't worth it. He had just never done that again. He was referring to his first contact with a prostitute. He made that clear.

He held firm and eventually the three hospitals realized they weren't

going to get any funds unless they merged. It was a shotgun marriage, but they merged. The man who made the study was staying around waiting for the merger because he was supposed to be the head of it. That provided the basis for the compromise that was worked out. The three hospitals would merge if he would leave town. So they did merge. Then, of course, the question was, these three Jewish hospitals were in three different parts of town, they came from different sub-divisions of Jewish culture--German Jew, Russian Jew and so on--and it was a question of what kind of Jew would they have to head this place up. They finally compromised on a Sicilian Catholic who had been the head of the city municipal hospital and was greatly skilled in politics, Dr. Pascal Lucchesi, who had great influence on me. I became his assistant. At any rate, he and I had some differences on how to affect that merger. But I did have that experience way back there in '51 when we merged. I got unhappy, as did another gentleman in one of the hospitals, named Mark Berke, who subsequently left and eventually became the elected head of the American Hospital Association.

I left then and went with the Commission on Financing of Hospital care in Chicago, which was a successor group to the Commission on Hospital Care.

WEEKS:

I wonder...you were on leave at that time.

SIGMOND:

Well, just for face-saving purposes we decided to call it "on leave" because I didn't want to embarrass Dr. Lucchesi. Mark Berke had just quit, he was so unhappy. Yes, technically I was on leave, but I never expected to come back. Harry Becker recruited me to the Commission job and Maurice Norby as well. There were three volumes came out of that commission. The first volume

was on what to do about rising costs. Another, what to do about poor people, and the third was what to do in terms of health insurance generally. I concentrated on the cost of hospital service. That's volume one. Dr. Bachmeyer headed up that commission. Harry Becker was number two. Dr. Bachmeyer died suddenly; had a heart attack in the airport coming away from one of our commission meetings. John Hayes took over. He had been an administrator at one of the hospitals in New York--kind of a semi-retirement guy. He, theoretically, supervised me in the preparation of volume one with Harry Becker concentrating on volumes two and three. We spent two years on that and in my opinion we came up with some of the best early studies and best ideas on what to do about rising hospital costs, all of which are in that first volume. That commission report came out at a time when nobody cared. Nobody was interested in the problem.

WEEKS:

That would be during the Eisenhower administration?

SIGMOND:

In '56, yes. It's been a great boon to me because I've been able to give speeches and make suggestions for the rest of my life, and folks say that's a very original thought. It's all something we developed back in those commission days. I spent two years there in Chicago and that was very helpful too because it gave me an opportunity to meet all the key people and meet them in a high charged situation, because nobody knew that report was going to be untimely. There was a lot of energy went into it.

Incidently, I should mention, I struck up a very unexpected relationship there that was very helpful to me. One of the members of the commission was Morris Fishbein, who to me was an individual that always had had horns on

him. The commission broke down into subgroups centering around these three problems that I mentioned. Somehow or other Morris Fishbein got on this subgroup on hospital costs and I remember at one of the first meetings the staff had prepared some material and sent it out in advance. He came in and said, "This material is the worst written material I've ever seen, but I can tell that these fellows know what they're talking about, but they just don't know how to say it. So, if there's any way I can help, I'll be glad to help."

The chairman said, "Well you're here in Chicago, staff's here in Chicago, the staff would be happy to meet with you." To me he said, "I want you to instruct the staff: Clear everything with Morris Fishbein."

I thought, my God, that's the end of any originality, etc. Well, let me tell you, I went out and had lunch at Morris Fishbein's house every two weeks--he served a wonderful lunch, was a great conversationalist. I always sent out material in advance. He always went over it. He told me, "I will never change your ideas but I'll show you how to write."

I didn't believe a word of it, but that was the case. That man had a feeling for writing, and whatever I know about writing I learned from him. The only time he ever, in editing, changed the meaning was when he was so absorbed in the syntax and in clarifying things that he inadvertently changed things. I can say, he never used that influence that he might have had at anytime. I came to have a very, very, high respect for him in terms of my own dealings with him. He taught me things about writing...I can give you an hour and a half talk on what I learned about writing from him.

WEEKS:

That's an interesting side of him. Now, he was about retirement age then, wasn't he?

SIGMOND:

He was out of the AMA. He never did retire, but he was out of the AMA. He had just been pushed out. I can't remember the exact timetable, but I would say within a year. He was busier than a one-armed paper hanger out of his home there in Chicago. Gracious, but very egotistical, very egotistical! It was very hard to get a word in edgewise with him. I can remember those meetings and some of them were really kind of funny.

At any rate, that experience with the commission did give me exposure to national figures. It gave me an opportunity to dig into the data and formulations that really put me kind of way ahead of everybody else in terms of such ideas as utilization review. It's all in the book and nobody's ever really read it. Well, when the study was over, nothing quite came along--along the lines of what I wanted to do--and Dr. Lucchesi was trying to get me back to the Albert Einstein Medical Center and I didn't really want to go back. I had certain concepts--this has something to do with my interface ideas--about how that merger should have been effected. Those three hospitals were in different sections of town. He was trying to run them like one hospital and I was trying to help him to develop a central office with decision making down at the community level. He was doing it the other way because he thought that's what the board wanted. The three hospitals had 1,000 beds. They were in different medical school catchment areas. He set up a single director of nurses. He set up one medical staff. The whole thing just didn't make sense. That's why I had pulled out originally. I thought we ought to have three hospitals with central supporting services, central input into policy making, but having each hospital relating to its community. The way he was doing it the hospitals were forced to relate to each other which

meant turn their backs on their own communities.

Well, when he asked me to come back as assistant director from the Chicago experience, he said, "Okay." He agreed with me we were going to change. To make a long story short, they weren't going to change. We did close up one of the three hospitals and I had that experience of how to close a hospital. That's a whole long story. I learned a lot about that.

After I was back about a year and a half, the Pittsburgh group invited me to come out and be the first full-time chief executive officer of their hospital council, which was also one of those that were set up in the days of the Community Chest into a 501(C)(3). That was a very interesting development. The Hospital Council of Western Pennsylvania had been set up under the auspices of the Community Chest out of the energy of one of the hospital administrators. The first thing that he did after he got the organization created was to have himself named executive director. So, he was the head of the hospital, and executive director of the Hospital Council. Then he went to work to set up the Blue Cross plan, which he did by having one of the Foundations give a $30,000 grant to the Hospital Council for initial capital. He then became head of the Blue Cross plan. His name was Abe Oseroff, one of the great men in the early days of Blue Cross. He headed all three organizations from 1936 until 1942 when he resigned as head of the hospital but he continued on as head of the Hospital Council and the Blue Cross Plan until 1955 when he retired. By the fifties there was a lot of concern on the part of some of the hospitals. It was hard to negotiate with Blue Cross when the Hospital Council executive secretary was the head of the Plan. So, when he retired, they split that job and Bill Ford came in as the first full-time director of the Blue Cross Plan and I came in as first

full-time director of the hospital council.

A few years before, the Mellons decided to fund a school of public health at the University of Pittsburgh and brought Tom Parran and that whole group that had decided to leave the Public Health Service because they didn't like Eisenhower's philosophies. The Pittsburgh community leadership visualized the hospital council moving its offices into their new graduate school of public health building and being one of the key links of that school of public health with the entire area. It was part of the philosophy. So, I came in there as the first head when the building was being built, which was finished about six months after I got there. We moved our offices in there. John McGibony was the head of the Program in Health Administration and I worked very closely with him. They probably were the most exciting, satisfying professional years of my own personal career.

I just learned a little anecdote about that that might interest you. Just learned it a couple of weeks ago. I was in Pittsburgh, visited a man who is now well in his eighties, in retirement. He was the man who was in charge of hospital relations at the Blue Cross Plan at that early time. He told me the first time he ever heard my name was from a young professor at Pitt at the time, Walt McNerney, who called him one day and said, "You know, they have decided to have a full-time executive at the Hospital Council and I'm on the search committee. I have a very strange request to make of you, but I think I know you well enough to make it." So said Walter McNerney, according to this story. He said, "We've got a possible candidate for this job, but there's some question as to how acceptable he would be to--especially to the outlying hospitals--and you being in charge of hospital relations for Blue Cross, you know all these things, so I really want your very frank assessment of this

question. How would those hospitals react to our bringing in an extremely smart Jew to run the Council?"

Larry Irwin said he told McNerney, "Well, that is a strange question but I'll give you a straight answer. Being Jewish won't make any difference at all, but if he's really smart, he's going to have a lot of trouble." So, I told that story to Walt the other day; he didn't remember it at all. He has no recollection of the incident.

When I came out there, a lot of people advised me not to move the Hospital Council into the Graduate School of Public Health--we were in a downtown office building--because, they said that everybody in the whole area would then know the Hospital Council would be dominated by the university. There was the usual town/gown situation. I checked with people, and almost everybody advised me not to do it. I just decided that my program was going to be so clearly not focused upon university interests that I would be able to move in there and the people would see that I could bring the benefits of the university to the field, as well as bring the benefits of the field to the university. Tom Parran wasn't going to create any problems for me in that regard. I guess a lot of people thought it was a courageous move, some thought it was a stupid move, but it turned out to be a very smart move. I will say this, that when I left the Council the first thing my successor did was to move out. But, he took a different point of view. I thought it helped me, I thought it helped the hospitals, I thought it helped the university. I must say that I know of no instance where anybody was ever able to say Sigmond and the Council were taking any position to please the university.

WEEKS:

It was about that period that Rufus came to Pittsburgh too, wasn't it?

SIGMOND:

Well, I came in '55. The period between '55 and '60 was a fascinating period in the development in hospital and health economics that is much overlooked by people that have come in later. That was a period where the insurance commissioners in Michigan and in Ohio and in Pennsylvania in particular, were kicking up their heels representing consumer concern about rising costs. The first one was Michigan, the second one was Ohio and the third one was Pennsylvania. But the Pennsylvania man, whose name was Francis R. Smith, was the most energetic and aggressive. You can go back and read the literature of the times...as I said, just about everybody has forgotten about it. They treat concern about costs and Blue Cross premiums as a development much later with Herb Dennenberg you know. But all these later folks owe a great deal to Francis R. Smith. Are you yourself familiar with that development at that time?

WEEKS:

Of course I'm familiar with the Michigan development, but, you know, you look at discrete events. There was a great growth in Blue Cross and other insurance, wasn't there? There was also a great growth in costs. It also was the time when, you mentioned, the emphasis on national health insurance for everybody began to taper off. Could these be tied in to the costs, do you think?

