HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Lowell E. Bellin

LOWELL E. BELLIN

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
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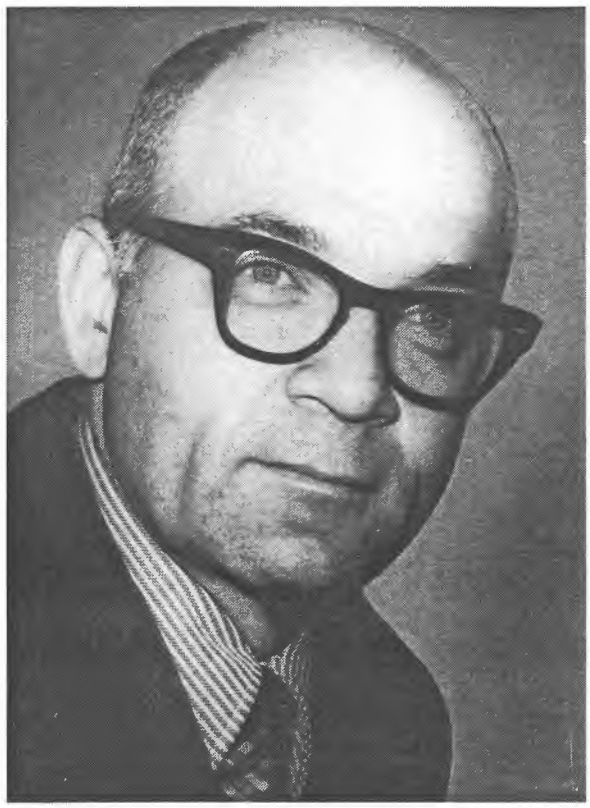

Lowell Eliezer Bellin

CHRONOLOGY

1928	Born in Brooklyn, NY, October 2
1948	Yale University, B.S.
1951	New York Downstate Medical Center, M.D.
1951-1952	Yale University Medical School Teaching Program: Internship, Newington (CT) VA Hospital, and Grace-New Haven (CT) Hospital.
1952-1953	Newington VA Hospital, Residency in Internal Medicine
1953-1954, 1956	New England Center Hospital, Boston, Residency in Internal Medicine
1954-1956	Otis Air Force Base, Chief of Pediatrics, subsequently Chief of Medicine
1956-1957	New England Center Hospital, Pratt Diagnostic Institute, National Institutes of Health Fellow in Cardiology
1956-1957	Tufts Medical School, Boston, Teaching Fellow
1957	Hadassah Hospital, Jerusalem, Israel, Resident Fellow in Cardiology
1958	Hadassah Hospital, Beersheba, Israel, Acting Chief of Medicine
1958-1962	Springfield, MA, in private practice in internal medicine and cardiology
1961	American Board of Internal Medicine, Diplomate
1962-1966	Springfield, MA, Health Commissioner
1966-1967	Harvard School of Public Health, M.P.H.

1966-1967	Health Insurance Plan of Greater New York (HIP), Associate Medical Director
1967-1969	New York City Health Department, Executive Director of New York City Medicaid
1967-1968	New York Downstate Medical Center, Clinical Assistant Professor of Community Medicine
1967	Columbia University School of Public Health, Lecturer
1967	New Youk University Medical College, Lecturer
1968-1971	New York State Medical Center, Assistant Professor of Department of Environmental Medicine and Community Health
1969-1972	New York City Health Department, First Deputy Health Commissioner
1969-1972	New York University Medical School, Clinical Associate Professor of Environmental Medicine
1970-1981	New York University School of Public Administration, Adjunct Professor
1971-	New York Downstate Medical Center, Department of Environmental Medicine and Community Health, Professorial Lecturer
1972-1974	Columbia University School of Public Health, Professor and Head of Division of Health Administration
1974-1976	New York City

-Health Services Administrator

-Chairman of the Board of the Health and Hospitals Corp.

-Health Commissioner

-Chairman of the Board of the Comprehensive Health Planning Agency (CHP)

-Chairman of the Board of Health

1976- Columbia University School of Public Health, Professor of Public Health, Director of Track in Health Planning

MEMBERSHIPS & AFFILIATIONS

American Public Health Association, Member

Association of Teachers of Preventive Medicine, Member

Herman Biggs Society, Member

Massachusetts Medical Society, Member

New York Academy of Medicine, Member

New York City Mayor's Task Force on Emergency Medical Service, Member

New York City, Office of Management and Budget, Technical Adviser

New York City Public Health Association, Member

New York County Health Services, Review Organization (PSRO), Member of Board, Chairman of Ambulatory Care Committee

AWARDS AND HONORS

Alpha Omega Alpha

Honorary, 1973

New York Downstate Medical Center

Alumni Achievement Medallion, 1975

New York State Medical Center

Senior Medal for Best Essay, 1951

Public Health Association of New York City

Merit Award, 1972

Springfield, Massachusetts Urban League Award,

1964

BOOKS

The Challenge of Administering Health Services: Career Pathways (editor). Washington: AUPHA Press, 1981.

WEEKS

Would you like to talk about your professional life in health care? Start wherever you think it makes a good beginning.

BELLIN:

Well, how did it all start? If anybody had asked me, when I was a student at New York Downstate Medical School from 1947 through 1951, what field or specialty I was most interested in entering, I would have answered orthopedic surgery. I had a spell of interest in that. Then I lost interest in that and became more interested in radiology. What was the best internship to help prepare a future radiologist? I was told that for radiology the most useful internships were the straight internships in internal medicine, in pediatrics or in pathology. I decided I would take the straight internship in internal medicine. That's how I found myself after graduation from medical school at the Veterans Administration hospital at Newington, CT, which was affiliated with the Yale Medical School at the time.

I found internal medicine so attractive as a thinking physician's specialty that I decided not to go into radiology at all--I stayed in internal medicine. I completed the typical postgraduate training program in those days consisting of three years of general internal medicine followed by a year of subspecialization in some subspecialty of internal medicine. I was awarded a

National Institutes of Health fellowship in cardiology in Boston at the Pratt Diagnostic Clinic of the New England Medical Center. It's now called Tufts Medical Center. I did clinical cardiology for about a year. My postgraduate training was interrupted by a two year stretch in the United States Air Force. I was stationed at the Otis Air Force base in Cape Cod.

I guess I shared with most physicians the typical disdain and customary lack of trust in regard to administrators. Administrators in the field of health and hospital care were to be avoided. They could only spell trouble for you. In any event, if you were a real clinician and genuine physician you didn't get yourself entangled in health administration. I recall giving brief consideration to trying to become a candidate for the chief residency in internal medicine at the hospital in Boston where I was located. I was discouraged from pursuing that by the argument of my colleagues that the major activities of a chief resident were paperwork and administration. If you want to become a practicing clinician, don't waste a valuable year of clinical training by being a chief resident. You do far, far better if you get yourself a fellowship in a subspecialty. That's how I moved into cardiology.

When I was an intern at the VA hospital in Newington, CT, my conventional attitude toward health administration was buttressed by a few educative events at the VA. One event was as follows: I identified a couple of patients who, as far as I could find out, were receiving just domiciliary services, hotel services, for months at the Veterans Administration hospital. There was no organic or psychic justification for them to remain hospitalized. So, naively, I discharged one of the patients. The next thing I knew I was summoned to the office of the director of the VA hospital. He told me--after a preliminary "Good morning" and "How are you doing?" and "We like your

work"--that a strong protest had been lodged by the local chapter of one of the veterans' organizations in Hartford. They wanted to know why this man had been discharged. I explained to the director why the man had been discharged, that there was no longer justification for keeping him there. It was only then that I began to realize that there are other variables that play a role in decision making. I had not been prepared for this in medical school.

Subsequently, my two years in the Air Force reinforced my antipathy toward health administration and health administrators. There was a similar experience. I was appointed Chief of Medicine at the Otis Air Force Base Hospital. (I had already completed about half of my postgraduate training in internal medicine.) I looked over the records, the charts of patients currently hospitalized. They were all healthy males. I couldn't for the life of me figure out why so many of them were being hospitalized--indeed, why they had been hospitalized in the first place and, moreover, why they were still hospitalized. So, I went from bed to bed, examined each of the patients, and started discharging them. I cleaned up the entire ward. I think the occupancy was down to three patients when I got through with this massive discharge.

It was similar to the experience I had with the VA except this time I was not called to the office but was visited by the captain from the hospital's Medical Services Administration. The captain said they were happy with the quality of work I was performing and so forth, but could I explain why there had been such an extraordinary number and percentage of discharges within a couple of days. I explained the situation to him. I provoked only glumness on his part.

Finally he said, "You know, there is a problem here, and the problem is

this--our hospital budget. How much we are going to receive, what would be budgeted this year, is correlated with the number of patient days generated the previous year. Whether you realize it or not, Doctor, what you will have done, if you continue this policy, will have very adverse effects on next year's budget of this Air Force Hospital where you work."

I asked, "What do you want me to do?"

He said, "Well, you know . . ." It was rather vague what he wanted me to do, but he didn't want me to do what I had been doing. He said, "The colonel is somewhat upset by this." (The colonel, a physician, headed up the whole hospital.)

I said that I was sorry the colonel was upset. I didn't want him upset on my account, but I didn't know what I could do. In my best judgment these patients should be back on duty flying planes and/or supporting others who are flying planes in the defense of the United States. Otis Air Force Base was an Air Defense Command Base. I guess I was a little bit snotty. At the time I was a young kid in my mid-twenties and I looked down on this type of thing. Now I'm older and wiser and understand the pressures on these people a little bit more, because the system transmutes honest people into crooks--maybe "crooks" is too strong a word, so let's say forces otherwise honest people into doing certain things they wouldn't normally do--in order for them to survive in view of the way the system is structured.

I felt, possibly wrongly, that the captain was definitely hinting that if I didn't mend my ways there would be something regrettable in my effectiveness report, my ER, as it was called. I didn't worry particularly about that because I had no intention of making the Air Force a career. I planned to serve my two years in the service and get out. I would do the best I could

while I was in uniform. (Parenthetically, I enjoyed myself enormously while in the Air Force.)

The way the complaint was resolved was as follows: I carried out the policies that I had insisted upon. I said, if the colonel wants to give me orders about discharging patients, I would like to receive such orders in writing. I didn't want oral orders. I was sophisticated enough to know that. As it turned out I never did receive those orders in writing, so I maintained my original policy. At least during the two years while I was there, I suspect there was a record low in the number of hospital inpatient days generated in that particular Air Force base.

In my career in the Air Force I was ultimately promoted to captain, but every physician and dentist was promoted to captain in those days after twenty months of service as first lieutenant. Evidently my promotion wasn't blocked because of my policy of discharge. I found some interesting things in Air Force medicine. I noted that there were significant delays in getting back laboratory tests in a timely manner. We ordered routine laboratory tests, and days would elapse before the test results were returned. As Chief of Medicine I had the ear of the colonel, the same colonel I have been talking about. I went to see the colonel and I said, "Sir, there is an unsatisfactory situation here." I didn't emphasize the fact that additional and unjustified days of hospitalization were being generated by the laboratory delays. I was clever enough about that. I emphasized that the lab tests were coming back very late. The colonel promptly had orders cut appointing me Chief of Laboratory Services as as well as Chief of Medicine. I now had control of the laboratory area.

I accelerated the work output and the lab tests began coming back. Then

at this point a new deficiency appeared. The lab tests were coming back in better time, but I still was delayed in discharging patients because the routine x-ray reports were not coming back. So back I went to the colonel again about a month later. I said, "The laboratory situation has improved but x-rays are being held up."

He promptly had more orders cut making me Chief of Radiology. We had no full-time radiologist on the base. We had a civilian radiologist once a week. So now I was Chief of Radiology. In all, I was now Chief of Pediatrics, Chief of Medicine, Chief of Laboratory Services, and Chief of Radiology. I found that willy-nilly I was drifting into administration. I was doing both clinical medicine and health administration. Administration wasn't that bad. As a matter of fact, from the standpoint of statistical impact upon people, I was having as much if not more impact, you might say therapeutically, on people by virture of being an administrator, as well as by virtue of being a clinician. But I certainly had no intention of going into administration at that time.