SIGMOND:

I think so. The insurance commissioners moved in to the vacuum, so to speak. Now, it gave me tremendous opportunity to do progressive, innovative things because I was able to tell our hospital membership, "This insurance commissioner is going to get Blue Cross and if he gets Blue Cross, he gets

us. He's not really attacking Blue Cross, he's attacking us because the money comes to us. Blue Cross doesn't waste it, they send it to us."

I was able then to crank up a whole series of activities. I think whatever reputation I have in the field grew out of that. We got the hospitals involved with their medical staffs, with the county societies in reviewing utilization and attempting to control utilization--not Blue Cross utilization--all utilization. We developed a concept of the utilization review committee of hospitals, pre-Medicare. We set up the hospital utilization project, jointly sponsored with the county medical society. We got the county society involved in everything we were doing, mainly because there was this concern that the insurance commissioner was going to cut those premiums. Also, Ig Falk, who was doing consulting--he had left the government--he was consulting with the steelworkers union about prepaid group practice. I had a lot of dealings with him; he was coming in and out of Pittsburgh at the time. That really created a fertile situation for incremental reforms. Everybody associated with hospitals and medicine wanted to do everything to avoid prepaid group practice. They knew they weren't going to convince the steelworkers to give the idea up. But they also knew nothing was going to happen unless the steel companies went along. The companies might go along if they could get enough tradeoff across the bargaining tables with wages or something. Once those two agreed, western Pennsylvania's doom was sealed, if you want to think of it that way. I didn't think of it that way. As far as I was concerned, if that was the way it was going to go, fine, but I was going to use that pressure and get some things done. So, we got hospitals, physicians, trustees and Blue Cross working together in western Pennsylvania because we had these extra forces bearing on

us. Both the external force of Ig Falk and the union, which never came to anything, for reasons I could go into if you are interested, and the pressures of the insurance commissioner. So, we set up group purchasing programs, we set up methods engineering programs, personnel programs, control in beds, utilization review. We got the richest program of responsible cost-effectiveness going any place in the country, I think, and made a tremendous reputation. Meanwhile, I realized when it came to hospital planning the Hospital Council couldn't do it. That would put too much strain on a hospital organization. So, we created the Hospital Planning Association as an independent corporation sponsored by the large companies. In the course of Francis R. Smith putting pressure on the situation in Philadelphia, Rufus got trapped. He got trapped where he allowed himself to get put on the record in hearings about the inefficiencies of the hospitals in a way that make it almost impossible for him to continue as head of the Hospital Council. So, when I got the Hospital Planning Association set up, you know, I recruited him for the Pittsburgh planning job and got him out of there. So, he ran the Hospital Planning Association from '60 to '64.

He and I worked very closely together. The Hospital Council supplied the data that he used, and the contacts with the hospitals, and I attended all his board meetings. So, we were working closely together again. In '64, by which time I think he was 69--he started this new job at 65--he decided to retire again and he went to New York as an advisor with Jack Haldeman. I moved over and became head of the Planning Association and gave up the Council. Those were very, very interesting times.

WEEKS:

As I remember hearing about it, the Planning Council board was composed of

representatives from business rather than from hospitals or they may have been incidently trustees, but it wasn't because they were trustees they were there, it was because they represented business and commercial firms. Right?

SIGMOND:

We didn't have just representatives of business and commercial firms. We had, without exception, the chief executive officer of every large national or international company in Pittsburgh, no substitution, no second man allowed. In other words, we had...

WEEKS:

Had Richard K. Mellon, I suppose?

SIGMOND:

He was the one person we didn't have because he didn't have any international firm. He didn't head up anything in those days.

WEEKS:

Was his son-in-law there then?

SIGMOND:

Alan Scaif and Adolph Schmidt. We had the chief executive officer of the Mellon bank, the chief executive officer of Gulf, the chief executive officer of Westinghouse, chief executive officer of Alcoa, we had the chief executive officer of U.S. Steel, Jones & Loughlin Steel, H. J. Heinz, you name it. They came to the meetings and they knew Richard K. Mellon was for this, but he didn't serve with very many things.

WEEKS:

He was getting older then too, wasn't he?

SIGMOND:

Even when he was younger. His men did the things. There were no hospital

persons, but we had a medical advisory committee and a hospital administrators' advisory committee. And the chairmen of those would sit in on the board meetings. When our board met, it was the power structure of Pittsburgh at a time when they knew how to work together and they could get things done--but that is gone.

WEEKS:

What did they do? Did they supervise, say, raising money? Did they decide anything about what should be built and what should not be built? Because, after all, the money would have to come from them, more-or less, if they were going to build something, wouldn't it?

SIGMOND:

In those days the philanthropic funds, corporate contributions, were very important in capital investment. It's a long story and a lot has been written about this, but just in brief, the decision was made that this hospital planning association would not be a joint fund-raising corporation. We would advise the corporations which projects were worthwhile and which weren't, then they could do what they wanted. Of course, the ones who were on our board never went against our advice. Now, our whole effort was to never be in a position to advise against any project. They didn't want us to ever advise against any project. Of course, knowing that we were going to advise them gave us the greatest opportunity to work with the hospitals. We put a lot of emphasis on the hospitals creating an effective planning process with a planning staff. This whole development of hospitals having planning directors and planning committees all started there at western Pennsylvania.

What you said, Lew, was right, back in those earlier days there were a limited number of movers and shakers and they essentially determined what was

going on. There was relatively good intercommunication between government and nongovernment and academic and nonacademic. Essentially, everybody knew everybody else. That all began to really break down after Medicare. Medicare made the difference because Medicare shifted so much of the money and of the apparent decision making--want to emphasize--apparent decision making to Washington. Then following Medicare, the whole new society, Great Society, shifting things ever more to Washington. You just couldn't keep up. People came and went. The world changed right after that and it had nothing to do with Republican/Democrat at all. I think it's much to McNerney's credit and I think the AHA's too, that those organizations didn't move their headquarters to Washington. Stayed right there in Chicago and tried to maintain some balance. I don't say that in a sense of being some kind of right wing antigovernment. Personally I don't feel that way at all. But, health care is a community affair and there's voluntary initiative and frequently at that level people try to do the right thing just because it's the right thing--it's terribly important. Those sorts of elements in the health care system are never understood in Washington. Even when they try to promote community action, even when they try to promote the kind of community action that health systems agencies are supposed to represent, it always gets distorted by the national focus, I think.

Well, I think a lot of things were incubated in Pittsburgh by the fact that pressures were put on there during the late fifties, early sixties, in a way that we could develop positive responses. I mean, there have been other periods where pressures focused in specific situations like New York State recently. But, there the reaction was a negative reaction. We were able to, I think because of circumstances, maybe luck, maybe a little bit of skill, I

don't even want to say anything about that, we were able to convert pressures, tensions, into positive programs and that's been a special interest of mine ever since. How do you take the inevitable external forces that work on the health professionals and that work on the health institution, how do you direct those into positive channels and not bring about negative responses? It's been increasingly difficult to talk to the individuals that represent those forces and help them to see how useful they could be if they would work with those in the health field that want to convert pressures into positive forces rather than negative forces. I'm still fussing with that problem today.

By 1968...From '55 to '64 I was head of the Council, '64 to '68 head of the Planning, which first was a voluntary sector project and then we got a federal grant under the old Hill-Burton support programs. (Our corporations didn't think they ought to take that money, but I thought it would be a good thing.) Then the CHP legislation came along--Comprehensive Health Planning legislation--and I was getting tired of giving people advice, I kind of felt I wanted to do something myself and just at that point Dr. Lucchesi was at retirement age and asked me if I'd come back to Albert Einstein Medical Center for a third time and be the chief executive officer. Then, whatever differences we had on how it ought to be done would be resolved because I'd do it my way. So I came back to Philadelphia in '68.

WEEKS:

I was going to say, before we get into your next stay in Philadelphia, we'd sort of passed over the Eisenhower administration. I was wondering if you had any firsthand meetings or dealings with Mrs. Hobby or what your opinion is of her appointment, her ability, her knowledge, let us say, in the field. I imagine she probably had ability as an administrator but Sam Rayburn

thought it was funny that they'd take that Texas girl and put her in there.

SIGMOND:

I have very little to say. I never had any contact with Mrs. Hobby. I've never been especially interested in getting involved with the federal government. I knew Marion Folsom quite well because when we were doing what we were doing in Pittsburgh, Marian Folsom was the unpaid leader of similar activities in Rochester. These were probably the two outstanding cities--maybe Detroit was third--there were a few things going on in Kansas City--but probably people would have said Pittsburgh and Rochester. They always said it's because of the unification of the industrial leadership. I spent a lot of time with Marion Folsom, advising him in Rochester and talking to him. He was a trustee and I was an executive but he was a pretty involved trustee-type.

WEEKS:

Was he Eastman Kodak?

SIGMOND:

Eastman Kodak, yes. Everything that's happened in health up there centered around him. You see, the hospital association didn't have a chief executive who was well-known. They always had a chief executive but you wouldn't just quickly think of the name of the person as, I guess, you might have men in Pittsburgh. Once Folsom got down to Washington as Secretary of HEW I never had anything to do with him. I only ever got involved in the Washington scene, actively, during the Medicare days helping to draft that legislation and then during the early days of the Regional Medical Program. It was mainly, as a matter of fact, because of my brother, a long-time servant, who developed leukemia at that time, and I used any excuse to come

into Washington until he died. So, I started to serve on all kinds of advisory committees and so on. I didn't like it, I just didn't like it. I have a sense that when you are in Washington you can hardly avoid the feeling that whatever meeting you're in is going to determine the whole future and course of the world. It's nonsense. The best thing for a person like me to do, who may get captured by that, is to stay away. What I used to do in those days when anybody invited me to a government meeting in Washington, I always used to ask: Who is going to be there from the BOB, the Bureau of the Budget? If nobody was going to be there from BOB, I figured it wasn't important enough to go to. Now it's the OMB, Office of Management and Budget. That's always been the side of government that's interested me a great deal because there is, in what was the BOB and now the OMB, there is a whole side of government that no one knows. There are people who mirror every agency of government. They're the ones who advise the White House. That interested me. Then also, I got interested in the whole development of congressional staffers. That's a development of the last ten or fifteen years that's almost out of hand now. But in the early days that was facinating, because there were just a few. I never met Hobby, I never made any attempt.

I never met Flemming. I just didn't bother with those people. I spent time with Bill Stewart when he was the Surgeon General and some of the people around him. I thought he had very romantic ideas. I really think that a lot of the problems that the federal government got into in the health field resulted from the romantic ideas of Bill Stewart. I don't consider him a villain but just a kind of romantic...and Phil Lee the same thing. There was just always a sense of unreality.