I finished my Air Force year in cardiology. I did no administration there. Then my wife and I went to Israel and worked there for a year. I was in Jerusalem for six months at the Hadassah Hospital and six months in Beersheba at the Hadassah Hospital in Beersheba. In Beersheba I was Chief of Medicine. I got the latter position at a rather young age. I was acting Chief of Medicine in Beersheba because the regular full-time Chief of Medicine had received a fellowship in Climatology in England. There were some clinical problems in immigrants relating to their inadequate physiological adaptation to the climate of the Middle East. So they needed an acting Chief of Medicine at the Hadassah Hospital, and I volunteered. I went down to Beersheba with my

wife and, then two year old, son.

While Chief of Medicine in Beersheba I could hardly dodge administrative responsibilities, particularly because hospital beds were so tight. This was the only hospital in th Negev. There were very few beds for a rapidly increasing Jewish population, plus an expanding B douin population. Our catchment area was the entire Negev. It's hard to know how many Bedouins there were. The estimates range from 80,000 to 100,000 Bedouins in the catchment area and about 30,000 to 40,000 Jews, most of whom were recent immigrants from North Africa and Romania.

We lacked a sufficient number of beds for this population, and I was obliged to initiate methods to cut down lengths of hospital stay. I guess I was twenty years before my time because, you know, terms like PSRO or utilization review committee were yet to come into being in a popular sense. Here I was, just beyond my mid-twenties, trying to handle a very serious problem. How do you care for very sick people and at the same time get them out of the hospital? One of the earliest papers I wrote was on the subject for a Hebrew medical journal. It was entitled, "How to Enlarge the Capacity of an Internal Medicine Department Without Adding Beds." What we did was this: A patient entered the hospital with pneumonia, for example. The patient began to respond to therapy. The temperature fell. The lungs began to clear. We would discharge the patient before the pneumonia cleared completely. Somebody with heart failure, full of brine, salt and water--as soon as he or she began responding to the diuretics, we would discharge the patient. This policy of early, early discharge would have been regarded as heresy here in American hospitals, but we had no choice. We cut down the bed occupancy to the bone. In fact, we had the shortest hospital length of stay in the country. To use

the cliche, "Necessity was the mother of invention." It was either that or putting two people in bed with each other. It was that kind of situation.

That paper provoked irritated protest. The letters that came in expressed annoyance with this policy. Wasn't I aware of the dangers of electrolyte imbalance? Wasn't I aware of this? Wasn't I aware of that? Those letters came from Tel Aviv and Jerusalem where they had far more beds for the population. We had quite a different bed-population ratio in Beersheba. This was in 1957 and I was immersed in utilization review, not as an academic exercise, but because I wanted to survive.

I remember one instructive experience at the Hadassah Hosptial in Jerusalem. I made rounds in internal medicine with the house officers. I came to a bed where a patient was supposed to have had a gall bladder x-ray the previous day--a question of gall stone. The patient was supposed to have had a cholecystogram. I asked the intern, "I don't see the cholecystogram report on the chart. Where is the cholecystogram?"

The intern said, "Gee, I am terribly sorry, I forgot to order the cholecystogram."

I said, "Are you aware of what this is going to cost somebody? That means an extra day in the hospital. Do you know how many Hadassah affairs and dinners have to be held in the United States (because this was an American supported hospital) to pay for just one additional day of hospitalization?"

The dean of the medical school happened to overhear me, and he had some of his own pithy comments to add to this. He was quite upset that the guest American physician making rounds would find such waste.

I gathered bits of insight from that experience in Jerusalem, from Beersheba, from the Veterans Administration Hospital, from the United States Air

Force, things I had never been taught in medical school: If your ultimate social objectives are to alleviate pain and misery and prolong the lives of patients, there are certain leverage points in administration that, in a statistical sense, have far more impact on achieving these objectives than the efforts of the most superb clinician.

Well, I surely had no intention then of going into health administration. In 1958 we returned to the States, and we settled down in Springfield, Massachusetts where I worked as solo practitioner, an internist and cardiologist and I suppose one is not supposed to say this--my problem was that I was terribly overtrained for what I was doing. I had been trained in the VA for two years; I had been trained in Boston for two years. I had been spoiled in Boston because a major number of cases you see ordinarily are intellectual challenges in the diagnostic clinic--when everything else fails you send them to the Pratt Diagnostic Clinic to find out what is wrong with the patient.

In Beersheba I had been spoiled also because in view of the small number of beds available we were limited to cases that constituted diagnostic and therapeutic problems. Moreover, there was a remarkably good screening program throughout the Negev. There were conscientious doctors in the paramilitary settlements. They screened out the routine cases, and they would send us their problems. It was like having a little Pratt Diagnostic Clinic in the Mid-East, and I was chief of that.

But to come back from that to the United States where fifty to sixty percent of the patients one sees in the practice of internal medicine are psychosomatic problems--where the nomenclature is inadequate--and where the therapy is even more inadequate, what can you do except push tranquilizers? Or so I felt! I was in solo, fee-for-service practice in Springfield,

Massachusetts for four years and became progressively disenchanted with what I was doing. Periodically I would come across matters of intellectual interest in practice, but not that often. Part of the internists' party line is that in the field of internal medicine every case is a diagnostic puzzle. As a matter of fact, that's not true. The majority of cases are quite straightforward, at least from a diagnostic and therapeutic point of view. My unhappiness, my boredom between 1958 and 1962 when I was in private practice, I think, in a sense, has been implicitly recognized in the idea that maybe some of primary care ought to be carried out by nurse practitioners or physician assistants. At least there is some talk . . . Dr. David Pomrinse writes about that. He argues that you simply cannot get physicians--well-trained physicians--to do primary care.

I don't know if I am quite as pessimistic as he has been. I had experienced a total of eleven clinical years in internal medicine--four years as intern and resident. I had two years in the Air Force, one year in Israel, and my fours years in practice. I figured I had put in my time for society, and I wanted to go on to something else.

I happened to be in practice in Springfield, Massachusetts. I was totally apolitical. I don't know the mayor. One day I told my wife we had to get out of this. I found the situation intolerable. Day after day it was the same thing. I felt incapable of handling many of the problems that people came to see the physician about. They don't get along with their husbands, or they hate their mother-in-law, or their children are sources of grief rather than of joy to them. It is very hard to address such problems in the medicalized model we have. In any event, I remember seeing a case of hyperparathyroidism and that kept me quite content for a couple of months.

You don't see too many of those cases.

I remember when I took my oral examinations for my board certification the kinds of cases I was shown about which I had to show diagnostic acumen and basic science acumen in order to explain the pathophysiology of the disease--I never saw those cases ever again. They were the kinds of cases you see in Boston or Beersheba--but you just don't pick them up in Americas private practice in number sufficient to achieve serenity.

I was interested in going into group practice. I thought that maybe if I were to organize a group practice in Springfield, the situation might improve. For a year I tried to organize a group practice, but my colleagues were too conservative to consider group practice in those days. I wasn't speaking about capitation group pratice. I wasn't speaking about replicating Kaiser or HIP. I was proposing fee-for-service group practice. Even that, I think, sounded radical to some. I decided that I would join a group already in existence someplace. We would sell our house and go elsewhere.

About that time I received a telephone call from the mayor of Springfield who said that he had heard that I was thinking of pulling up stakes and leaving. Would I come down to his office at City Hall and discuss another possibility with him? I can't say that this telephone call came as a complete surprise because I had been speaking to the Director of Urban Renewal of the City of Springfield, a chap named Sidney Shapiro, who was working with and had been appointed by the mayor. The mayor's name was Charles B. Ryan, Jr. Mr. Ryan had run for mayor on the platform of improving the performance of the local health department which he deemed deficient. There had been no health commissioner for about eighteen months and he wanted to do something about it. He made an issue over the fact that his opponent while in office

allegedly had paid little attention to the health department: restaurants were not being inspected properly and customers might be eating off dirty plates and dirty spoons, and so on.

Ryan was now elected mayor, and by keeping with his campaign promises he wanted to get somebody competent to take over the job as health commissioner of Springfield, Massachusetts. He couldn't find anybody through the usual channels. He now faced the same problem as that of his predecessor. The position remained vacant. Mr. Ryan paid a visit to the Harvard School of Public Health. He discussed his problem, which was both a political and public health problem, with Hugh Leavell, who at that time was Professor of Public Health Practice and an internationally known public health expert. Professor Leavell told the mayor that there must be one or a few MDs in town--who are unhappy with the conditions of practice--there must be somebody in family practice, in pediatrics, or in internal medicine. He said, "Find that person. If he or she qualifies academically and can come into the Harvard School of Public Health on a half-time basis, you will have your health commissoner." That's how the mayor called me.

So, I met with the mayor and he asked me if I would be interested in going into public health. I already had my boards in internal medicine. It was an idea somewhat intriguing because for me public health might conceivably be the answer. What did I have to lose? They would send me to school. At least I would come out of this enterprise with a Master of Public Health (MPH) degree in two years. If it didn't work out, I could always go back into private practice. Besides I would be living in Springfield anyway. We had sunk our roots there. We had friends there. So I started. I was appointed health commissioner of Springfield. I enrolled as a half-time student at the

Harvard School of Public Health. What was a revelation to me at Harvard was that I was not the only practitioner in the country with this feeling of unhappiness about practice. I found physician classmates of mine at the Harvard School of Public Health who had similar feelings. I received much psychological reinforcement from classmates who had faced similar minicrises professionally. After a couple of months of being health commissioner and Harvard student, I wondered why I hadn't done something like this five years earlier. I was absolutely content professionally and I have been content ever since I entered public health in 1962. It is now eighteen years. People ask me if I miss clinical practice. Occasionally I do, but not too much.

I was health commissioner in Springfield for four years. I left after four years because the mayor who had appointed me originally was leaving himself. I was quite compatible with him. I was not only health commissioner. I was also a member of his unofficial kitchen cabinet so I dealt with public problems other than public health as well. I found government fascinating.

I answered a blind ad in the American Journal of Public Health. The ad sought somebody, as I recall, who had three or four years experience in health administration, and who had a clinical background in internal medicine. It was as if the ad had been written for me. So I answered the box number. It turned out to be from Edwin F. Dailey, who was at that time Medical Director of HIP. He was a notable person in public health, public health administration, and health care delivery. He was originally an obstetrician. So I went down... Well, I had no desire to go to New York City. I had gone to medical school there and I hadn't been happy there. Although I was born in New York City I had no desire to return and settle. I had completed four years of

medical school there but I had been glad to get out. I preferred New England.

However, my wife prevailed upon me. She said, "Look, you're not happy where you are right now. At least go down there for the interview. It's a useful experience to be interviewed."

So I followed her advice. We drove down to New York City together. She went shopping around New York City that day and I was interviewed by Dr. Dailey.

Before the interview I had told my wife that I was not going to consider any job at HIP unless it was at the level of Associate Medical Director. (Dailey was the Medical Director.) I didn't even know if there was a title called "Associate Medical Director," but if there was one, whatever the nomenclature, that was the job I would consider, and only that job. I was not enticed by New York City.

My wife went shopping and I went to see Dailey. He interviewed me and at the end of the interview he said, "I have a position for you. Let's say as Associate Medical Director of HIP."

So it was like a message from heaven.

I was surprised that Dailey offered me the job that quickly. He said he had already checked me out. He had called some people we both knew, some friends of his. He said he had received some peculiar reports about me. One was that I controversial. I was controversial in Springfield. I remember when I interviewed with Mayor Ryan for the job of health commissioner at Springfield that he said he had checked me out and that some of colleagues had said I was preachy. So for Dailey I was controversial and for Ryan I was preachy. Dailey made the job offer and I took it. I stayed with it for fourteen months.

What happened was this: There had been unhappiness on the HIP Board of Directors. Among the members of th Board at that time were people like the head of the teachers' union, the head of the sanitation union, the head of District Council #37. It was a union dominated board because the initial enrollment in HIP during the early days, as you know, consisted of New York City employees and their families.

The union people who were on the board had been receiving complaints from their membership that not enough time was being spent by the HIP physician with each HIP patient. Moreover, when you were referred by your primary physician to a specialist consultant, an enormous amount of time allegedly elapsed before the consultation was consummated. The rank and file were becoming increasingly unhappy with HIP's services and were communicating their unhappiness to the union heads who served on the board. There was increasing pressure to have some kind of a quality control study done in HIP, followed presumably by appropriate policy changes.

So, I think to mollify the natives who manifestly had become restless, HIP leadership said, "What we will do is advertise and bring in a quality control expert."

I became the quality control expert. I was brought in but at the time I was assuredly no expert in health care quality control. At that time there wasn't much literature on the subject. Avedis Donabedian was still to write his seminal book. It came out in 1969 and this was 1967. So I read the literature, such as it was. In fact, some of the more important literature had been written by Ed Dailey himself and Mildred Morehead and Paul Densen, Sam Shapiro and Ray Fink--under the auspices of HIP. So I read the literature that was available and I decided to attack the two problems that the union

rank and file enrolled in HIP had complained about.

One problem was how much time was spent by a doctor with a patient. There aren't too many ways of finding this out. I had one assistant to do this study. It was a mundane subject: how much time is spent by a doctor with a patient. It's financially prohibitive to station somebody with a timeclock in every one of thirty HIP groups with thirty or forty doctors in each group. What we did was go to the log books that record when a doctor comes in, when he leaves, and how many patients he sees between these times -- during let's say, three hours. We then divide the number of patients into 180 minutes and came up with an average of 15 minutes spent by the MD per patient. But then we did some spotchecking. We found we couldn't rely on the accuracy of the log book. According to the log books, the MDs were allegedly coming in at 9 and leaving at 12. In reality they might come in at 9:30 and leave at a quarter to 12.

That's how we got to know how some doctors behave. This is no secret anymore. Anybody who knows anything about the pecadillos that take place in the outpatient department in ambulatory care clinics would hardly be surprised by our finding--but I was learning by doing. I didn't know about the dirty laundry. Evidently researchers are reluctant to study the subject in a systematic way. So, the log's recording of the doctor-patient time contained some temporal hyperbole. In some cases during office hours some MDs took a break, or got some coffee, or went to the john, or called their stockbroker. Any of these activities could lessen the true doctor-patient time per patient.

I began collecting the first hard statistics on doctor-patient time within the HIP, and HIP had been in existence twenty years. If there had been any studies done on what actually went on, I was unaware of them. I couldn't

find anything in the HIP files on the subject. Through this study I began finding out what was the norm; not what was normative but what were the norms by specialty and by HIP group--thus what were some of the variables. Then I came across a HIP study that was quite relevant. The previous year HIP had asked representative specialists in various HIP groups how much time should be spent for primary visit and how much time should be spent for a follow-up visit. So I had some quantification of what the doctors felt was desirable, and I compared those numbers with what actually took place. Then, as I recall, we collected some other numbers: how much time did the MDs think they were spending? Perceptual data. So now I had three sets of numbers to compare. Some of the MDs thought that they were spending much more time than they actually were spending. Some thought they were spending less time than they thought was appropriate.

What about the second complaint of the union members? We did some studies to ascertain the amount of time which elapsed between the primary MD's referral and the consummated appointment with the specialist to whom he had referred the patient. I made recommendations to the HIP board about what should be done. HIP already had a system of incentive payments relating to desirable HIP group behavior that HIP Central was plugging. That is, if a group had a clinical laboratory open Saturday morning, there was a certain additional monetary reward paid on a capitation basis to the group. If the group was open evenings another financial reward per patient was added to the capitation rate.

I said, "Let's apply this technique of fiscal incentives. Let's see if a HIP group spends a desirable amount of time for a pediatric visit, measured on periodic reviews. (And we'll do these studies at least four times a year to

account for seasonal variations.) We'll reward the HIP groups with financial incentives. Also, if the group cuts down the time of consummated referral between primary MD and specialist, the HIP group in question will receive a financial incentive. These are my findings and my recommendations." Then I submitted my resignation.

That is the shortest job I ever had--thirteen to fourteen months. I didn't want to stay longer for a couple of reasons. First of all, the quality of care at HIP was probably good care for the lower middle class, but it was not, as far as I could determine, superlative care...it didn't fulfill the dreams that the HIP founders had in 1943,'44,'45 when LaGuardia was mayor of New York City. Also I found that there was a definite distinction between what the HIP leadership still believed was going on and what, in fact, was really going on.

One of my duties as Associate Medical Director was to answer complaints. Complaints from HIP enrollees were often justified. Certain of the HIP groups seemed to have a cluster of complaints. There wasn't a random distribution of complaints throughout the HIP groups; some of the groups generated more complaints per MD than others. The people of 625 Madison Avenue, the HIP Central Office, knew this.

I asked Central Office, "What kind of sanctions do you apply? How do you change professional and group behavior?"

Well, Central Office had no sanctions. They had fiscal incentives but no sanctions. Reward but no punishments. Carrots but not sticks. "You call yourself an organization", I argued, "something called HIP, but in fact you have a loose confederation of thirty-one autonomous groups. What can you do after you find this or that inadequacy? Jolly them, cajole them; there is no

way you can compel them." That was the situation. It was not the fulfillment of the original HIP idea.

With respect to the Kaiser plan, I don't know. I've never worked for Kaiser. One thing I have learned is this: I have learned to take a lot of the operational stuff that's in the literature, particularly in the medical care literature, with a grain of salt. It's like getting letters of recommendation. I've yet to read a bad letter of recommendation, and I have yet to read a bad report about an organization written by somebody inside an organization. So, I am skeptical about some of the quality control literature, particularly when it is potentially selfserving.

In any event, there was the appointment of a new New York City Health Commissioner named Ed O'Rourke. O'Rourke was looking for somebody to run the Medicaid program. Ed Dailey, my boss, and I left HIP within about a month of each other. We both went to work at the health department. Dailey took over the big grant in the department's family planning program, and I became the Executive Medical Director of New York City Medicaid.

O'Rourke had been looking for somebody who had done quality control. I had done that for fourteen months. I had completed four years of public health administration in Springfield. I had my boards in internal medicine. That kind of combination was relatively rare in those days.

So, I took over the Medicaid program. That was how I developed much of the aggressive reputation I have today--running that Medicaid program. First of all, I found that I had not been their first choice. They had tried to get others within the health department to take the job. Nobody wanted to go near it. There had already been a six month history and anybody with discernment could see what was going on, that there would be cost overruns, that stealing,

poor quality and overutilization were becoming rampant, and that that there were inadequate administrative controls.

One person recruited for the job made a comment to the effect, "I didn't go into the field of public health to be a cop. I don't want to become a cop."

Well, I wanted to get out of HIP and I was prepared to become a cop. When I had been in Springfield I had been approached to ascertain my interest in a state Medicaid job. I turned it down. I was not interested in Massachusetts Medicaid because the locus of the program was in the State Welfare Department.

I didn't want to associate myself with a welfare medical program. What was attractive about the New York program? Although New York State Medicaid was nominally under the Welfare Department, the legislation that brought it into New York State said that the State Health Department was to have a consultative relationship with the State Welfare Department, called the State Department of Social Services. As Executive Medical Director of Medicaid, I was supposed to deal with promulgation, monitoring, and enforcement of standards of health care. Welfare would take care of eligibility and take care of payment. Quality control would be assigned to the health department. There were predictable problems with the administrative two-headed monster, two separate agencies in charge of the program.

But that interested me. Within a year of my appointment, I was already responsible for a program whose annual budget for expenditure in health services was three-quarters of a billion dollars.

In the Medicaid program, we had to pay for health services rendered in hospitals, in nursing homes, in practitioners' offices--services provided by

physicians, dentists, podiatrists, optometrists, pharmacists, and even by chiropractors--any licensed health care practitioner. As you know, the New York program, like the California, Illinois, Michigan programs, ranked among the most generous of the Medicaid programs in the country. The states within certain constraints could choose the degree of comprehensiveness they would support. Rockefeller was Governor of New York at that time, and he enthusiastically and somewhat uncritically plunged into it. I think six months later he realized what he had done, but by then it was too late. Medicaid had become tainted.

I soon found what was involved in as Executive Medical Director of the program. First of all I should explain the setup. I had 300 people on the staff, which made it the largest Medicaid staff in the country. Some of them were on the health department staff, and several were on the Department of Social Services (welfare) staff. I supervised staff in the two municipal departments. Rather than try to transfer these people from agency to agency, I let them stay where they were. I wore two hats--I was simultaneously on the staffs of the health department and the social services department, and attended the weekly departmental conferences of both agencies.

Getting back to the abuses. One of the first cases brought to my attention was the following: A Puerto Rican lady had moved from one part of the Bronx to another. She kept the same doctor but changed pharmacists. She had osteoarthritis in one hip for which she had customarily received Darvon. As I said, she switched pharmacists when she switched neighborhoods. She brought home the first Darvon prescription from the new pharmacist. She was supposed to receive fifty Darvon capsules. Then she would go back for a refill. When she came home she found that she had only fifteen capsules. So

she went back to the pharmacist protesting that a mistake had been made. He said there was no mistake.

She argued with him. She said, "I am sure my doctor said fifty." (Her doctor later confirmed that he had prescribed fifty Darvons as she had said.)

The pharmacist was very foolish. He said, "No, your doctor said fifteen. Fifty and fifteen sound alike in English" (They don't sound alike in Spanish). Had he been wise, he would have given her the other thirty-five capsules. He didn't do it; he was stubborn.

She went home very unhappy and she telephoned us. How do you confirm that a prescription was "shorted?" Well, I looked around. Do we have any information on this pharmacist? We did. Anytime a Medicaid prescription was written we would receive a copy of the prescription for our files. So we dug out the copies of prescriptions. Some of our people would visit some homes where there were filled Medicaid prescriptions. We were looking for other examples of shorting, discrepanices in count and product between the prescription written and the prescription filled.

I sat down with my staff pharmacist. I asked, "How do you suggest we identify a fraud?"

He said, "One technique we might use is to check liquid medications."

He said, "Well, for example, if the doctor writes for four ounces of terpin hydrate and codeine, the medication would be dispensed in a four ounce bottle. If it is a two ounce bottle, the prescription was shorted. Four ounces of liquid medication can't be squeezed into a two ounce bottle--even in New York City."

So it was with little nuggets of information like this that my staff and I constructed a program of quality control and cost control. We never

developed a manual, but we could have. That's how we learned--by doing these things.

About twenty-five papers for the professional literature were generated in my office. We didn't just use the Amercian Journal of Public Health and Medical Care to publish our stuff, we use the New York Times, the New York Post and the New York Daily News. Those were also our journals.

All hell broke loose when we found and publicized all varieties of abuse. Fraud was the least important. With stories of fraud we got the headlines. More significant were poor quality of care, and major problems of overutilization, i.e. providing service justified neither for preventive or for theratpeutic reasons.

Forty-two half-time dentists were working for me in the program. These dentists worked in the city welfare department's dental clinics. Now they had time on their hands. Patients who previously had gotten their dental care at welfare dental clinics were now covered by Medicaid. Many of these patients abandoned the clinics and armed with a Medicaid card began seeking and getting their dental care from private dentists. I had inherited these welfare dentists, and what was I going to do with them?

I said to them, "I want to use you for quality control of Medicaid dental services."

They said, "What's that?"

I wasn't too certain myself. Fortunately I had a dentist on the staff named Morton Fisher with experience in dental administration who helped me. What do you look for? One of the first things, obviously, is to review the invoices, and match them to the dental services performed. Dentistry is relatively easy to check. A dentist always leaves an audit trail: When he

extracts a tooth you have a gap. When he fills your tooth, you have got an amalgam. If he puts in a bridge, you have a bridge. There is evidence that the dentist has been there professionally. There is less evidence that a physician has been there. A physician performs a physical examination. What are you going to look for? Bruise marks from the physician's fingers on the abdomen?