WEEKS:

Weeks

Well, I get that impression that many of the people who are trying to pass social legislation are not concerned with how it's going to be paid for. If you ask them how it would be paid for, if not by Social Security payroll deduction, as an example, they say they'll take it out of the general fund. That's the end of it. There's never any concern whether there is enough in the general fund. It would seem that benefits and funding should have to go together some way. If you legislate benefits then you should decide to pay for them and find a means of doing it. Maybe I'm naive.

SIGMOND:

No, that's right. I would have put it a little differently. I thought that they never gave a lot of thought how the program is going to be managed at the community level and how the financing was going to impact. So, my emphasis was towards management.

WEEKS:

I was just wondering if you want to talk about your third experience at Einstein.

SIGMOND:

Well, my third experience at Einstein was an extremely educational one and probably, from my point of view, the least successful segment of my career, as I think about it. I achieved some of what I wanted to achieve but not the goals I had set for myself when I went back. Part of it, I think, was that the scene had changed between the time I accepted the job and when I went there. Partly that it was just more complicated than I realized. You see, I took that job in '68--in the summer of '68--and it never occurred to me that Nixon was going to be elected President. I assumed that Humphrey would be elected President and that we would go on with some extension of the Johnson

programs, maybe with a little more realism. It was a period, you know, prior to '68, with great emphasis on community action. Under Dr. Lucchesi, the Albert Einstein Medical Center had not responded to that at all. They were just all involved in quality, technology, in medicine and doing a very fine job. I think the institution has a good reputation. It seemed to me that the timing was just right for a person like myself to come in and bring that institution in tune with what was going on. I think that's right, and I think I did do that. What I didn't realize was that by the time I got there that whole setting was going to change because Nixon just knocked all of that out. So I found myself not in the position where I always feel most comfortable, where there are a lot of outside pressures that I can help a group respond to. The pressures were the other way, and the pressures got to just be on cutting costs, you know. I think I did a reasonably good job at that, and did accomplish my reorganization in terms of having two institutions with some identity within their own communities. But, I also had some ideas that I could elaborate on about the importance of bringing physicians into management and on reorganizing the medical staffs so that you would have responsible physicians in management as contrasted with the role of medical staff leaders representing physicians against management. I never resolved that to anybody's satisfaction. I did bring about a corporate reorganization and we did develop some interesting programs.

In 1970, I was 50 years old, I remember that, I was 50 years old and I started to think about my future and then I realized by 1975 I would be 55 and I would have ten more years of what you might call "active" career. In that period I just kept thinking to myself if I had all the breaks in the game, which you never do, what would I have accomplished? And would I be happy?

All during that period between '70 and '75. I got involved with the American Hospital Association and helped them to organize their first council on research and development. I was very active in some developments up there, but that's a whole other story. During the period 1970-1975 I was becoming increasingly of the opinion that to accomplish what I wanted to accomplish I had to look at it in the time frame from '75 'til I was 65 years old which would be 1985. I was becoming increasingly of the opinion that being CEO of Einstein wasn't what I wanted to do with my talents.

Simultaneously there was the feeling that relationships between Blue Cross and hospitals were deteriorating. I used to, during that period at each AHA convention and whatnot, always end up in Walt's hotel suite. Usually Shirley would tell him to go to bed or get dressed. It was one or the other. She was always either in a nightgown or slip. Time to go out to dinner or time to go to bed, but get that guy Sigmond out of here. You know, talking to him about this. At any rate, this all kind of came together then in '75, Walt said "Look, you ought to come and help me. Let's make a study of this thing and see what's what."

That was one side. The other was that I decided the next step at Einstein had to be fundamental corporate reorganization. We had an organization where the president of the corporation was unpaid--a member of the board, he was like the chairman of the board. I was executive vice president, which was the CEO, but not on paper. On paper he was the CEO. I said we had to have a corporate reorganization, we had to make him the chairman of the board, the person in my position as president with a vice president for each of the two hospitals, so we could really clarify lines of authority, policy making vs management. I talked to the chairman of the board, whose title was

"President" about it at some length. He was totally in agreement and thought we ought to get a board committee and work that through. Right there I came to the conclusion that the best way to really work that through was that I should announce that if we did it and created a position of president that I wouldn't be a candidate, which was a big help. That answered some of those people who thought that all I was trying to do was consolidate my power, you know. So, anyway, that's what I did in 1975. I became the staff person for this new committee. We did create this corporate change, and I left. I took on this assignment with Walt. I figured I'd do that for a year or so, until I decided what I was going to do when I grew up. I did not want to move to Chicago, for personal reasons, and there was no way I would take an executive position with the Blue Cross Association. So, I took three months off as the Edwin L. Crosby Fellow and went to England to look at the English health system with Gordon McLachlan then I came back, did this study with Tom Kinser which you've seen, and essentially have been helping Walt ever since. I turned 60 this past year. I'm beginning to think that probably I'm just going to gradually work my way into retirement from this job unless something very unusual would come along to get me excited. The job I have has certain frustrations because I don't have any managerial responsibilities with it. I find that's not bothering me so much. I do play, I think, a fairly significant role in terms of reflecting that part of Walt who wants to keep the hospital-Blue Cross relationship vibrant. So, I'm a link with the AHA. Blue Cross folks see me as an influence on the whole organization not to forget that relationship. The pressures within Blue Cross/Blue Shield to become an insurance organization or computer company--they're very, very great. So, Walt just keeps insisting that I stay there and I keep insisting

that the longer I'm there the less he faces up to certain issues. But I guess I've told you that before.

WEEKS:

You do a lot of traveling in this job, don't you?

SIGMOND:

Yes, I would say generally I spend about one-third of the week in Philadelphia, which would be the weekend and one other day, and a third of the time in Chicago and a third of the time on the road.

WEEKS:

I have a question I think I asked Walt and Walt very nicely answered me, but maybe you'll answer me even in more detail. How many plans are there now?

SIGMOND:

There are 130 all together, corporate plans.

WEEKS:

The 130 plans have many different parts, of course. They're all over the country and with many kinds of political feeling behind them and many kinds of cultural situations and industrial vs. rural--all this sort of thing. So, that you have a lot of different viewpoints and I assume you have a few prima donnas also. The Blue Cross Association, which I hope we can talk about before we're through here, has to represent these people. Also, I assume that many times you have to monitor them. How do you keep them in line? For instance, we'll say a Plan off here somewhere either is not handling its customer relations in the way it should or not doing its marketing right or having executives taking too many perks and so on. How do you keep them in line?

SIGMOND:

Okay. It's a very complicated process and let me see if I can discuss this in terms of different levels. Number one, let's just talk about the Blue Cross Association. Everything I would say about the Blue Cross Association would be true with variation, with the Blue Shield Association. They are separate associations, as you know, now with one staff, a joint executive committee and so forth. But, let me talk about Blue Cross and then I can pick up on the variations on Blue Shield, if you're interested.

WEEKS:

Yes.

SIGMOND:

I'll talk about Blue Cross because it's easier to talk about one and the one I know more about. There are probably about as many as eight pieces to the answer to your question and none of the eight really work well unless seen in relation to the other seven. I'm not sure the number is eight, I just picked that...It'll be whatever I come up with. Okay, first and most formally, the Plans must conform to the standards which were originally developed by Rufus Rorem and have been amended from time-to-time and-- the approval standards--you can get a list of the approval standards. The Plans are required each year to complete certain forms which signify that they think they're in conformance with the approval standards, along with supplemental information. There's an entire staff that reviews that material and takes appropriate action. What does appropriate action mean? In theory, it means that a Plan could lose the Blue Cross symbol by action of the board on recommendation of the approval committee. In practice that has not happened in over twenty years and it's not likely ever to happen again. However, when these papers are submitted, and I'm talking about the approval standards part,

and are reviewed, site visits are scheduled at periodic intervals, depending on what the material looks like, correspondence may be exchanged. Problems are identified and at least once every three or five years, there's a full-fledge site visit. It is very much like a Joint Commission on Accreditation visit or an AAMC visit for accreditation of medical schools. These always result in assessments in which areas of weakness and areas of strength are pointed out. This visit has to do with fiscal stability, with management, with relationships with hospitals--the whole approval standards. Now, this is all treated relatively confidentially, nothing said to the public, etc. But, of course, the reports of this activity go to the board of directors of the BCA which is made up of plan execs. Any Plan executive who gets a critical letter tends to respond, you know. Now, if his response is inadequate, that fact will be reported to the board. There are different kinds of actions that are taken. Really, the most extreme action that I can think of that's been taken in the last year was, when following a number of intermediate steps, the Blue Cross executive committee requested the chief executive officer of a plan to arrange a meeting with his board, which was done. This had considerable effect. So, that kind of thing goes on. Action moves from an exchange of letters through to a delegation of plan executives that met with the Plan CEO, and so on. I don't want to mislead you: I cannot imagine a situation where we would actually take the symbol away any more, but that doesn't mean that this is a totally powerless process. This is a very powerful process. Do you want to comment on that?

WEEKS:

I was just going to say that probably, instead of taking the symbol away, there'd be a change of management somewhere.

SIGMOND:

Well, yes. But BCA wouldn't do it, the Plan board has to do it.

WEEKS:

So there's always this final threat there.

SIGMOND:

Well, now we have some other threats also. We have some other things that have been used. As I say, the whole set of activities is not to be minimized. Second, BCA is the prime contractor for Medicare. The Plans subcontract with BCA. Nationally, as a group, the Plans handle more Medicare money than subscriber money, especially in the weaker Plans where the ratio maybe eight Medicare dollars to one subscriber dollar. If these Plans didn't have Medicare, they'd be dead. BCA has the power--obviously through the board structure--but BCA has the power to say that this Plan isn't measuring up and it's threatening our prime contract with Medicare which means it's threatening the stability of every Blue Cross Plan. So, Blue Cross might have to take Medicare away from the Oklahoma Plan in Oklahoma and give the work to the Texas Plan. We've done that sort of thing. Of course, Blue Cross Plan people know we can do it and before you do that you go in and say, "Hey"...and that's very powerful.

WEEKS:

Just as a sidelight here, how does the Plan benefit? Are they paid on a percentage of funds handled or on the number of subscribers? How are they paid?

SIGMOND:

Well, I don't want to answer that as an expert. Barney or somebody else could give you the correct answer. Essentially, they are paid so much per

claim processed.

WEEKS:

It's a little more than their administrative costs, in other words?

SIGMOND:

Well, there's a different way to look at it. The way to look at it is this: Essentially they're paid their administrative costs but if they weren't doing Medicare, their administrative costs for their other line of work might double. You wouldn't suddenly cut half the building off. There are also many people who are there doing both jobs.

WEEKS:

They have to be there anyway.