We found interesting things in our audits on dental care. We found that Medicaid had paid for phantom bridges that had not been put in. We found a dentist who, as a matter of policy, seemed to extend all his fillings to hit every one of the surfaces of the tooth, presumably because he received a larger reimbursement by having a three surface amalgam rather than a one surface amalgam. I won't say that this was a common run of the Medicaid practice, but the more bizarre practitioners' behavior sticks to one's mind.

We say analogous problems in medicine, podiatry, optometry--and pharmacy--there was no group excluded. If you had asked me then what my best estimate of the percentage of scoundrels we had, I would have said about five or ten percent, which is pretty good. We have ninety-five percent reasonably decent people.

We developed an on-site visiting program, of visiting doctors' offices where Medicaid patients were being cared for. That program provoked an AMA resolution against us. The AMA was meeting here in 1968 or 1969 in New York for their annual meeting. They passed a resolution against private office on-site visiting. I wrote a paper recently in which I mentioned this event and that protest. This seems kind of a silly reaction when you think that today we accept audits by PSROs. But you have to remember that we were pioneers--before PSROs.

On a few occasions I was called down to Washington to testify. I testified in executive session of the House Ways and Means Committee when its Chairman, Wilbur Mills, was still in Congress. They had us down a few times before the Senate Finance Committee. We testified before Senator Wallace Bennett who was setting up the PSRO; he wanted to know what our opinion was of PSROs. Regarding Wilbur Mills: Wilbur Mills was listening, as I remember, on one occasion when I spoke. He didn't interrupt and I was getting a little nervous, since he looked at me in a peculiar way. At the end of about twenty-five minutes I kind of ran out of steam. I just stopped, hoping he would say something.

Finally he spoke: "Dr. Bellin, if you hadn't gone into medicine you should have gone into police work."

He was from Arkansas. He didn't think some of these things happened in Arkansas--as much as they did in New York. He acknowledged, however, that there might be some analogous happenings in Arkansas.

We received nothing but encouragement from Washington, I wish I could say that we received nothing but encouragement from the state. I think they tolerated us. We never did receive the money we needed from the state to apply the proper administrative controls that we proposed.

I would argue annually during budget negotiations that my agency was the only agency bringing money back into the city and state. Twenty-five percent of Medicaid payments came from the city; twenty-five percent from the state; fifty percent from the federal government. Whatever Medicaid moneys we recovered, were returned according to this formula to city, state, and federal governments. Part of the problem was that one public agency A doesn't want additional expenditure on its books even if the regulatory moneys spent bring

in more money to Agency B. The other agency, Agency B, gets credit for the money recovered. What is forgotten is that A and B are part of the same government.

After two years of this I was promoted. In 1969 there was a new City Health Commissioner, Dr. Mary McLaughlin. She appointed me her First Deputy Commissioner. Now I had Medicaid plus other administrative responsibilities in the department.

In 1971 I came to Columbia University after a total of about four and a half years in the New York City Health Department. I was here at the School of Public Health for two years. Then Abraham Beame was elected as mayor. I had not known Mr. Beame when he had been Controller during the Lindsay administration. In 1972 Mr. Beame called me back into public health service as City Health Commissioner. when I got back I looked into the Medicaid program again. I was curious about what had been happening with Medicaid clinical lab work. Clincal lab expenses were quite high. Expenditure for Medicaid lab services had evidently increased about two and a half to three times during the two years that I had been away from the Health Department at Columbia University.

I said, "My God, what's happened? Has the physiological status of the typical New York City human being deteriorated so much that he has to have more than double the number of lab tests? Maybe the lab fees have gone up."

The official Medicaid fees had not gone up. Had Medicaid enrollment gone up? I knew better than to even ask that question because New York City's Medicaid enrollment had been halved. The State of New York had redefined medical indigency. One way to address a social problem is to redefine it out of existence and thereby diminish eligibility and entitlement. At the zenith

we had 2.4 million people enrolled in Medicaid in New York City. We had one out of three people--the largest enrollment in the country. Is was now cut to 1.2 million.

So I sent out my scouts. In a few days I was getting reports of what was happening. There were kickbacks, as I had suspected. There were kickbacks taking place between the physician feeders and the clinical laboratories. You couldn't get them to testify against each other. Transactions were in cash. MDs were paid by some of the clinical labs on a basis of commission. You had built in fiscal incentives for generating more and more lab work. So I went to see Mayor Abe Beame and his First Deputy Mayor James Cavanaugh.

I summarized the entire situation and said, "I have a way of addressing this problem but I have to have a political support."

The mayor said, "What do you want to do?"

I said, "I want to put the Medicaid laboratory work out on bid. We have five boroughs, five counties--Brooklyn, Queens, and so on. Each county will be served by its own low bidder laboratory, and that laboratory will be assigned all the Medicaid lab work in the borough. Moreover, the lab work will not be paid on a fee-for-test as we are doing now. We have no end point at present, just infinite laboratory expenditure. Under my plan there will be a maximum, a cap. The low bidder lab can reach this maximum and no more, no matter how many tests the lab performs. If the lab performs more tests than restrained by cap, then the lab will perform such work gratis for the City of New York. The lab will not be reimbursed for such work." I said, "The problem is obvious. All the smaller labs are going to be very unhappy with us when this gets out and I need to have tremendous support on this. What's you position?"

You see, the fiscal roof had just collapsed on New York City. I can only speculate about what their position might have been before the local crash, but Mayor Beame and First Deputy Mayor Cavanaugh said, "Go ahead, you have our support."

We put all Medicaid lab work out on bid. As soon as the labs learned about his, they put together a $100,000 war chest to sue us. I was involved in all kinds of litigation in those days. So they sued and the case came to court. Then I heard that the Department of Health, Education and Welfare had entered the case as amicus curiae.

I was delighted. I told my staff, "Why not? They've come down from Washington to support our lab control program. They're interested in frugality."

They answered, "What are you talking about? Haven't you heard? HEW is coming in as amicus curiae to testify on behalf of the other side, on behalf of the labs who are suing us."

I said, "What do you man, the other side?" I said, "You mean HEW is testifying for the people with the $100,000 war chest to oppose our plan to have Medicaid clincial laboratory work put out on bid?" When you build a sidewalk with tax money you put the work out on bid. The analogous procedure is happening here. I said, "What is the basis of this HEW opposition to us?"

"Bidding on lab work is violative of the Medicaid Law."

I asked, "How have I violated the Medicaid law?"

"Freedom of choice, by the Medicaid patient."

I said, "Freedom of choice? Are you talking about some theoretical freedom of choice by the patient to choose the clinical laboratory he or she prefers?"

They said, "That's right."

I said, "Freedom of choice refers to a patient choosing his own physician, choosing his own dentist, but the patient's choosing his own lab is a little far-fetched, isn't it? Is the patient to exercise his preference of how Lab A measures uric acid level over a competing technique of Lab B? Since when have patients become competent to make such distinctions?

"It is freedom of choice."

I said, "It is inconceivable to me that the legislative intent in Medicaid was that the patient would have the right to choose his own laboratory."

So I telephoned Jay Constantine who was the staff of the Senate Finance Committee. I said, "Jay, you're acquainted with the typewriter on which the original Medicaid legislation was drafted. (I presume you know Jay Constantine?)

WEEKS:

I don't know him.

BELLIN:

He is the key person in health affairs on the staff of the Senate Finance Committee.

WEEKS:

With Russell Long?

BELLIN:

With Russell Long.

I said, "Was it the legislative intent that Medicaid patients have the right to choose their own clinical lab under the rubric of patient's freedom of choice?"

He said, "Of course not."

I said, "I just want to tell you what the HEW people are doing to us." And I filled him in. There was little that he could do. What happened thereafter was predictable.

Judges, as you know, are loath to second guess the administrative decisions of the public agencies.

If the HEW rpresentative testifies what operationally is the appropriate interpretation of the statute and related regulations, it's difficult for an "outsider" to gainsay him. So we lost.

The good guys lost again. That's another thing I learned in this business: Good guys don't always win, notwithstanding. Sometimes they win but not very, very often, at least not in the short run.

So we lost the case and to this day I have no idea why HEW did what it did in connection with that case. I could speculate why HEW behaved in so incomprehensible a manner, but most of my speculations, I am sure, would be unkind.

I make a parenthetical comment: I have serious concerns about national health insurance because I feel that the Medicaid program and the Medicare program were a prelude-- a rehearsal, if you will--to national health insurance. The abuses that have occurred in Medicaid and Medicare will occur in national health insurance. You don't hear much about Medicare abuses since the Medicare fiscal intermediaries are gentle and protective. The intermediaries are not about to hang out the dirty laundry as we customarily did as a City Health Department overseeing Medicaid. I would tell you this: There is no reason to believe that physicians and other practitioners behave any differently in a Medicare program than in a Medicaid program. I'll tell you

why we don't have Medicare scandals. It is because intermediaries are not looking for Medicare scandals.

That is one of the questions I once asked Wilbur Cohen: Why the fiscal intermediary? He explained the reason was that this concession was necessary to blunt the opposition in organized medicine in order to get the Medicare legislation promulgated. He is probably right.

But I would comment--and I suspect Cohen would agree--that a fairly heavy price was paid, and the inadequacies of the Medicare fiscal intermediaries have come back to haunt us all. Later I'll comment on why I have come to prefer this fiscal intermediary with all its faults.

I found a useful way of handling quality control issues. In optometry and podiatry the relevant professional school worked with us on a subcontractural basis to audit the quality of their Medicaid work by following explicit protocols. In the Medicaid dentistry program we did our own auditing. The local dental societies complained bitterly about such in-house activities. They made invidious comments about us. "You know," they said, "you are like the cop who must pass out a certain number of parking tickets. A quota. You want to justify your existence as an entity. Besides we believe only in peer review."

I said, "You have peer review. Dentists on our staff are looking at the work of their colleague peers in practice."

They said, "They are not really our peers if they are working for government."

You know, that kind of answer. You won't find memoranda about this but this is the kind of dialogue that took place.

The physicians felt the same way, "We insist on peer review."

I said, "I am having physicians check you. I am not antiphysician. I have two brothers who are physicians."

They said, "Your staff physicians are not our peers."

I asked, "Why aren't they your peers?"

They said, "We don't think internists should check surgeons, we don't think surgeons ought to check internists."

I said, "I agree with you completely. I don't have internists checking surgeons. I have internists checking internists and surgeons checking surgeons, optometrists checking optometrists, ophthalmologists checking ophthalmologists, not opthalmologists checking optometrists, and vice versa."

"They are still not our peers."

"Why aren't they your peers now?"

"They are not our peers because you selected them, and you really can't have peers if government is selecting them."

"I'll tell you what I will do," I said during a conversation with one of the guys. "You select them."

"You mean," he said, "you are going to let me select people who are going to work for you part-time?"

"Absolutely. You select them."

"How come you are going to do that?"

I said, "My experience has been that you can select the colleague most adversarial to what we are trying to do. After he has been on the job for two days and sees what we see, we'll have to get him under control because there is nothing so zealous as a recent convert. Choose anybody you want and I will convert them--or the Gestalt will convert them, because you and they have no idea of what is going on."

Well, they never chose anybody. They might recommend a few people from whom we might select. They said, "They are not our peers because they are government doctors. They are not in practice."

"Quite the contrary." I said, "I don't hire full-time doctors. I only hire part-time doctors. Every doctor whom I hire has to be a member of the medical society, and has to be in practice. I don't want any cloud-nine physicians performing audits. I want physicians who are in the trenches of actual practice."

I never made that mistake again after dentistry. Why get into superfluous cat fights with colleagues? As I've mentioned previously, what we did in podiatry was to sign a contract with the College of Podiatry, which graduates about ninety-five percent of the podiatrists in practice here in New York City. We helped put together a protocol with the help of the faculty of the podiatry college. We said, "We are going to give you a chance. We are going to pay your school.. We'll give you professors the opportunity to review the quality of the professional work of your graduates, of the alumni of your school."

We entered into a similar arrangement with the Optometric Center, (What was left of the Columbia University College of Optometry after it closed. The New York State College of Optometry was in the preliminary state of its reformulation.) We signed a contract with the Optometric Center to audit the Medicaid care rendered by the optometrists in town. Such arrangements blocked many of the potential complaints, because who would they be complaining about? Their own professors.

Look at the podiatrists. Forty-three percent of the podiatric molds for children and adolescents were found to be professionally acceptable by the

faculty of the school that had taught local podiatrists how to prepare a podiatric mold.

Once again it's the town and gown adversarial relationship--here the gown being the school and the town being the professional society. One study by the Optometric Center showed that about twenty percent of the optometric work was deemed professionally unacceptable. I must mention parenthetically that we could better interpret the meaning of such statistics if we had statistics on non-Medicaid optometric patients, i.e., on middle class patients in middle class optometic offices. I don't know. Nobody knows. I am going to find out one of these days, I suspect that the statistics that will emerge won't be much different from what we found in the Medicaid class. At the moment that's my hunch, but the subject needs studying.

Medicaid and Medicare, besides providing indispensable health care services to those eligible, gave federal, state, and local governmental agencies a chance to examine the quality of care that government was paying for. The programs also gave government an opportunity to employ fiscal leverage to alter practitioner and institutional behavior for the better.

I remember one of the last things I did shortly before I left the health department the first time in 1971. I was sitting with the Medicaid audit staff. I said, "We've allocated many of our resources to audit the ambulatory care rendered by practitioners. We deliberately have done little auditing in hospitals."

The JCAH, had been and was doing auditing work in the hospitals at that time. I had wanted to do something original. Ambulatory care review was more innovative. Ambulatory care review would and did break new ground.

Ambulatory care is still neglected as an area of quality control. PSROs

work primiarily in hospitals, but in no ambulatory care areas to speak of. There is an evaluative PSRO project, in Allentown, PA and in the Bronx. Ambulatory patients are not as captive as inhouse hospital patients. You are dealing with records that are more illegible in the offices than their counterparts in hospitals.

The concept of caveat emptor continues to apply. The emptor here is government. The government is the third party payer. We publicized this principle in the auditing of Medicaid by the New York City Health Department. Government need not be defensive about its attempt to find out where its money is going. We checked the ambulettes and found significant discrepancies between the names of the passengers who were being transported to the clinics from their homes and the names of the patients logged in the OPD clincs for that day. We also found names of the patients on invoices of the ambulette company when by our own Health Department death certificates the patients in question had been dead for some time. But why belabor the subject? Read our papers about the fraud, poor quality, and overutilization encountered.

The PSRO represents the last opportunity for health care practitioners' groups to get their houses in order. Whether they'll succeed remains speculative.

WEEKS:

What are the effects so far of the PSROs?

BELLIN:

Well, it's a mixed bag. I get around the country on various things. I was in a major city not too far from here and I asked an informant: "Tell me about your PSRO."

I was told it was chocolate cake, no trouble. When a prominent hospital

administrator perceives that the local PSRO is no trouble, then we are detecting something ominous. A PSRO ought to represent some trouble.

Also in that community I asked, "How is the HSA doing?"

"The HSA is no trouble either."

You can't speak about PSRO and HSA as generic entities. There are HSAs and there are HSAs; there are PSROs and there are PSROs. I know that right here in New York City the effectiveness of the PSROs varies from county to county. It's a mosaic. That's all within the same city.

I think that if PSROs are too permissive, they had better prepare for serious trouble, a nationwide battle going on between state and agencies and PSROs. If I were a governor, I would suspect PSROs organized as they have been by local county medical societies. I'm a Manhattan PSRO Board member. Moreover, the medical society is more interested in quality control, more than cost control of health service.

The governors say, "We as governors have to be interested in cost control. We have the contract with the federal government. We prefer that the cost and quality control agency be directly accountable to us who are responsible by law to administer these programs. The state agency can go into the site where care is rendered to assess what's going on. We prefer a state agency answerable to us to an agency composed of physicians who go in and check on their own colleagues. We know too well how ineffective have been the Medicare utilization review committees from 1965 and onward. Had they been any good, we wouldn't have the PSROs today."

As you know, utilization review committees have been farces. Within the same hospital, within the same referral and social network, one physician checks another physician. In such a situation how can you get an objective

assessment in utilization review?

WEEKS:

What about computerized reviews? Are they used?

BELLIN:

Yes. Again it's what information you are going to feed the computer. We have physician advisers, so-called PAs, in the hospitals. We were obliged just in the last couple of weeks to "de-delegate"--this is what it is called--two hospitals. These two hospitals had originally been permitted, i.e., were "delegated" to perform their own house reviews. We rechecked them after a year. Their performance had been so bad that we removed this authority; i.e., we de-delegated them.

It has been with reluctance that we have delegated authority for internal review. But we had little choice. We lacked the staff or the money or the time to do it ourselves. So we had to delegate somebody. We chose those hospitals most likely to do a reasonably good job, those having the sophistication, the competence to do the job properly. We came back a year later, two years later, and found that they had been kidding us. We would take 100 charts that they had reviewed and ask how many days they had disallowed in those cases. They disallowed 2 1/2 days out of the 100 charts. We looked at the charts and maybe disallowed 150 days. There is a big difference between 2 1/2 days and 150.

So we would say, "Maybe you don't understand the criteria that we are talking about. Let's sit down. Let's have a working session. We'll have our staff work with you. We will consult with other hospitals who evidently understand somewhat better what our policies of disallowance are."

You do that and sometimes they respond and sometimes they don't. We have

to de-delegate them if they don't. That's what is happening here in New York.

Just to give you and example, I received a telephone call about a year ago. The director of a very well-known voluntary hospital called me. He was in a state of hysteria. His voice broke.

I asked, "What's the problem?"

He said, "You don't know what they are doing to me here?"

I said, "Who are you taking about?"

He said, "The state. The state just disallowed 1,000 days. At 300 bucks a day I have got to explain to my board this coming Thursday what happened to $300,000 in the last forty-eight hours. They are sticking around, they won't leave. They're probably disallowing more days."

You have to understand what I am talking about. There is a degree of subjectivity. The PSRO and the state are two judges who may assess hospital charts somewhat differently. The state agency is out to prove that it's tougher than the lcoal PSRO. That is very easy to do. Just be tougher on those grey areas and disallow more days. The PSRO can't win under those circumstances.

So, consider the different levels of severity in the review process: The traditional utilization (U.R.) review was a joke. Then, you have the "delegated-to-the-hospital" review--somewhat above the joke level, but not too far above it. Delegated review to the hospitals resembles the U.R. program, because Hospital A audits Hospital A. Then comes the PSRO with non-delegated review. And to top this hierarchy of severity is the state. It's not fun being a hospital administrator anymore.

One hospital administrator told me confidentially, "Look, I know what you are doing, and you know what I am doing, but let me tell you as a friend: If

we were really to adhere to the rules and the spirit of PSRO, my hospital would have to go bankrupt."

You know something? He's not far wrong. The current method of reimbursement is threatening all the hospitals in town including those that are internationally known. They are all in trouble. I've read Berman and Weeks. There are various ways to spend money more effectively. One can cut out administrative fat. But it's no longer fat that we're slicing. We've moved into the bone marrow.

The hospital administrators view much regulation, including PSRO regulation as incalculably damaging harrassment. I feel sorry for them but I have my own role to play, as well as I can on behalf of the PSRO.

When I became New York City Health Commissioner, I harbored feelings of respect toward the public municipal hospitals intermixed with feelings of loathing. I am reminded of shocking things I had seen as a senior medical student at Downstate. I remember King's County Hospital as a house of horror.

When I was appointed Health Commissioner I also was appointed Health Services Administrator whose responsibility it was to head the superagency which encompassed all the municipal health agencies. I was Chairman of the Board of the New York City Health and Hospital Corporation which was the agency that ran all the existing twenty-one municipal hospitals in New York City. After I had been the Chairman of the Board about six or seven months, I concluded that anybody who claimed to be compassionate to the poor, was morally compelled to exercise his ingenuity to closing the public hospitals. It's cruelty incarnate to keep them going. Maybe this would have been a theoretical subject some years ago because then every bed in existence was needed. When I was medical student during the late 1940s we had 100 to 115%

bed occupancy. This was just after World War II, and patients were in the halls, literally in the halls.

Under Hill-Burton we built new hospitals and caught up with the most compelling needs. Moreover, there has been a decline in length of hospital stay. Decline in length of stay antedated the PSROs, so they can't take complete credit for this national phenomenon.

Now, if you have declining length of stay you have increased, in effect, the potential absorptive capacity of your hospitals. So, now it's numerically possible to hospitalize in voluntary hospitals a significant portion of the indigent population. You couldn't do that before in New York City. There was no room. But now it's at least possible. This has important policy implications. But the voluntary hospitals can't afford to care for no-pay patients--those without access to fiscally supportive parties like Medicaid, and Medicare, and Blue Cross.

Medicare and Medicaid enacted in 1965 to pay hospitals for inpatient care. Those programs pay. The group that can't pay is the so-called working poor who are not covered by Medicare or Medicaid.

What's happened in New York City? What's happening in Boston? And what's happening elsewhere when via Medicare and Medicaid you grant fiscal enfranchisement to the poor? The New York City statistics show a three to five percent decline each year in patient days in the municipal system. At the same time there is an increase in patient days in the voluntaries. Nobody really denies this anymore. I was very much alone then I was beating the drum for this obervation when I was Health Commissioner. We see here the transfer of allegiance on the part of the poor from public hospitals to voluntary hospitals.

This phenomenon, I would argue, is not unique to New York. We see it in Boston--that's why Boston City Hospital is on the financial ropes. Mayor Rizzo closed the famous public Philadelphia General Hospital. This provoked accusations and all kinds of predictions that in the absence of Philadelphia General Hospital people would die on the streets of Philadelphia. The fact is that people did not subsequently die on the streets of Philadelphia. Patients were successfully absorbed by other hospitals in Philadelphia when they closed Philadelphia General Hospital. They are talking about this problem in your part of the country, about Cook County Hospital in Chicago. Right?

WEEKS:

In Detroit too.

BELLIN:

In Detroit they are just not opening a new hospital already built. I was at the VA conference in Detroit recently. I see a new hospital is going to take title to the local city hospital, isn't that so? Cities don't have the money to do it. If it were a question of patients spilling over into the wards, they wouldn't be talking about not opening that hospital, you know. I don't know what they are going to do with it. Maybe they are going to mothball it or sell it to a managerial firm. Maybe sell it...

WEEKS:

Detroit Medical Center is going to take it over.

BELLIN:

Because of my position about public hospitals I found myself very much in the political thick of things. Public hospitals advocates were enraged. I stirred up a good deal of controversy and public comments. Here I was chairman of the public hospital board talking about the phasing out of public

hospitals.

Somebody said, "I suppose there is some justification for you to criticize public hospitals. However, to have you as Chairman of the Board of public hospitals in the City of New York willfully recommend that people preferentially ought to seek hospital care in voluntary hospitals is the equivalent of the President of Chrysler driving a Ford."

I said, "I plead quilty." I said, "Look, I am the Health Commissioner. I get telephone calls all the time from the Commissioner of this or the Deputy Commissioner of that, from this person, from that person, his parent, his loved one--seeking recommendations as to what's the best hospital, who's the best practitioner to treat this or that."

"I get such calls all the time. Any physician in public office does. It's instructive that in my experience never has anybody said to me, 'My ideology says I ought to go to a public hospital, so get me a public hospital, and I want to have a good ethnic balance. Get me a red-headed Puerto Rican Jewish female physician. That will cover four or five representative categories.'"

I said, "Maybe other people are getting ideological calls. I never do. I get panic calls: 'Get me the best person in the best institution.'"

If I say, "Go to Hospital X," they are grateful, and that's where they go. I make a telephone call to Hospital X in advance, you know, to indicate delicately that I am the advocate to get them an appointment sometime between now and the next jubilee.