SIGMOND:

Have to be there anyway. So, it's not that we make a little bit extra; you don't make anything, but it makes all the difference.

WEEKS:

But you avoid costs on the other hand.

SIGMOND:

Yes. I would say for many of the Plans to lose Medicare would almost be unthinkable. I guess it would be like some company that had gotten where it was producing 60% of its product for Sears Roebuck. That's point two, Medicare. Point three is national accounts. A word or two on national accounts like U.S. Steel or General Motors with employees in various Plan areas under common policies centrally administered. National accounts are not handled by the national association. Except in certain instances, they are handled by a syndicate of Plans in which that national account has a certain minimum number of subscribers in each Plan's area, with the Plan in the

corporate home office town being the head of the syndicate. So, the Michigan Plan obviously is the head of the syndicate for all the Detroit auto companies and the Pittsburgh Plan for the steel companies. The Allentown Plan--Allentown, Pennsylvania--probably wouldn't exist if Bethlehem Steel went commercial. It's there because Bethlehem Steel wanted to have its own Blue Cross Plan. There's a certain overhead sharing there. Now, again, the national association has the power by the agreement of the Plans that if a national account plan is doing an unsatisfactory job, after going through appropriate process, to take it away, and to say, for example Michigan, sorry the Illinois Plan is going to handle General Motors.

Well, aside from the financial implications of that, because here again, you've build up big pieces of your overhead, there would be the embarrassment of that Michigan Plan. The national association doesn't do that very often, but it has been done. For some Blue Cross plans the national account business is a very large part of their business.

Furthermore, when a Plan gets into real trouble, it doesn't get into trouble with the national association, it gets into trouble with the state insurance commissioner. One of the things Rufus did early on was sponsor model legislation.

WEEKS:

Enabling acts?

SIGMOND

The enabling acts. They almost all provide for the insurance commissioner to supervise. Now, we get calls in Chicago. There have been two of them since I've been there in five years, two that I know about. An insurance commissioner calls McNerney, "I'm in trouble." He doesn't say to McNerney,

"You're in trouble." He says, "I'm in trouble."

"What are you in trouble about?"

"I'm going to have to declare that Plan bankrupt. I can't afford to do that politically. You've got to help me."

I'm fantasizing that conversation, but in effect an insurance commissioner with a problem Blue Cross Plan has got a problem on his hands. He doesn't have that many people to turn to, and we're there. Now, he invites in the national association...we have every reason to call the Plan and say, "Hey, we'd better come in."

They ususally say, "Yea."

Then we'll come in. In both of these two situations I know about, the national association representatives sat down with the Plan's board and, as you just indicated, urged that they get new management. The insurance commissioner is usually scared to death and accepts our recommendations. We don't take over the management but we do make very specific recommendations to the Plan board, and in one of these two cases we did, for the first time and I hope the only time, we did lend the Plan some money which they are paying back. I don't think we should ever do that, but we did it. There was a long BCA board meeting before they agreed to do it. So, we have all those kinds of powers. Now, that adds up to a lot of power.

In addition to that, and I think Walt's interview gets into that, there's increasing understanding that it is important for the Plans to remain autonomous community institutions, but that with the growth of national accounts, with the population moving the way it is, and with the nature of public policy debate, failures of any one plan hurts them all. So there's increasing sense of the appropriateness of the group as a whole influencing

the individual plan. Now, there's a big difference between the group as a whole and the BCA bureaucracy and that's where it takes a good deal of skill on Walt's part. There are continuous problems that must be dealt with on a case by case basis. But, Walt's basic assessment I would agree with, some people might not, and on some days I don't agree with him, but I think his basic assessment is that, when the chips are down, the Plans as a group do what is required by the public interest. Day-to-day they're protecting their autonomy, but the long-range, key decisions are soundly based.

WEEKS:

This is another point I wanted to bring up. We've seen a merger movement in the past few years, less and less plans. I'm thinking of John Mannix, whom we haven't talked about yet, and his idea of the American Blue Cross. Do you think that will ever come about, that there will be one Blue Cross national plan where they can offer a variety of contracts and offer a national employer...?

SIGMOND:

I don't think it will come about any different than it's coming about. I don't think there'll be a dramatic move like John was looking for. I have great admiration for John and have had for many years and he for me, as far as I know. You know, he puts on this conference every year in Cleveland and I may have sent you a copy of the paper I gave there--the last one--he says I'm one of the two people he ever invited back. But, John gets impatient. He did all his life. Not only did he promote the American Blue Cross idea, but at one point he dropped out and set up an insurance company and a lot of people will never forgive him for that.

WEEKS:

He was sincere, wasn't he?

SIGMOND:

Always sincere. Always sincere. I don't think anybody ever accused John, for instance, of having gone into the insurance business to make money or having proposed the American Blue Cross so he'd become a big national figure. No, I don't think anybody has ever questioned his motives, they question his judgment. I think the national Blue Cross idea was peculiarly ill timed. It came at a bad time. I think that we will move simultaneously toward stronger community programs and stronger national framework at the same time. I don't see these as conflicting goals. I don't see marriage as essentially a conflict and yet almost all mariages have day-to-day conflict. The strength of Blue Cross is that it can reflect the working out of conflict within the framework of community affairs. Health care is a family and a community affair primarily. It's not primarily a national affair.

WEEKS:

Are you saying, that by having sixty Plans or whatever, that it's more likely that the Plan will be closer to its people--its community--then it would be if we had a national...?

SIGMOND:

No question about it.

WEEKS:

So this would be the strength of it?

SIGMOND:

The strength of it. Now, I think we also have to pull together in terms of certain aspects of policy and in certain aspects of mechanics to the extent that a larger scale is indicated the Plans will do that. To me, it's

interesting that in the Blue Cross field when they talk about regionalization they mean a region covering more than one plan. When you come to things like computers, and other activities like that, we're going to get into more and more regionalization. To me, regionalization means something quite different. It means that in Michigan there are different regions and you deal with Detroit different than you deal with the Upper Peninsula. That's what regionalization means to me. I say that simultaneously we're going to see, within the Blue Cross Plan, more of what they call regionalization on mechanical stuff and more of what I call regionalization on the nonmechanical stuff. For me, the ideal of running all hospital relations in Michigan out of Detroit is crazy. As a matter-of-fact, hospital relations in New York--I'm not talking about New York State, I'm talking about New York City--should be broken down into subregions with somebody in charge of each of these subregions, because that Plan is such a massive thing. An executive in a hospital in New York City trying to deal with a New York Plan doesn't even know who to talk to. It's crazy. There's no way you can talk to the guy in charge of hospital relations (you can never get him on the phone) on a minor problem. So, I think the strength and the weakness of the Blue Cross Plan is all tied up in both local autonomy and national systems that we've got to evolve in ways that give the system the strength of both of them, and avoiding the weaknesses of both. When you come right down to it, health care starts with a family, and an individual in that family, and some kind of relationships with professional health supporting people. First of all, you can't put that into a pattern because everybody's different.

WEEKS:

That's right. You can't run it like General Motors or any big

corporation. This is the best answer to strong plans working together under Blue Cross Association.

SIGMOND:

Right. Now the Association's got to appreciate the importance of the Plans adapting to that local scene. In part of my CV there are reports of some work that I did with the Indian Health Service at one time. The main thing I was doing with the Indian Health Service was trying to convince those bright physicians, who joined the IHS during Truman's time instead of going to Korea, to pay attention to the local environment and culture. Somebody had told Truman that the only population he was responsible for totally was the Indians and they had the worst health record in the world. If he was going to be honest in pushing national health service he had to put some energy in that comprehensive health service obligation. So he put a lot of money into the Indian Health Service, and all those bright docs out of Harvard were going there and working hard; the health records remained just as bad as before.

Some of us--I wasn't the leader at all--some of us went out there for short-term assignments, essentially asking, "What's the relationship between you and the Indian medicine men?"

The answer was always the same, "We don't have anything to do with them."

"Well, my gosh, how do you relate to the Indians?"

"Well, we don't relate to them, we treat them."

It didn't work. I used to tell that to some of my bright residents who were upset with some of our attending medical staff at Albert Einstein Medical Center. I'd tell them about the Indian Health Service, the Peace Corps, and the necessity to relate to the culture in order to get results. Well, our medical staffs are the Indian medicine men of our communities. You know, you

can't yell at them, you got to relate to them. The same thing with Blue Cross. A Blue Cross man's got to relate to the culture, and the culture is an extremely variable thing. Lansing, Michigan is going to be just different from Mackinac Island and so forth. And that's our big strength. That's never going to go away.

The thing that we're moving towards is much greater recognition of how to develop a health system that accepts the idea that the health system must encourage people to be responsible for their health in the framework of their own culture. Not to feel guilty if they're not, but to assist them and encourage them. That's the key to cost containment, too. It's the key to better health; it's the key to cost containment to pass as much of the services back down to the people who could really give tender, loving care and that's the people themselves. Nobody can give tender, loving care to me better than I can, unless it's my wife. All of that means relating to the culture and relating to the culture means recognizing the diversity of the culture. Now, Blue Cross can do that.

WEEKS:

I want to make a couple of comments on Blue Cross in general. One is way out. This has to do with your last statements about people being conscious of their health and doing something about it. I'm among the senior citizens now and you soon will be. When you look around at people, many people today have enough money so they can eat out more, they do things like that, but many of them, who don't have any interests, think about their health and going to the doctor and taking pills. I wonder if this day will ever come that Blue Cross will feel as part of their...should be a part of their program to promote other interest among the elderly so they don't feel sick.

SIGMOND:

Absolutely. I think that the whole future of health care is in this newest interface and that is the relationship between health care and other human services. That is where we're going to have to go.

WEEKS:

It seems to me that something is going to have to be done because our elderly are increasing in ratio all the time.

SIGMOND:

That's absolutely where we go, and I think McNerney is sensitive about it.

What I started to say before, and I want to get back to that, is there's no question in my mind that a lot of people at the national Blue Cross/Blue Shield Associations look upon the Plans and the Plan management as the obstacles to problems rather than the vehicles through which progress is achieved. That's something Walt has to struggle with all the time. And I don't think he does it as successfully as he might.

WEEKS:

Do they get out and see how these Plans work?

SIGMOND:

Yes, but they see it with a certain eye. Generally speaking, when a BCA/BSA staffer goes out to a Plan, he's going out in relation to a computer problem or some problem in utilization review or some problem in hospital reimbursement, so he's focusing on that particular issue. And then he may very likely hear from the person he's dealing with, "Well, gee, I would do this better if the CEO of the Plan would let me." The people we're sending out don't generally have a perspective about the Plan, they have a perspective about a particular process. So, they either come back telling us that we got

to get the CEO fired or we got to convince the CEO to fire the guy they were talking to.