"The ideologues--people who speak so enthusiastically about public hospitals--where do they go? Victor Gotbaum, head of District Council No. 37 is an excellent example. He had a shoulder injury from a ski accident, so

where did he go? Lenox Hill Hospital, I read in the paper. Lenox Hill, I would remind you in case you don't know it, is not a public municipal hospital. Lenox Hill is a voluntary institution."

I said, "There is not one person on the Board of Health and Hospital Corporation who uses a public hospital. With one exception: There was a woman, I remember, who as a matter of principle went to Bellevue. I have got to give her credit. Nobody else had or has that kind of principle. I didn't have it. I publicly proclaimed that."

I said, "It's ironic. The same group while fighting for the preservation of the public hospital system at the same time supports comprehensive national health insurance. A public hospital system and comprehensive national health insurance are mutually incompatible. With the advent of univeral coverage, what is now a three to five percent trickle from the public hospitals into the voluntaries will become an avalanche. It's happening already. You go into the voluntary hopitals now, the patients are not all lily white. Black, brown, Martian, they take anybody, any ethnicity, or any religion. Got the long green? That's the color that counts. Medicare and Medicaid pay. Blue Cross pays."

They say, "They used to turn us away."

I said, "You are right but how long are you going to carry a grudge? In the past Hospital X turned you away. Hospital Y turned you away. Hospital Z turned you away...Maybe they turned you away in the past because you didn't have the money. Maybe they turned you away because they didn't like the color of your skin. Whatever it is, it's no longer the same situation. There are different people making policy and working in the institution right now. Only the hospital's name is the same. They are ready to take you right now--if you

have Medicare or Medicaid. You tell me what you want. You want to go to the public hospital, say Harlem Hospital? Or to a voluntary hospital like Columbia Presbyterian? They go to Columbia Presbyterian. That's where they go."

With all that, Columbia Presbyterian had to close 150 to 200 beds last year because their occupancy had declined. It had declined in part because of the shorter length of stay. So, we are witnessing shrinkage to closure of hospitals with low occupancy amidst a large amount of political strutting.

An example of that political strutting is reflected in the case of Fordham Hospital in the Bronx. The hospital was falling down; it was going to come down. The original plan was to put up a new Fordham Hospital. I opposed that because we already had too many beds in the Bronx. We had the new North Central Bronx Hospital opening up and the new Lincoln Hospital. If anything, the Bronx is depopulated right now. The Bronx phone book is skinnier today than a decade ago. We just don't need a new Fordham Hospital. We can't afford it.

Well, a short time after I mentioned my views on this at a staff meeting, I received a telephone call from the President of the Borough of the Bronx. He had heard about my comments. As someone once said to me, "If you want something in the New York Times write a confidential memo to someone. A photocopy will be on the desk of the health editor of the Times within thirty minutes." That is only a mild exaggeration. It's true.

So, I wasn't surprised when he called and said, "Commissioner, I would like to have you come down to my office. I'd like to discuss the hospital issue."

When the Borough President calls you in, you go. I brought some of my

staff along with me.

He asked, "What's this I hear that you oppose the building of a new Fordham Hospital?"

I said, "Yes, I do." Then I asked, "Why?"

He said, "The reason is?"

I said, "Too many beds."

He said, "Don't you believe in outreach?"

I said, "Yes, I believe in outreach."

He said, "What I am talking about is there are a number of people who should be hospitalizaed, and, in fact, are not. They should be treated. Moreover, there are people from the Bronx who go the Manhattan hospitals."

I said, "We took that into consideration. We have the data from a patient origin study of how many people go from the Bronx to Manhattan. Even if these people were to receive all their hospital care in the Bronx, the Bronx would still have too many beds."

He was unhappy. I suppose if I were Borough President I would be unhappy too with an obdurate health commissioner.

Subsequently the Chamber of Commerce got in touch with me--the Fordham Chamber of Commerce. I hadn't even known there was a Fordham Chamber of Commerce. I figured there was a Bronx Chamber of Commerce, but didn't know about a local chamber. They came. They wanted to see me. They came to my office. I didn't have to go to their office.

They said, " Are you unaware of the impact that the closure of Fordham Hospital and plans not to build a new Fordham will have on the Fordham area of the Bronx?"

I said, "What are you referring to?"

They said, "Commercially what impact that decision will have. Don't you know that stores and boutiques are dependent to a significant extent, on the people who are the employees, you know, who go out on their lunch hour or before and after work to shop? Aren't you aware of that? The Fordham area of the Bronx has suffered much economically already, but would suffer much more if the hospital were closed and not replaced."

I said, "Gentlemen, I find I have a problem here. I understand what you are saying. I have been in public office, off and on, since 1962 when I became Commissioner of Health in Springfield, MA. One of the common criticisms people in public office receive is, "The trouble with those bastards at the public trough is that they never have had to meet a payroll. They don't even know what it is to meet payroll. They are not like us businessmen, because when a businessman fails to meet his financial obligations, he doesn't receive an appropriation to bail him out. We go bankrupt. No public agency ever goes bankrupt. They have no pity for us taxpayers."

I said, "Sometimes that talk even comes from the Chamber of Commerce." I continued, "There is some truth to it, you know. I'll acknowledge there is some truth to it. Not as much as some anti-government people would believe, but there's some truth to it. I am looking after the public purse and you are telling me about the boutiques in the Fordham area of the Bronx. I am not Commissioner of Commerce. I am the Commissioner of Health. You have a valid concern but you are in the wrong office. My job description addresses the provision of health services and the prevention of disease."

They were annoyed and unhappy and left.

I was visited by some priests and nuns who represented the Catholic church. "There was a promise made to the Italian-Americans who constituted

much of the population of this area when the whole section was razed. Weren't they told, Commissioner, years ago when that property was being taken by eminent domain that theirs was a sacrifice for the common good, that someday a hospital would rise in this area and make up for that sacrifice?"

I said, "I suppose they were told that. But right now there is no money to build a superfluous hospital in the Bronx. There is no money! Moreover, I can't even associate myself with tht promise. I wasn't ever here; I was in Springfield, MA in the private practice of internal medicine and cardiology when that happened. I wasn't even here in the city."

They asked, "Who will serve the Central Bronx? North Central Hospital was built in the north. The new Lincoln Hosptial was built in the south Bronx. What about the central area? Why was North Central put where it was?

I said, "If I could, I would put that building on wheels and take it down to you, but I can't. That is where I found the new hospital. That's where they built it."

District Council #37 also went after me. (That's the union of employees of the public hospitals.)

What am I saying? Everybody wants frugality, economy, prudent spending--from the other guy--but don't gore my ox. I am not being critical of them. It's just an observation. It's the workings of the political process. You have to all kinds of constituencies. Each constituency has its own Weltanshauung. To the union the hospital is a place of employment. To the Chamber of Commerce the hospital is a facility of commerce.

Somewhere along the line we are supposed to deliver health care services efficiently, effectively, and so forth, but, you see, people in public office like myself receive mutually contradictory signals. What are we supposed to

do? We begin to wonder. Maybe some of those guys are right. Maybe we are not being as holistic as we should. Maybe we can have greater impact on public health statistics by encouraging employment in the Fordham area, you know. Lower the mortality that way. It's difficult.

The public wants low taxes but at the same time wants more services.

But let me be responsive to some questions. Why are the public hospitals as bad as they are, and why do they appear to be getting worse? I guess it was Galbraith who once commented that in the United States we have private affluence and public squalor. Today we see public squalor in public agencies, in education, in transportation, in the total system--and in health services. We lack a tradition in this country of high quality public service, let's say, such as in the Scandinavian countries. A few years ago I was visited by somebody from Stockholm who was the equivalent of the Dean of the School of Social Work. He was amazed by the low standards of delivery of services in public hospitals in New York City, at least as he read about them in the local press. He said that such a phenomenon would not be tolerated in Sweden. I assured him that in the future it wouldn't be tolerated here either, but I said that we needed a special confluence of sociolinquistic circumstances: at the very least 100% of the people in New York City would have to speak Swedish.

I said, "On that same day we would have Swedish standards. Until that day I am afraid we are saddled with what we have. You can speak out all you want about self-fulfilling prophecies. People don't expect much of public agencies, therefore, public agencies don't deliver much. Under those circumstances the question is: Do you want to reform the system, change the American culture to such an extent that it begins to resemble the Swedish culture? Or, do you face the fact that change is glacial? You don't change

cultures that rapidly; you don't change attitudes that rapidly. You have to work within a fairly permanent culture in place. If that's the case, and I would argue that it is, then I am devoted to the tactic of getting government out of the business of running the public hospitals, for which demonstrably government has little talent.

You have a problem with a public hospital. Let's say a public hospital pays a director $30,000 to $35,000 in New York City. The more important bigger, voluntary hospitals pay, with perks, $100,00 to $120,000 to a director. That tells you something immediately.

Some have argued, "The way to handle that situation is to cut the salary of the $100,000 person to $30,000."

I would say quite the contrary. I would say that they should bring up the salary of the $30,000 person to $110,000. That's not going to happen in any public agency, not when the mayor of the city gets $60,000. You can't expect somebody who runs a municipal hospital to get $100,000; it's not going to take place.

One of the major attempts to address this issue was done by Dr. Trussell when he was Hospital Commissioner of the City. He developed the affiliation program which was modeled after the Veterans Administration program set up back in the late 1940s or early 1950s under General Omar Bradley. The advantage of having this affiliation was that you could officially have people on the private hospital payroll and pool public moneys so that for the first time you could begin to pay competitive wages. There would be competitive amounts of money through this rather complex device to ricochet money into the appropriate areas. In order to get better physicians and better administrators you simply have to pay better salaries.

There is another problem: The public hospitals have little political clout compared to the voluntaries. They may make a lot of noise but...I am reminded of one well-known voluntary hospital here in town where one member of the board has one indispensable duty each year. They don't care whether he otherwise attends meetings. According to the story, he is supposed to make one telephone call a year. He is supposed to call Albany on the day the hospital daily rates are decided upon--and try to persuade the Albany people to reconsider the obviously inadequate per diem rates. He is supposd to make the phone call. He's still on the board, so he must be making some very effective phone calls.

I am not discussing whether morally this is a wrong way or a right way of doing things in the health field. I am saying again that this is part of the political process. Rate setting is a political as well as a technical process. The municipal hospitals simply can't compete in this kind of arena. They are clearly the hospital of last resort, but I don't want there to be any hospital of last resort.

The advantage of having a hospital chain is that if you have somebody who's particularly skilled, let's say in maximizing reimbursements, or somebody particularly skilled in minimizing accounts receivable, or somebody skilled in dealing with the food service, you can fly that person from one part of the chain to another part, move that person in, a sort of flying squad of competence, and get something done.

The problem with the municipal system is you lack this level of competence in any of the institutions. You are driven by no demon to succeed. The opposite is true in a proprietary chain, where profit ultimately depends on your ability to attract and retain clientele. Public institutions, at least

until 1965, didn't have to worry about retaining clientele because they had clientele nobody else wanted.

An interesting phenomenon has appeared in the last fifteen years and it deserves far more attention that it's getting. The fact that's sneaking up around us is that for the first time municipal hospitals, county hospitals, state hospitals, have had to compete. They have not competed successfully. The bottom line I am talking about now is not how much money is coming in but rather how many patient days did they generate in the past year and how does that compare with five years ago and five years before that. Where are the patients going and why are they going there? You see, a patient with a Medicaid card, if he or she wishes, can go to a public institution. Yes, the majority of them still remain at public hospitals; that's a culture lag. But, there is no question about it, the number declines each year. The VA hospitals are worried about it. The major reason why you haven't heard about the Veterans Administration hospitals' concern about this is because the VAs have something the municipals don't have. The VAs have organized constituencies, the Amercian Legion, the AMVETS, the Veterans of Foreign Wars--some powerful veterans' constituencies. The only thing that will ultimately save the VA hospitals, God forbid, is another war. They are running out of veterans.

You have attrition of veterans so now they are talking about taking veterans' families and becoming community hospitals--doing something else. That was not the original VA plan, at least not when I worked there in 1951 through 1953.