WEEKS:

This would probably be aggravated if there was an American Blue Cross at the top; it would be even worse.

SIGMOND:

Oh, then it would be, yes. I guess you know that if we were a private corporation, measured by volume, we would be in the Fortune 500 and we would rank number one. Number one. There's no private corporation that handles as much money as all of these Plans put together. Now, we're not a private corporation; we're not even a combined nonprofit corporation. So, we don't handle all that money. If McNerney did, his manager's job would be much easier. It really means that he's got the hardest manager's job in the country, even maybe harder than the President of the United States. Because he doesn't control them, but I think it's better.

WEEKS:

He has to be quite a diplomat to survive, doesn't he?

SIGMOND:

Unless he wanted to keep his head down, you know. He often talks about that. You can keep your head down where a person can't see anything and secondly, the bullets all go over your head. He wants to keep his head up and then you see things but how do you dodge the bullets? When I see the difficulties that Walt has in trying to get competent people to manage in these special areas and trying to help them to see the larger picture, his job seems almost impossible. There are examples of what are evident failures there. Much of it comes to a focus in terms of my interests around the

handling of the so-called intermediary relationship with Medicare. I think that a great many of the people who work for BCA, who, incidently, are paid out of federal funds, and they know it, think of themselves much more as federal workers than they think of themselves as Blue Cross people. If they think of themselves as Blue Cross people at all they think of themselves not as intermediaries but as in a government agent role--that Blue Cross is in a government role. Well, intermediary means Blue Cross is in a government agent role and in a hospital agent role at the same time. That's a very difficult set of concepts. Now, the fact of the matter is that the government people lost interest in the intermediary role a long time ago. They do not see the benefits to them of having an intermediary, they want an agent. The thing I keep emphasizing to Barney and Walt is you'll never please the Feds. You'll never be a good enough agent. And, as a matter of fact, today if the HCFA people had their way they'd get the law changed tomorrow and put the whole thing out.

The future fiscal intermediary relationship depends upon the hospitals thinking that it's worth something to them. If the hospital thinks it's worth something to them, and Blue Cross is convinced it is, then Congress won't change it just because the bureaucrats want to change it. You see, the bureaucrats--and I don't mean that in a pejorative sense--the people that have those jobs tend to look at what's the cost of the administering claims, if EDP or somebody else can do it a cent cheaper, then they ought to do it. They'd take it away, from Blue Cross and have them do it.

What they don't see is that of the typical Medicare dollar we get 2¢; 98¢ goes to the hospitals. Now, they can cut that 2¢ down to 1¢ which might result in higher claims payable. It's conceivable, if they raise the 2¢ to 3¢

and challenge us to get the 98¢ down to 57¢ we might be able to do it.

As I was telling a group at Medicare the other day, "You know, you folks remind me of that cartoon that was in the New Yorker once." I don't know if you ever saw it, it shows this lady in an art museum with people with easels and who are painting copies of art hanging there. Here's this great big rival, rustic scene; immense thing. She's painting a reproduction of it and she's just focusing on this one male figure down here, not even on him, just on his penis. That's the whole thing. She's missing a whole big picture, you know.

They're continuously putting pressure on us to knock down the cost of processing claims and threatening to put it out to bid. That's such a trivial thing. I keep saying to Walt, and I haven't convinced him yet, that we should come forth with the idea of underwriting Medicare. Underwriting Medicare, not contracting, underwriting the whole thing. We'd be better off. Do you understand what I mean?

WEEKS:

I don't understand just what you mean.

SIGMOND:

Well, we are managing that program for the federal government. We pay out the claims money. We get paid money to do that, but our contract centers around the cost of processing claims. And that's what the contractor is. What I think we ought to do is put in a bid, which will include not just the processing but the payout for benefits and say, "For this much money we'll see your old folks benefits are provided." We guarantee that we'll pay what's required. Now, that looks like a bigger risk but it's also a bigger opportunity.

WEEKS:

That's quite a daring idea.

SIGMOND:

Well, it all depends on how you look at it.

WEEKS:

But presenting this to most people it would seem like quite an unusual and daring idea with a great risk, as you say, attached to it.

SIGMOND:

Right. I'll tell you. Califano tried to interpret the law to permit him to put the intermediary relationship out to bid, but the law guaranteed the intermediary relationship as a selection.

Then he said "Under the experimental provisions of the law I can do anything, so, I'm going to experiment with this." So he decided to experiment and put the hospital relationship out to bid for five states. He sent out a bid proposal two inches thick; five states for five years. The Blue Cross Plans in the area and the hospitals in the area all agreed that they would take that to court. They said that wasn't what was meant by experiments in the law, but simultaneously they didn't know how the court was going to act so they had to start putting the bid together. I was out there in Colorado when they were putting the bid together. They had to make estimates on how much it would cost for various elements of processing a claim. It was all broken down in detail. The guy who was in charge of preparing the bid said "Boy, my neck is on the block on this. I could be off by 4 to 1 and that could bankrupt this plan." All he's bidding on is that 2¢ for bill processing.

I said to him, "Let me ask you a question. Would it be more or less risky to bid on the whole thing?

He said, "Oh, my God, it would be much less risky."

It sounds like it would be more risky but he saw right away it would be much less risky. You got a lot more to play with. I guess in a sense it would be more risky because....as far as he was concerned he could go broke on the 2¢ because that 2¢ was half that Plan's budget. If he is dealing with the full 100 cents, then if he is off by 1¢ or 2¢ of processing costs, that can be offset by a reduction of 1¢ out of 98¢ of benefit payments. So, he saw right away it was less risky.

I said, "Why don't you go tell your boss.

He said, 'Oh, gosh, that's not my business."

I think that's what we're going to come to. We've got to get the intermediary relationship working in the interest of the subscriber, the hospital, and the government. It doesn't work that way now, the government doesn't let us.

WEEKS:

Do you have any theories as how this fiscal intermediaryship came about?

SIGMOND:

Well, nobody knows more about that than Walt and I guess maybe Bob Ball and Art Hess. Those would be the three and Wilbur Cohen, of course, and the other Wilbur, Wilbur Mills. Those would be the people to really ask. I wasn't in on it.

WEEKS:

Well, I have the feeling that the idea is sort of an evolution that came down...I'll test this out on you. If you look at the legislation during the Eisenhower administration, or anytime there's been a Republican bill, the Medicare-type of bill, there's always been the private insurance company

that's come in there. Either the bill says we'll subsidize private insurance for people who can't afford to pay the premium or I noticed that in several of the bills there's even a time when they called for an administrative intermediary as well as the fiscal intermediary. Wilbur Mills talks about a three-layer cake when he was trying to satisfy everybody and he came up with Medicare/Medicaid. I've been wondering if maybe the planners have said, "Well, maybe we'd better put in a little bit to appease the insurance companies, which would include Blue Cross Plans."

SIGMOND:

Yes, that could be. The other side of it is, that maybe they realized that they just couldn't do it by themselves.

WEEKS:

Well, I'm sure that as far as handling claims they had no setup and certainly Blue Cross had the experience with their own plan.

SIGMOND:

I think it's some of both. I just don't know. I know that selling Blue Cross to the hospitals as the intermediary was a major effort by the American Hospital Association.

WEEKS:

I think this was a big input. Now, this brings up another point. For years there was a move to separate Blue Cross and the hospital association, thirty years before it happened. Do you have any feelings about their being separated? Did the time come when they should have been? Were there benefits lost by their being separated?

SIGMOND:

It was necessary for them to separate but I think it was very poorly

handled. Walt agrees with me on that, not only privately, but has said so internally, at Blue Cross meetings. He will take the blame for it. The concept was: Let's separate so that we can have a more effective working relationship. Let's separate so that we can pursue our common goals and objectives better. I say it was poorly handled partly because the move to separate occurred just before Crosby's death and partly because Walt was distracted and a number of other causes. I think the emphasis became let's separate because we're too close. The positive aspects of it were never gotten at. The original documents, which were worked out between Ed Crosby and Walt McNerney, were interpreted by everybody as BC and AHA moving way from each other and moving towards an adversary relationship. That was not the intention but that was not marketed nationally among hospitals, nor among Blue Cross Plans nor within the AHA. That's one of the things we tried to address in that little Sigmond-Kinser report released in 1976. I think we made a lot of headway since 1976. That's one of the things I've been working on very hard in the last few years. I think today, there are much, much better relationships at the national level between the two independent organizations, than there was before. Not only was the situation complicated by the death of Ed Crosby, but also by the fact that Alex McMahon came in as his successor at a time when Alex undoubtedly felt special need to develop his identity separate from Blue Cross. Especially, as I think a lot of people know, Walt McNerney was a leading candidate for that AHA job.

WEEKS:

That's what I wanted to ask you. What happened? Then speculate on what might have happened if Walt had gotten in there. I don't know if you want to do that.

SIGMOND:

Well, I was on the advisory committee to the search committee; there was a small search committee, Nathan Stark was on that, then there was an advisory committee, of which Horace Cardwell was the chairman. The advisory committee made input to the search committee, which made a recommendation to the board. The decision rested with the board of AHA. To the best of my knowledge (and if this doesn't agree with the official records, I guess I'm wrong) the recommendation that went to the board was Walt McNerney, and I was for him. I wasn't sure if it was a reflection of good judgment on Walt's part to move from the one job to the other but he was clearly willing to do it and wanted to do it. I thought that could be greatest thing that could have happened. So it had my full support. Based on a lot of gossip that I've had with a lot of people, the simple explanation why he didn't get the job was that there were too many people on the AHA board who felt that he was too strong a person. They just didn't want that strong a person. They just got cold feet. I don't know if it would have made all that difference. Walt was obviously grooming Alex to succeed him at BCA. See, Alex had a lot of association experience. He was only head of the Blue Cross plan in North Carolina for a few years. He became head of the Blue Cross Plan as the attorney who was hired to bring the two North Carolina Plans together, which he succeeded in doing. Prior to that he was a practicing attorney in the state capital of North Carolina.

WEEKS:

I didn't know that.

SIGMOND:

Most important, Lew, I am told that as a practicing attorney he was the

legal counsel for all of those multiplicity of local government organizations that I mentioned to you that I was associated with in Pennsylvania through Dr. Aldefer's Institute of Local Government. In effect, Alex was not only legal counsel but executive secretary of the various organizations of township commissioners, county judges and whatever those groups are in North Carolina. He was a very skillful association executive and had great power in North Carolina because of that. As soon as he became head of the Blue Cross Plan, Walt became acquainted with him and Walt moved him right on up to the executive committee. He (Walt) found a man of comparable skills, in terms of association work, maybe superior skills, and in terms of representation and government circles and so on. He was the logical person for Walt to figure to succeed him. Well, when the AHA folks decided that Walt was too strong, the guy that was around who seemed to be most capable--the association person who didn't have a record of having a strong point of view, and I'm not saying that disparingly--was Alex McMahon, and they grabbed him up. So, it was a strange set of circumstances that he got that job. My guess is that this is the first time that Walt McNerney ever wanted anything he didn't get. As I say, Alex had to establish his own identity, Walt probably had to lick his wounds. That didn't contribute to bring those two organizations together. Then Alex, who really needed a good number two person from the hospital field brought Larry Hill on board; I think that was a disaster. I think it was a move to bring somebody on board who would relate well to Walt and maybe Walt recommended him because, as you know Larry Hill and Walt both came from the University of Michigan faculty. But Larry Hill had a managerial weakness...and I know this from my personal experience with the AHA Council of Research and Development, Larry didn't want to make a move until he was sure that he and Alex were on

the same wave length. Well, that wasn't the way Alex was used to working. But, Gail Warden, Hill's successor, has been a godsend to everybody. Gail's approach is: He won't make a move until he's told Alex and if Alex says no, he's not going to do it because Alex is the boss but he's not going to wait and make sure that Alex understands all the reasons. If anybody approaches Alex and wants to be sure they're on the same wave length, Alex will revert to being a lawyer and think of all the reasons why you shouldn't do it. Nothing would ever got done. So Larry Hill was a disaster. I think the appointment of Gail Warden was brilliant. First of all, Gail has a very, very high regard for Walt. He was in Walt's last class at Michigan and almost hero-worships him. (Maybe too much so.) Increasingly he is the chief executive officer of the AHA, because Alex is reverting back to the things he's best at: dealing with legislatures, public appearance, broad policy, constituency relationships.

WEEKS:

I was asking somebody about the change in the Washington office when they put the man from the coast in and the man...

SIGMOND:

Al Manzano.

WEEKS:

Yes, Manzano, went to CPHA. When he went to Washington I said "Has he had any experience in that kind of work."

They said, "It doesn't matter, Alex is there."

So, Alex is really the representation in Washington. That was the point that was put to me, now whether this is true or not I don't know.

SIGMOND:

Well, I don't think I even want this on the tape. As far as the American

Hospital Association goes, do you want to talk about that a little bit? One of the things that I worked on very hard when I was still at Einstein, was the Council on Research and Development at the AHA.

WEEKS:

Did this finally become the Trust?

SIGMOND:

No, no, the Trust existed way before. Colin Churchill ran the Trust. Very ineffective mechanism. David Drake was in charge of research and development and Churchill was in charge of the Trust. This all reflected Ed Crosby's interest in those areas, but it never reflected any sense by Ed Crosby that R&D should make effective input into management and policymaking. That's what I stood for. I kept fighting with Larry Hill. We had to get somebody in charge of R&D and the Trust who would be an effective participant in policymaking and bringing the best information forward and not simply just responding to the constituents. Larry Hill could never sell that to Alex because of his crazy approach. Well, as soon as Gail got on board I started talking to Gail and we got Howard Berman over there in charge of R&D. Howard started bringing good people in. Not only is the R&D Council one of the key councils, but the whole division of R&D under Howard with Gary Bisbee is the engine that's driving the American Hospital Association. I consider that--privately, I would not want to say this in public--was one of my major accomplishments in my career is turning the AHA around by totally reconceptualizing R&D and its relationship to policymaking and getting the right kind of people on board. The AHA is an entirely different organization today mainly because of Gail Warden. But--and I don't want to take a thing away from him--but, the input that I made was helping him to bring Berman on

board and helping to keep that a happy relationship. I'm just delighted. What they have done is even better than ever visualized.

WEEKS:

We both know Howard is a real mover, and things will happen.

SIGMOND:

Things will happen around Howard, but, also, Howard has a way of creating controversy. I keep working on Howard all the time now that he's got to learn to be a coalition builder. He's not a young guy trying to fight for his department, he's got to be thinking now of the whole organization. He's got to grow.

WEEKS:

He has a tremendous loyalty in his immediate staff. I noticed.

SIGMOND:

And they to him.

WEEKS:

That's what I mean, they're very loyal to him.

SIGMOND:

Right. He's got to get beyond that - there's nothing wrong with that.

WEEKS:

No, I know, I understand that. I know Howard very well and I'm sure he wouldn't mind my saying it.

SIGMOND:

I spent a lot of time on the Howard Berman-Gail Warden relationship in the past few years, because it seemed important to do so.

WEEKS:

Whatever you've done has certainly paid off in dividends, because, as you

say, it's a different organization now.

WEEKS:

Well, we haven't talked about the relationship between the Plans and the provider hospitals like you did in your monograph. What do you finally conclude after...this was written, what, five or six years ago? Has there been any progress made between the Plans and relationship with the hospitals?

SIGMOND:

Not as much as there should be. I would say that if the move at the time we turned that report out was to an increasingly adversary relationship, that we've turned that around. I won't say we turned it around, we stopped it. You don't hear much about that anymore. I think there is recognition that you just don't get much done in a typical situation on a continuous adversary relationship basis.

WEEKS:

There has been a lot written that the hospitals and Blue Cross shouldn't lie down together, they should be adversaries. But, you know, from practical experience there can be cooperative efforts, which will bring the costs down, which is better for everybody.

SIGMOND:

I used to say to public policy folks when I was running Einstein: What do you want me to fight with Blue Cross about? I think that we have changed the national view about Blue Cross, among some hospitals. I don't think we have made anywhere the progress I'd like to see us make on moving forward with an interdependence concept. Certainly on the national scene, there still is this feeling: If they aren't adversaries they must be working against the public. I don't think we've made anywhere near enough progress on that. I would say

that people like Nathan Stark, and Howard Newman understand.

WEEKS:

Well, the fact that you've got two strong people who understand the business in there, they may in a way be able to reduce the pressure somewhat.

SIGMOND:

Right. Now, this whole question is clearly related to the degree of cynicism or sense of reality, or whatever you want to call it, about the Voluntary Effort, because it's the same thing. In a sense most people who are not directly involved with hospitals and Blue Cross think about the Voluntary Effort as fluff; a PR move. For many of the people directly involved that's what it is. But, there was a potential for more than that.

WEEKS:

It's a difficult situation, isn't it? If you show improvements, it can only be in a fraction of a percentage or one or two percent at the most. You can't make a dramatic 50% difference.

SIGMOND:

Right. On the other hand, the whole economic situation has been so screwed up that I think myself, that the Voluntary Effort gained a certain respect just because there has been some dedication by the leaders to try to do something.

WEEKS:

It certainly had held off any legislation in putting caps on, such as we had.

SIGMOND:

Yes. Now, I'd like to see it go beyond that. Walt would too. Again, it's difficult. See, we never had a national coalition before like the

Voluntary Effort with AMA, AHA, Blue Cross/Blue Shield, health insurance industry, corporations and so on. That's just very important in itself. Whether we will be able to institutionalize it for constructive purposes, I don't know. Walt said a few things about that in his interview. He and I would think quite the same about it.

WEEKS:

I'd like to ask you a couple questions about the future. One, why is Blue Cross losing some ground to the insurance companies and what can they do about it?

SIGMOND:

Okay. I think there are two or three different answers to that. I think they're losing ground to insurance companies, at least in part, because they're trying to compete with insurance companies at their game. As far as I'm cncerned, there's no reason why a nonprofit corporation can do the insurance function better than an insurance company. Then they're trying to compete to some extent with software houses. There's no reason why a nonprofit software house should do better than a profit-making software house. I think that anytime they try to compete on the other fellow's turf, they're going to lose. That's point one. I think, point two, I don't particularly measure Blue Cross success or failure in terms of its enrollment in relation to commercial insurance. I think there's a lot of development in the insurance market today that may work against traditional Blue Cross/Blue Shield, may work against traditional insurance, as well. Companies are looking for different kinds of things. I think Blue Cross should probably deal with that segment of the market that it's able to take care of. I think that to the extent that some of the companies are looking for ways to restrict

benefits they pay for, the protection they offer their employees, I would attempt to take a general position that that's a mistake and tell those companies goodbye. I do think that Blue Cross has got to find better ways to deal with companies which are looking at health care differently. I think, for example, one of the reasons commercial insurance has been gaining on Blue Cross--although we're still ten times as big as the biggest one, they do have a bigger share of the market, all put together, than we do--I think that commercial insurance companies are in a better position that either Blue Cross or Blue Shield have been in in terms of dealing with comprehensive health insurance for health protection. Blue Cross/Blue Shield, if the company was talking about health protection, they'd have to say, "Wait a minute. Are you talking about hospital or medical?"

If you talk about hospital, you have got to deal with Blue Cross Plan. If you talk about medical care, you have to deal with Blue Shield. Then we have got to try to figure out how to fit that all together. Now, one of the driving forces for the BCA/BSA merger, was to minimize that. But just because they merged didn't change it. You still have all those independent Plans which have to learn how to respond to the market much more effectively. I think we're doing some things in terms of matrix contracts, along that line. We can't get so hung up in old forms of dealing with doctors and hospitals that we can't adapt flexibly to the market. I think insurance companies have had a big advantage over Blue Cross and Blue Shield in that respect. Secondly, commercial insurance companies have been more responsive than Blue Cross to corporate accounts that have wanted to go into different approaches of what's called of what's called ASO--Administrative Services--companies that wanted to play a larger part in the management of the handling of claims. I

think we should encourage corporations and unions to get more involved and we can devise mechanisms using the doctor/hospital relationships that we have and the kind of benefits we have to do that. I don't think we've been as flexible along that line as we might have been. But, in the long run, I think, the public still wants service benefit protection like Blue Cross has. I think some companies are opposed to that. I think we have to do a better job of demonstrating to employers and to unions that we can add value to the dollar they spend on health insurance, which commercial insurance companies cannot do. But, for us to add that value, they (the employers and the unions) have to become involved and we have to help them to become more involved. The future role of Blue Cross and Blue Shield is through the HMO mechanism or through other mechanisms to bring the consumers and the providers in closer interaction around the expenditures of their money. Now, we are ideally situated to do that because of our relationship with providers. We are not taking advantage of that at this time. You have a strange situation in the country today where the latest buzz word in the hospital field is "marketing." All the hospitals are hiring directors in marketing. All the directors in planning are changing their title to directors of marketing. If you ask them what's the major characteristic of the hospital market, they never give you the right answer, which is, that people like to buy hospital care by the month. All hospitals have arrangements with an organization that does that for them: a corporate community organization does that for them. So, if you're interested in marketing, I tell hospital folks, go down and see your marketer. Who's your marketer? It's the director of marketing of the Blue Cross Plan. They never do that. Now, if they did, it would be a disaster. Because if they did go down there and see the director of marketing

he'd want to know what they were doing there. He wouldn't understand. When they explain what they were doing there, he would say, "There must be some mixup. You really got to go over and see the vice president for provider affairs."