You have an undercapitalized public system which needs, I would argue, needs better and more skilled personnel and better and more skilled adminis-

trators then the voluntaries have. The voluntaries have more money so they don't have to be as skilled. The municipals need greater skill in how to husband and spend their resources. They need greater ingenuity, they need greater innovativeness, greater imagination. What do they get? They get people who are clunks. Anybody who is good, who rises in the public system often gets bought out, is identified early on, and makes a career in the voluntary system, sooner or later.

The first time I saw this phenomenon was when I was in the Air Force during the mid-1950s. It took us four years to train an airplane mechanic for the jets we were flying. In the four years, as I recall, the top rank that person who graduated from the school got was the equivalent of sergeant, and your life depended on the quality of work that these people put in. I mean you were up there. How well that mechanic performed on your plane determined whether you are coming back in one piece. The pay was, as I recall, under $400 a month. The story goes that airplane manufacturers would come out and take these people who came out of the excellent air force training program and hire them at twice the pay. So the feds were subsidizing the education. The airplane manufacturers didn't train the people, they took them already trained. So they got it both ways: got trained people, and also got the original contract to manufacture tha planes from the federal government.

I said, "You are right. It's unjust. It's absolutely unjust. It reeks of injustice. It's not fair. Terribly unfair, but that's the way it is."

They respond, "Why don't you go ahead and change the system?"

I said, "I don't have enough resources in intellectual energy to change it appreciably--all I can do is to modify it a bit. I try to humanize it in a few particulars. The system is unchangeable in the short run. It would take

four or five generations of benign autocracy to change it. But I have to be concerned about the welfare of the current generation. As Lord Keynes put it, "In the long run we are all dead."

I said, "I am doing what I can to take this generation of the poor out of public hospitals with all their deficiencies and transferring them to better private hospitals. I can do it now because I can call upon Medicare and Medicaid, as resources--as a means of access to middle class care. Yes, I want to have comprehensive national health insurance. Once that is promulgated, that is the end of your public system because your patients will vote with their feet." I said, "The poor may be poor, but they are not necessarily stupid. They know where the best care is."

Not that there are no blemishes in the private institutions. I could write five papers on that subject. I have no illusions about what is going on there, but I am talking about comparisons. When I was a medical student at Kings County, the story was that if a patient wanted a bed pan, he had to pay a dollar to have the bed pan brought to him, and the story continued that the patient then had to pay another dollar to get that bed pan removed after he had used it. You know, little horror stories like that. True or false, I never was able to verify. But, there were no stories like that floating around Columbia-Presbyterian, or Mount Sinai, or St. Lukes, or St. Vincent's.

I would phase out an independent Medicaid program and put it entirely under Medicare. Of the two models, the Medicare model has proved to be more workable and for reaons I would have opposed earlier. I was critical about the fiscal intermediary approach, but as it turned out, it was a logical approach not only for political reasons but also from the standpoint of administrative efficiency. At least here in New York City, the public sector

has been notoriously lax in paying in a timely and accurate fashion. One of the reasons why the Medicaid program flopped here in New York City was because few of the physicians, dentists, optometrists, and podiatrists were prepared to accept lower fees--far lower than Medicare fees for the same service. It's bad enough to accept lower fees. It's another thing to have to use mysterious codes and be unable to match what your own books say you should be receiving and what the government deigns to pay you after a lapsed time of five, six, seven, or eight months. So, I have conluded that a fiscal intermediary ought to be paying the bills. They handle the paper work better than the government.

But, there are less positive aspects of fiscal intermediary performance in the Medicare program. They push paper very well. They push it rapidly, they push it efficiently, but do they watch what they push? I would argue that they don't watch what they push. It's very easy to make the hospitals, practitioners, and the nursing homes happy with you: Pay what they ask for and do it "soonist." But these are public funds that we are talking about. It's like the machine that allegedly makes salt at the bottom of the sea; nobody can turn it off. Once you have these programs, you can't turn them off. You need some kind of active governance, like what you might have on your car that would restrain it from going over so many miles an hour. There needs to be a kind of mechanism to monitor standards, insist on standards, and enforce standards in quality sense. It can be done. The PSROs are beginning to show some evidence that they can do this.

I'll give you an example, and this relates to your question about national health insurance. One of our most important diagnoses with respect to payment in the City of New York is cataracts. The Manhattan PSRO did a study of cataracts in Manhattan. How many days does it take on the average to

have a cataract dealt with? Answers varied all over creation. There were some hospitals where it was six days, other five days, three days. As far as we could determine there was no difference in the age groups, or ethnicity or geography to account for why there should be a 3-4 day difference from hospital to hospital. So an additional two days stay is $600. Well, we put the heat on in respect to cataracts. If you compare statistics this year and look at statistics a couple of years ago you will notice there was a decline in the number of days.

Hospitals think twice now because they know the PSROs are coming around. We have told them either to learn to live with us in the Manhattan PSRO or learn to live with the State Department of Social Service or the State Department of Health. In other words, choose your poison: Do you want to take barbiturates or do you want to take aqua regia? You are not the autonomous agency you once were. We know what you can do. We have enough informants, who tell us that you have a six or seven day stay because you have low occupancy. So you keep them in beds. We know about the informal instructions that go out. I have been in practice myself so I know whereof I speak.

It is silly to have two separate programs. When you have two separate programs you have Gresham's law in effect. On two or three occasions this has happened in respect to nursing homes. Sometimes Medicaid would pay more than Medicare; sometimes Medicare would pay more than Medicaid. Each time the consequence was that the nursing home operators would throw out less reimbursing patients. Let's look at a nursing home of 100 beds. If there were a dollar a day difference between the Medicare and Medicaid payment, we are talking about big money, $100 more per day. That's $700 a week, and that's just a dollar a day difference per bed. I would place Medicare and Medicaid

under a single auspice. I don't believe in separate but equal in schools; I don't believe in separate but equal in hospitals. Separate but equal never works. I also don't believe in separate but equal in government agencies that are running cognate and overlapping programs.

I prefer Medicare because it pays better and in a timely fashion. I am not necessarily a champion of what current payments are, which depend on "what the traffic will bear." But, I would sooner support that than support the reprehensible fee schedule established in Medicaid, allegedly after negotiation between the professional society and the state agency that sets the fees. So, 85% to 90% of the physicians who used to provide Medicaid services have abandoned the program here in New York City during its fifteen year history. We are down to 10% of the practitioners who see Medicaid patients. These are not always the best practitioners in the city.

I prefer the Medicare model but one with aspects of the New York City review as an integral part of the program. Who should do the review? Although I serve on the board of the PSRO in Manhattan, I acknowledge that the PSRO concept simply cannot work all over the country. It cannot work in smaller communities because the doctors in such communities know each other. A few hundred physicians practice in a non-metropolis. Most them know one other, refer cases to one another, socialize with one another. In such circumstances how can you expect an objective assessment of the quality of each other's professional performance? You have to have a large community for the PSRO to work--or you have to fly in doctors from other areas. How can you have doctors from Hospital A checking doctors from Hospital B, if you entertain any hope of objectivity?

Senator Wallace Bennett, the Utah Senator and father of the PSRO wanted

an "arms length relationship" between evaluator and practitioner. If you have an arms length relationship you can have a fighting chance for integrity. That is why banks have a system of external audit, viz, outside bank examiners. Banks don't depend exclusively on internal audit, viz their internal accountants and other auditors. This outside bank examiner concept is a useful one to apply to the delivery of health services. The trouble with most of the schemes for national health insurance is that insufficient attention is paid to this audit idea.

The terms "regulatory" or "regulations" or "controls" have negative connotations. But the English language is rich in synomyms and euphemisms. I am sure we can come up with some other terms that perhaps would sit better with people. I am afflicted with no defensiveness about my view about auditing. After all we are talking about billions of dollars a year in potential expenditures nationally--over two billion a year spent in the Medicaid program alone in New York City. Tax payers are entitled to be protected. I would point out that this way of thinking is politically acceptable. Much of this support I used to receive in public office came from the political right. Not exclusively from the political left where we expected to receive it. The political left tends almost routinely to badmouth the physicians who, they say, are making too much money. I got support from conservative Republicans in the state legislature because they understood what I was doing, that I was concerned about the taxpayer.

I would remind you that Senator Wallace Bennett of Utah, the father of the PSRO, was a conservative Republican, former president of the National Association of Manufacturers. He was from the political right, not the left.

The political right and the American Medical Association parted company

in the early 1970s, over the PSRO issue.

National health insurance should be so structured that enrollees aren't fiscally penalized for seeking and receiving ambulatory care. A system that compels hospitalization by threat of bankruptcy if the enrollee seeks ambulatory services is absurd. Moreover, if we are going to have a proper national health program, we have to address the problem of maldistribution of practitioners. That's a soluble problem.

WEEKS:

What would you do?

BELLIN:

Two things. During the mid-1950s when I was in the Air Force, there was an air base called Thule in Greenland. People were terrified about going there. People broke down psychologically in six months. At least that was the story, perhaps somewhat exaggerated. Thule was a terribly lonely place with howling winds and snow and ice, and so forth. But if you went to Thule you received extra pay, as a bonus--like combat pay. Recruiters could get some people to go to Thule under those circumstances. The extra pay was the carrot.

The fact that a major portion of all Amercian psychiatrists are settled around the Brookline-Newton area outside of Boston is socially indefensible. If psychiatrists have social utility they should be distributed better. In some parts of Manhattan there seems to be one doctor for every few hundred people. In contrast you have one accessible doctor for a couple of thousand people in other parts of New York City. Rural America also suffers from maldistribution.

A young man or woman goes to medical school. This student's family pays

via tuition 1/3, 1/4, or 1/5 of the actual cost of the education. Somebody is paying the remainder. I'll tell you who is paying for it: The state and nation are paying for it. Every future MD is so subsidized. On a quid pro quo basis, each new MD should serve for at least two years in a medically underserved area.

To the extent possible we will give you a choice of location that is medically underserved. A young MD may work on an Indian reservation, or in Harlem, or in Bedford-Stuyvesant, or in the South Bronx. We don't need any more MDs in Scarsdale or Shaker Heights. Some would object and insist that compulsory service is unAmerican. The M.D. is now paying back to the public the huge subsidy from the public that financed most of his professional education in the first place. It's a social contract. There would be no buyouts! Everybody would have to put in their time. Not like the Civil War where you could hire somebody for $100 to take your place in the draft. None of that. The problem is eminently soluble.

There are counties lacking a single ophthalmolgist.

Within a few years we will have a ratio of one physician for every 450 people in the country. By 1990 we will have a ratio of 1:350 assuming estimates are correct. I would keep that ratio. I don't want to close medical schools; I don't even want to shrink medical schools. I prefer a glut of M.D.s. I want a return to the 1930s when doctors were hustling for patients, not patients hustling for doctors.

WEEKS:

Would you care to comment on catastrophic insurance as a means of ensuring proper health care?

BELLIN:

With respect to catastrophic insurance a serious political and tactical error was made some years ago. Senator Russell Long of Louisiana pushed catastrophic insurance. The attitude on the part of those who might ordinarily support such legislation was, "No, we are not going to support catastrophic insurance, we want all or nothing. We insist on a comprehensive national health insurance package. The promulgation of catastrophic insurance would be diversionary."

As it turned out they got neither. They didn't get catastrophic insurance because there wasn't enough support for it, and they didn't get national health insurance because Congress was terrified by the cost overruns of Medicaid and Medicare, and by Social Security problems.

I think proponents of national health insurance should have settled for half a loaf and suppported catastrophic insurance. An enormous amount could have been learned, a lot of experience could have been gained with catastrophic insurance. Then they could have built on that.

The New York City Medicaid program taught me about the virtue of deliberate gradualism when starting programs. Medicaid would have been more successful in New York State had the program initially been less ambitious about comprehensive benefits. Any new and complex program ought to be phased in. The administration can learn from experience what the strengths and weaknesses are. One corrects these deficiencies before going on to the next phase.