So, that's an interesting situation and I'm talking about this with Blue Cross all the time where the marketing people have got to get involved with hospitals as in the old days. In the old days, if a Blue Cross Plan executive talked to a potential major account, he brought the main hospital administrator along. You found out which hospital board that guy was on before you talked to him. Today, most Blue Cross marketing people have nothing to do with the health system anymore. We have had opportunities and we've missed. If our marketing people and our corporate leadership are going to try and beat the commercial insurance folks at their game, they're going to lose. But there are some hopeful signs; part of it is the merger of Blue Cross/Blue Shield so we can deal with a single product. The distinctions between hospital and doctors don't mean a thing to a corporation executive or a union leader. We've got to help them understand that we are part of their community and they got to participate in our program and then we can add value to the dollar they spend. Now, if all they want is to insure some pocketbooks, go commercial insurance. We don't have to have everybody. The Blue Cross people don't have to have everybody. But we ought to have everybody who is interested in health--which means everybody. We got to get bigger in HMOs; we have to get bigger in approaches to primary care and new payment arrangements like capitation reimbursement that we're experimenting with in North Dakota, and whole new approaches to the marketing, the cost containment, the hospital relations functions and that's what I'm selling

within Blue Cross...

WEEKS:

Well, on the radio this morning...

SIGMOND:

Did that mean anything?

WEEKS:

Yes, it does. Driving to the airport this morning there was a report that UAW in Detroit yesterday had a meeting of one of their boards. They decided that their members were paying too much for doctor's services, I suppose, outside of Shield, office calls, that sort of thing. They were going to set up their own--several of their own clinics in the Detroit area. Now, is this an indication that maybe they'll move into something else? Will they self-insure?

SIGMOND:

I think these are opportunities. I really think there are opportunities. I don't know the details of what your talking about...

WEEKS:

I don't know the details either because that's about all they said.

SIGMOND:

You know, way back when Reuther was still alive, he set up that prepaid practice in Detroit. Last I heard the Michigan Blue Cross/Blue Shield took it over. May be they should have taken it over a lot sooner.

WEEKS:

Well, they managed it for awhile. Administered it. Then I think they took it over and now it's an optional thing, I believe.

SIGMOND:

That makes sense.

WEEKS:

Okay. Talking about Blue Cross, as we did about BCA, does BCA help in a situation such as faces Michigan Blue Cross/Blue Shield now where its Michigan legislature is trying to tear them apart or restructure them or cut them down to size or whatever you want to call it? They're pretty nervous about it, I think.

SIGMOND:

Yes. I don't know the details of that situation but again, I would say that the biggest problem that I see and I look at this with my own spectacles, the biggest problem there at Michigan is the growing adversary relationship between the hospitals and doctors. McCabe is probably the most talented guy in the system other than Walt McNerney, but I don't think John McCabe understands the potential of the relationship that his organization has with hospitals and doctors.

WEEKS:

He doesn't project well to the public either. On TV you get a feeling of arrogance.

SIGMOND:

Yes, he sounds like a game cock, right. But, by gosh, he's talented.

WEEKS:

I don't question that, but, I mean, the public sees him...

SIGMOND:

He always looks like he's heading for self-destruction. But if he could understand the power of the positive relationship with the doctors in hospitals... In terms of saving a Plan, the doctors and hospitals will save

the Plan but nobody else is going to save them. Who else cares?

WEEKS:

Then again, you may have another factor too, there may have been a change in the Michigan Hospital Association. In the past few years I think there has been.

SIGMOND:

There had to be. It's good for Blue Cross/Blue Shield that this talented young man, I forget his name right now,--came from New York to head the state association.

WEEKS

I think he was really from Detroit, I'm not sure. But he was in New York. An industrial engineer is what he is.

SIGMOND:

Yea, right. But, you know, if you're going to have a McCabe you'd better have somebody who can stand up to him.

WEEKS:

If the Michigan Plan should ask BCA for advice or help or whatever, would this be a part of the function of BCA to move in and help them?

SIGMOND:

Sure. But, you know, it's awfully hard to get Jack McCabe to ask for help.

WEEKS:

I realize you have personalities here too. But that's just a matter of principle, leaving personalities out.

SIGMOND:

I tell you, I wouldn't even wait to pack my bag. If Jack McCabe were to ask for McNerney to get me in there, I'd be in there in a second.

WEEKS:

But you don't expect it.

SIGMOND:

I'm not expecting it; not this year. I don't know how much...

WEEKS:

One of the topics nowadays is multihospitals and I see you've got Howard's book on your desk--Howard Zuckerman's--and I've been wondering, can we project this multihospital organization thing far enough to say that we know that one of the objectives is to share services, share administrator talent and to share professional talent, and so forth, financial talent. Will the day ever come, do you think, when the multihospitals will try to sell some kind of regional policies--insurance policies or will try to sell services to--going back to the old contract type of thing they had in the lumber camps--would it be conceivable that somebody who dominated a state, some of the western states, for example, might try to do these things on their own? Or is this silly projection?

SIGMOND:

No, not a silly projection. I've been encouraging hospital capitation reimbursement which is the basic idea. I believe that the more that we can pay hospitals on a capitation basis and have the hospitals assume responsibility for a population, the better. I've talked to the head of Utah Plan, where we have, you know, the so-called Intermountain System. This was a spinoff of all the Mormon hospitals. When the Mormon Church decided hospitals were getting too close to government, they set up their own multihospital corporation. I suggested to the Utah Plan that they enter into a contractual relationship with Intermountain, pay them on a capitation basis. First of all

that's the only way you'll probably avoid them eventually setting up their own marketing staff. I think that we are going to move more and more into a situation where hospitals either will be marketing their own services by the month, or making arrangements through Blue Cross to market their services. If Blue Cross can market HMO services, why can't they market an individual hospital service? Or a multihospital corporation? And that's going to happen. It's going to happen with or without Blue Cross. Now, I think the typical multihospital system, no matter how big it is, if Blue Cross is responsive, will still have Blue Cross do the marketing. This will be better for them. But, that's all in our interest. In terms of multihospital systems, I've done a major paper on that which was published in our AHA book. If I didn't share that with you I can get it for you. I keep making the point, in that paper, that there are two kinds of multihospital systems. There are multihospital systems in which the hospitals work together to serve a population in a given geographic area. Then there are multihospital systems joined together corporately, but in entirely different geographic areas so the relationships are between each hospital, the multihospital corporation and the corporate headquarters, but no relations among the hospitals. Those are the two different kinds. Now, a lot of people when they visualize multihospital systems visualize the first kind--with relationships among the hospitals. There are very few of those in this country, but there are lots of the other kind of which the Catholic order was the model like Ed Connors' group. That's the typical kind. Now, I personally believe, I make this prediction, that as we move down the decade the typical hospital is going to have to belong to two kinds of multihospital corporations at the same time. One, a highly structured one that will be modeled after the Ed Connors' kind. Then they're

going to have to belong to a less structured one that's in their own community involving most of the hospitals in the community. Then the issue is: How do you balance the forces of the two? In other words, the multihospital corporation covering a large geographic territory better not be dictating to each hospital exactly how to run everything because that will interfere with each hospital's interaction and coordination with other hospitals in its own area. Each hospital in a community should join in some kind of corporate community organizational structure to coordinate community health affairs. However, American communities are such that they are not going to allow all the hospitals in a community, except for very rare instances, to form a tight corporate structure and fit one mold. So, we're going to have loose corporate structure at the local level, tighter corporate structures above but with power down below. That's what Ed Connors is trying to develop if I understand him. He is trying to develop a corporate structure where the head of each hospital is supported but not dictated to. Each one of those, then, is encouraged to go out and develop effective relationships with the hospitals in its area. So you got to think about the complexity in two kinds of multihospital corporations. As I said, I wrote in that detailed paper...

WEEKS:

When Howard Berman was still with Blue Cross R&D, he and I went to Kellogg one time--he asked me to go along with him--to talk with Andy and Bob about a grant. This was off record and just to see if there was any...

SIGMOND:

You wanted to start running hospitals?

WEEKS:

Yes.

SIGMOND:

He wanted me to head that up. So, I know all about it.

WEEKS:

Well, okay. So, the point I'm bringing is, does this in any way portend what might happen? Might Blue Cross someday go into the management end of it?

SIGMOND:

I think the individual Plans should; not the national associations. I have said that in my opinion it would be a good thing if every Blue Cross Plan ran a hospital. Someone said that's a conflict of interest. Nobody says it's conflict of interest for Kaiser to run a hospital. Why shouldn't Blue Cross Plans run a hospital? The best way for them to run a hospital is, they ought to put a price on a lot of the hospitals and whenever they're talking to hospitals say, "By the way, if you'd be interested we'll buy you for so much money."

You know, there might be just a lot of community boards that would just love to get bought out. I think they should. In dealing with other hospitals in town, Blue Cross would deal with a lot more reality if they had to go through all the problems of running a hospital themselves and they could run it as a model, the way Roosevelt saw TVA in relation to the utilities.

I didn't like the Berman proposal because Berman wanted to run them himself. I said, "No, no, no, you don't want to circumvent the Plan. What you want to do is come up with a proposal, have Kellogg fund it, where the Plans could go out and offer to manage hospitals and wherever they were able to do it then you'll come in and be the advisor."

He was part of the syndrome of seeing the Plans as the obstacle. I say that with love. There's an exact example of what I was talking about. I

really couldn't get Howard to change that project to get the Plan involved in terms of basic responsibility.

WEEKS:

I think that there's another factor that enters into it. All of us who are in any kind of profession or business where we see something is going wrong feel that we could run that better than the guy who is doing it. We would like to prove that we are an operator as well as an administrator or an executive who could do the job better.

SIGMOND:

I only allowed that feeling on my part to ruin my life once. That's when I went to Einstein.

WEEKS:

But isn't that true?

SIGMOND:

Sure, but it's crazy.

WEEKS:

Yes, it may be crazy but...

SIGMOND:

It also narrows your impact. It's just another variation of a manager who is a lousy manager because he's got to do everything himself, he doesn't know how to delegate, you know. That's the same thing.

Yes, I think Blue Cross is going to get into health services management, and hospitals are going to get more into financing. You can't separate these two things. The other side of the coin, as Walt said in the Bachmeyer lecture years ago.

WEEKS:

We mentioned a little while back that the national health insurance issue had been rather quiet recently except for Teddy Kennedy. I was reading over some of the details of the so-called Health Security Program that started out with Walter Reuther. One of the things that he proposed was--it would be wonderful if it could happen, but I was wondering what you think the chances of its happening are--and that was the way he would handle providers, hospitals and physicians particularly. His idea was that hospitals and physicians would be paid on a fee schedule of some kind or physicians would work for salaries. If the money were distributed on a regional basis, and if the region ran out of money, then the fee schedules would be cut for everybody. What do you think the chances of a thing like that passing, and working, are?

SIGMOND:

Zero.

WEEKS:

Well, that's what I thought.

SIGMOND:

Let me make some general comments about national health insurance, okay? I have a very special point of view on national health insurance. Let me say it in a most provocative way, then explain what I mean. My point of view is that we have national health insurance today in a sense that there's health insurance all over this nation--it's pretty pervasive--it probably involves more use of the insurance mechanism than any country in the world, including those that are supposed to have national health insurance. I don't know many countries that have national health insurance. I know some countries that have national health service, which doesn't use the insurance mechanism very

much, if at all. Health insurance as a mechanism can never be comprehensive in terms of the whole population and all the benefits. By definition, health insurance has to be partial because if it ever covers everybody for everything, it disappears. It is no longer of any value to anybody. It's a dead weight. The week that you got health insurance for everybody for everything, then you'll eliminate the insurance part of it. Why bother any more with insurance? It would become national health service. Health insurance is a great thing, but it's a little bit like government or heaven. I mean, if you ever get all the way there, you're gone. That's what people don't realize. Health insurance is a mechanism to permit partial solutions to problems. Now, I don't think Teddy Kennedy really is talking about national health insurance anymore. In most instances he's talking about national health service. Of course, the national health service people in England are now trying to figure out how to get some more insurance back into it. Do you understand the distinction I make between national health insurance and national health service? I mean, the Veterans Administration is a national health service for the Vets. I cannot visualize in my lifetime--don't have many more years to go but even if I live to be 100--I don't visualize this country developing the public administration skills, as applied to the health field, to be able to develop a national health service that would be responsive to the people and acceptable to them. I'm not saying that maybe some day we can't. In the absence of that level of public administration skills, we're going to have some kind of national health insurance that isn't going to look very much different than we have today. We may shore up some benefits here, we may add some children's programs, but it's going to be the kind of thing we have today, and I think the sooner we get over the idea that,

well, maybe it's going to be five years or ten years, or whatever, but sooner or later we're going to go to national health service. I don't think we're going to go to national health service until we have the administrative skills. As I say, that's so far ahead, that there are no projections about it. I don't think there's something inherent about public administration that we can't build in the kind of input that can make it work. The interesting thing is, that if you look at the national health service in Great Britain, they've been working very, very hard to build volunteerism activities into their system. I don't mean voluntary insurance, I mean voluntary involvement, voluntary participation. They have regional authorities, area authorities...it's almost all voluntary structure. The government pays all the money and certain key decisions are made by the government but all the rest is voluntary. So, there are ways to develop a national public administration structure that incorporates volunteerism within it. I don't see us moving in that direction in this country, certainly in the next couple of decades but maybe later. Does that answer your question?

WEEKS:

Yes. Speaking of voluntarism, brings up a very important thing as far as I'm concerned, and that is, if we want all these things we're asking for, isn't it going to be necessary to increase voluntarism?

SIGMOND:

Oh, I think so. Both in terms of financing and in terms of management and action. I think we've got to increase the role of voluntarism. Another point is that we touched on before. That is, to begin to work more effectively at the interface of health services and other human services: housing, recreation, and so on. That's the challenge that lies ahead. If we can

visualize health services as a part of human services, I think we can then get better health for less money.

SIGMOND:

In my opinion, health planning in the United States today is in very unsatisfactory condition because the planning mechanisms that have been developed do not relate effectively with the planning that is done continuously by all of the decision makers in the health field. As far as I'm concerned, planning is essentially a management process, an integral part of managing your daily life, an integral part of managing any kind of an organization. The activities of a planning organization, per se, can only be effective if they are viewed as impacting on and having a positive effect on the planning process of management. That's not the way health planning is visualized in this country today. Health planning in this country today is visualized as the planning organization making plans that managers should fit their plans into. That will never work because the managers will never look at it that way. They will see the activities of the planning agency as just one more input that they have to cope with in a hostile environment. And the best analogy I can give of where I think a health planning agency ought to be is like a family planning is. This recognizes that there are problems in society from inadequate family planning which can be corrected to some extent, by a family planning agency that helps every family to realize the wisdom of planning better, of having tools, of having insight, of having better understanding of their own goals and objectives and how they relate to society.

We would never visualize a family planning agency that would say, "This family should have children and that family shouldn't." Or calling up this family and saying, "Tonight's your night." That's essentially the view of

health planning today. The planning agency is going to decide how many beds, and the planning agency is going to decide this, and the planning agency is going to decide that. Instead of focusing on the weaknesses in the planning programs of all the health agencies and what can be done to shore up those weaknesses. There are weaknesses in terms of focusing on health as contrasted with other types of objectives. They don't take a long-range plan point of view to the extent that they should. They don't think about the interactions of various parts to the whole. A planning agency can help managers and trustees to improve those processes. A planning agency can identify weaknesses in planning process. A planning agency can emphasize to a funding agency that they should not fund organizations that don't have an effective planning process. But that is not the approach of planning today. The approach is that the planning agency should have the teeth. Well, that approach hasn't worked any place where it's ever been operationalized. I guess it's in the Soviet Union or some countries like that where they call them the planning agencies but they're really the management agencies. I think there's great confusion as to whether planning agencies are planning agencies, regulatory agencies, management agencies. In this country, either the Health System Agencies will go through three or four more evolutions until they become health systems authorities--like in England--or they will back off and become health planning organizations. They can't be something in between, with confusion as to their role and confusion as to their authority and confusion as to their resources. As presently constituted, the whole thing is a confusing step towards something--I'm not sure what--end of comment. Is that clear?

WEEKS:

It's very clear. The public authority in England is operating within one system. Everything is part of one system where here...

SIGMOND:

They're the authority. They're the management.

WEEKS:

They're the decison makers, yea.

SIGMOND:

Any manager worth his salt spends better than half his time planning. If he spent two percent of his time making a decision, he would never call himself a planner. He'd think that's a derogatory thing. If at U.S. Steel the planning department tried to tell the executive what to do, he'd throw the department out. He'd say "I don't need you to do my job. I want you to help me to think; not to help me make decisions."

The health planners get involved in trying to substitute their decision for people who have the responsibility of management and that's just plain wrong. The two health experts that I know in this whole country that understand that: Sy Gottlieb and Steve Sieverts.

WEEKS:

If they were a regulatory agency that had certain standards set and then they took somebody's plans and compared them with the standards, that would be a different thing. That would be an authority too.

SIGMOND:

Right. Now, if on the other hand, they had certain standards of planning process, and then they could advise people, "We don't want to tell you what to do with this planning result. All we can tell you is how they got to it." Makes no sense whatsoever.

That's very significant because there's no way I know of, in Massachusetts, for example, that an HSA or any other planning agency is going to stand up and say to Massachusetts General Hospital and to the community, "We could have planned their future better than they and we don't like their outcome. They should have had this outcome."

Massachusetts General would beat them out every time, but if the planners say, "Look, there are certain planning processes and one of them is that before you develop a plan you talk to the people you're planning for. That's pretty obvious. Massachusetts General hasn't done it."

Nobody can argue with that, including Massachusetts General. Either they have or they haven't. Or talk to the other hospitals in the service area. They either have or they haven't. So, a planning agency can take Massachusetts General on with respect to planning process; but can't take them on the end product. I use Massachusetts General as an example but the same thing applies to any hospital. A planning agency should be concerned with planning and not with plans, then they could play a useful role because the weakness in our society is weak planning. We all plan all the time, if by planning you mean thinking in advance before you do something. But, you did manage to get here from Detroit, you know, and you presume you'll manage to get back. That was by planning. Then you executed the plan. We're all planning all the time. The only people who don't plan are people in nut houses. But, literally, the only thing I know of in our society that ever reflects something getting done without planning is a riot.

WEEKS:

And, as you say, sometimes those are planned.

SIGMOND:

Well, they're always suspected--so it's a Communist planning it. I'll tell you, I once participated in a totally unplanned event. It was amazement to me. When I was in college in 1939, Penn State beat Pitt. Pitt had Marshall Goldberg--I don't know if you remember back to those days. We hadn't beaten Pitt in I don't know how many years. We beat Pitt. Since then, of course, we've come into our own, we beat Pitt frequently. But, the people poured out of those stands and they tore down the goal posts and I was part of that. They took those goal posts down and planted them on the front lawn of old Main; nobody planned that. I'll tell you, the way out of that stadium had these metal bars, you know, so you had to go single file? I'm going into that stadium--just walking in, practically lost my masculinity by bumping into everything--and these crowds went out of there with the goal posts over their heads. Didn't break stride. As far as I know, nobody lost his testicles and the thing went most smoothly. I mean, if somebody had planned that for a year, it wouldn't have happened with that kind of efficiency. So, things can happen without planning. Nobody thought we were going to win. But, I mean, that's a very unusual thing.

People are planning all the time, but mostly they don't look far enough back, they don't look far enough ahead; they don't look far enough around them, they don't think about what the other fellow's planning, and they don't stop and think, is our mission health? Is our mission filling beds? In the absence of that, you almost inevitably do poor planning. But the substitute is not for some agency downtown to do the planning and force you to implement. For, first of all, if you try to implement it and you don't really believe in the basic concepts, you'll screw it up. That's where we are. It's more complicated than that. I just think that right now we're off track.

Just off track. Because people don't think about the interface of planning for management and planning for community. What's the nature of that interface? The whole effort on planning originates from Washington. There's no planning there on the interaction of the various health programs. the first thing the VA gets itself exempted, and they have a special initiative at HMOs so they get themselves exempted. I'm not saying that to make fun of it all...

WEEKS:

It makes it an impossible situation.

SIGMOND:

We are in an impossible situation. I think largely because people got impatient with the evolutionary path that we were on. Sy Gottlieb is the only person that stayed on the evolutionary path. The rest of us got disgusted and quit. So, now I can say a lot more...and I think there are ways to change that law to put much more emphasis on requiring effective planning processes and penalize the folks that have ineffective planning processes, which is essentially what we did with quality of care. We never defined quality of care in this country. Ever. We got organizations that just put a lot of energy into it and certify that this is a quality institution based on evaluation of processes. People get confused about process and outcome. Outcome is more important than process, but if you're really not clear on your outcome, you'd better concentrate on processes. Enough on that?

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