WEEKS:

Will you talk a little about compensation to physicians under these programs?

BELLIN:

I can share an experience I had with respect to payment. When I as in private practice in Springfield we had a small hospital called the Wesson Memorial Hospital, established by the Wesson family, of the Smith-Wesson gun manufacturing. The hospital didn't have interns or residents. Each private practitioner had to work on the roster to cover the emergency room about 2-3 times per year.

One night while I was on duty in the emergency room a young man of 17 came in who had been struck in the chest by a baseball. I examined the patient and ordered a chest film to make sure that there was no rib fracture. I put a couple of pieces of tape across the ribs to alleviate the pain on respiration. I sent the patient home with some mild analgesic. I would say that took all of ten minutes of my time.

Another patient came in shortly after that. He was a young adolescent who had been horsing around in the family swimming ppol. One of his playmates jumped astride the back of his neck and he was now experiencing numbness and odd sensations in both his hands. Had he suffered some trauma to his spinal cord? I performed a meticulous neurological examination. I ordered a neck and skull film to help rule out fracture. I must have spent a good forty-five minutes with him before I was assured that whatever he had was a temporary thing. His symptoms were abating. I sent him home with his father. I told the father that if symptoms persisted for more than a few days he should be seen by his regular physician.

Blue Cross/Blue Shield paid me about $25 for putting three pieces of tape on the ribs. In contrast I receive no payment for the neurological case because that was "diagnostic" work. That was the Blue Cross reimbursement

policy in Massachusetts at that time. So reimbursement didn't relate to the amount of time or the intellectual effort that went into a patient. It bore no relation to any equitable principle that I could fathom except as I found out the popular history of how these fees were established.

My perception is that the fee schedule was established by the surgical specialties. I would say that most colleagues in internal medicine and pediatrics would argue that something substantive has to be done about reforming the fee schedule. At least a fee schedule should be based on something that is comparable, generalizeable, intellectually respectable, and logically defensible. We don't have that now. If a revision were to be made, I suspect that some surgical fees would be brought down and some nonsurgical fees would be brought up.

Until recently it would have been impractical to implement such a reform, but now we have the beginnings of a glut of physicians in the United States. We already have a glut of surgeons in New York City. The glut puts the third party payer--which either directly or indirectly is government--in the saddle for the first time. The third party can adopt a more vigorous negotiating posture that has ever been the case up till now. That is a marketplace effect. Everybody seems to favor the marketplace except when the market place reacts adversely upon them. Then they call for controls for tariffs, for protectionism. Government is in a better position right now to renegotiate some of the unconscionable fees that are now being paid. I hear all kinds of stories. A few years ago somebody from one of the unions told me that they were sent a fee for $850 for cystoscopy plus removal of polyp, a bladder polyp. $850! Colonscopies currently command an office fee of $650 to $850. I don't know, maybe these fees ought to be even higher. Maybe these

fees ought to be lower. I am not even going to suggest a figure. What I am asking is: Was there some kind of mystical experience that produced these figures? I would say no. Rather, these fees are ultimately the result of negotiation and history. Today's negotiating activity is tomorrow's history. Maybe we ought to get involved a bit more in current history and cease accepting those numbers that are handed down as if these figures bore a sacred character.

I am not suggesting that this is the only source of expenditure. Our major loci of expenditures are still the institutions rather than the practitioners. I am not saying that you carry out all reforms at one time. You don't want to enrage all your opposition simultaneously.

WEEKS:

There are so many wheels within wheels because of the variance in fees or costs in one part of the country from another.

BELLIN:

That's the problem figuring out the differences. There has been some interesting work done about laboratory fees for different procedures. I think you have a section in your book about that, don't you?

WEEKS:

Yes.

BELLIN:

A study would analyze the time, the equipment needed, the procedures and so on. To my knowledge that type of cost analysis has never been used for formulating a defensible fee schedule for surgery--or for non-surgical procedures and services.

I accept the Wallace Bennett legislation on PSROs, albeit with certain

reservations, which I made clear at the time of the testimony. I thought it was the best we could get at the time. What I really wanted, and what I still want, I don't think it is too utopian, is that PSRO activities not be carried out by medical societies, but that PSRO activities be carried out under the aegis of health departments.

We have to make a decision sooner or late whether we want to phase local public health departments out of existence. Historically health departments have been providers of personal health services to the poor. But the poor are now being categorically and definitionally removed from the population because they are increasingly covered by social legislation. So now, the person who used to go to the maternal and child health clinic run by the health department can, via her Medicaid card, go see the private pediatrician. I think that is fine. I'd like to close all the MCH stations in the City of New York after giving to the poor access to middle-class pediatric care.

What then will the future health department do--assuming you favor the survival of the health department? A health department will handle certain kinds of communicable diseases: tuberculosis, venereal diseases, and the follow ups on these, and so on. They will have disease registries and follow these problems for years to come. The health department can develop certain demonstration projects. When the demonstration project has proved to be practicable, then the health department can turn the new program over to some appropriate health care entrepreneur to run and develop. The health department can monitor the contract.

There is something else the health department should do--become involved in safety. For example, when I was health commissioner, I started a program calling for compulsory window guards as an interventionary technique to

prevent falls from windows. You will see more and more window guards going up in the City of New York. A health department is a logical locus for carrying out the regulatory responsibilities of auditing cost and quality control of health care services. You cannot leave it to the PSRO. Sooner or later there are going to be scandals in the PSROs analogous to the scandals of utilization review committees. Somebody is going to go to Des Moines, or somebody is going to Duluth, or somebody is going to go to Springfield and say, "Let's take a look, let's do a PSRO on the PSRO. Let's assess the assessors."

I know the enormous temptations our PSRO has had to overcome to stay honest. To maintain integrity is a hard task. It's tough to be objective when you know the fiscal agonies that trouble the people on the other side of the table. You know they are not cruel, heartless people. They are good citizens too.

Pressures are overwhelming when you are in a small town. In a large metropolis you can be more anonymous and more objective.

The problem with the recommendation on behalf of the health department is that many health departments are neither equipped with the resources nor with the will to carry out PSRO activities.

WEEKS:

You would need a new breed of health officers.

BELLIN:

You would have to have a new breed of health officers. The current breed of health officers, unfortunately is not necessarily top drawer. A lot of steam has gone out of public health. We used to have giants in the old days when we had Leona Baumgartner. We don't have too many Leona Baumgartners around. I don't think we have any around anymore.

WEEKS:

Probably not. We have had a couple of persons in Michigan who have stood out in the past also, but they are not around anymore. When you were speaking about the role of the health department, a question came to mind. We heard so much about sensible living: about smoking less, drinking less, eating less, exercising more. A thought has intrigued me: How do we convince people this is the way to live, how do we educate them? I am supposed to be a communicator by profession. I have often asked myself: How could I change people? How could I convince them that they should live as healthful a life as they know how to live? How can I convince people that they should eat less, drink less, smoke less?

BELLIN:

I'll tell you, you are asking a profound question. I don't know how you do that. I know that one-third fewer physicians smoke today as was the case ten or fifteen year ago. So there has been some impact. I think it is a matter of returning to the old fashioned verities. Today the people who are held up as models for the young and not so young to emulate are those who have a rotten public health life style. They are whoring around, carrying on and drinking and smoking heavily, taking drugs and jumping into each other's beds and so forth. There are epidemiological consequences of that kind of behavior. I am not discussing good vs. evil, just talking about epidemiological statistics. I saw an ad on television last night for a certain brand of perfume. The girl jumps in a car and she rides forward into the night with a song chanted in the background that she prefers to be alone...Well, you know, prefers to be alone, all kinds of implications, other kinds of behavior. In the old days she would have preferred to be married and settle down, have a

family, and carry on her portion of societal responsibilities. This self-indulgent life style is glamorized. Well, I would say that public health educators have done a poor job over the years. I don't think they are as good as the ad men and women on Madison Avenue. I would turn over a significant portion of responsibility for public health education to Madison Avenue. They can persuade people not to drink Coca Cola, for example, because they were able to persuade people to drink Coca Cola in the first place. Can they make it work either way? I think there is a certain amount of malleability of the population and that we just haven't used the more skilled communicators like those who have successfully sold to the public desirability of non-offensive sweating.

I was at a meeting a couple of years ago. A friend of mine said, "Do you see that guy over there?" He said, "He is the ad man who discovered the armpit in Europe." The idea of using deodorant is an American phenomenon. If you have ever been to Europe, you know, you can pass out in crowded trains sometimes because of the inadequate personal hygiene, at least according to Amercian standards. Anyway, this guy my friend had pointed out transferred to Europe the American proclivity about being concerned with armpit odors. The advertising industry discovered a portion of anatomy which is commercially useful to them. I think the same thing could be done in other areas. It's mainly a matter of hitching the wagon to this kind of Madison Avenue star. I think you can do it.

WEEKS:

Advertising has sold the idea of taking vitamins.

BELLIN:

Remember Jack Armstrong, the All American Boy, on radio? I can remember

when, if you wanted to go out for the team, you didn't smoke. Any athlete who smoked had failed his high school and his team. A real tough sportsperson didn't smoke. That is what was held up for emulation.

WEEKS:

We have different heroes today.

BELLIN:

We have different heroes. We have got to change our heroes. I think that it is possible to do this. I think surely that sooner or later there will be a social reaction to what is going on now; which will take us to some kind of era of pseudo-Victorianism.

WEEKS:

One of the most popular television programs at present is "The Dukes of Hazard." I don't care to watch it because there is so much destruction, the crashing and smashing up of automobiles, and so on. I don't know how this type of program affects the public, but in Detroit a day or two ago there was demonstration. A Chevy dealer bought an old beatup Toyota and he invited some young strong autoworkers to come over to this car lot and beat and break the Toyota up with sledge hammers. My wife said to me when we saw this on the evening news, "I wonder if this will carry over and we will read about people going about the streets with a sledge hammer?"

BELLIN:

I think it is a reflection of their frustration. Today I would buy a Toyota sooner than a Detroit product. The approach with sledge hammers wouldn't convince me.

Getting back to education. About 1969, during the latter part of my first time with New York Health Department there occurred a phenomenon which I

call "deprofessionalization." People with public health experience, people with the M.P.H. degree became suspect. If you have a medical degree and a M.P.H. you were deemed twice as untrustworthy. The solution to the current public health problems was considered the province of people of the M.B.A.s. The M.B.A. was the glamour degree. The justification for replacing M.P.H.s by M.B.A.s in the health department was that the M.P.H. lacked the smarts to even keep an eye on his lunch money, while the M.B.A. was tough, hardnosed, etc., etc. I saw a number of devoted and competent colleagues leave the department. This policy gradually and progressively converted the New York City Health Department from its historic position of public health Olympus to something less. The department was changing. The agency bore the same name of the historic department, but functionally it wasn't the same old New York City Health Department.

I thought to myself: Is there some truth to these claims on behalf of the M.B.A.s? The answer to that is yes, there is some truth. It seemed to me that rather than spend time and crack wise about the M.B.A. when the ink is still wet on his diploma, is to do something. Surely an intelligent person ought to be able to learn about introductory accounting, ought to be able to read your book on hospital financing, for example. There is nothing esoteric about the M.B.A. curriculum.

When I did join the faculty in the School of Public Health here at Columbia in late 1971, I told the people who interviewed me that if I came here there would be a couple of things I would do. Number one, I would lengthen the program. The M.P.H. program here at the School of Public Health was originally two semesters of didactic work, followed by a practicum, or by a year of residency. I thought that was inadequate.

I was asked, "How long would you lengthen it?"

I said I would double it. Instead of two semesters, I would make it four.

"What else would you do?"

I said I would bring in certain courses that were not currently in the curriculum, nontraditional courses. I would bring in accounting. I would bring in finance. I would bring in operations research. These were subjects I myself had never taken. I have an M.D. degree from New York Downstate, I have an M.P.H. from the Harvard School of Public Health. I said that any institution that grants a master's degree after a mere eight months work is debasing the degree.

I got my master's degree in one year. That's what most of the master's degrees are: one year degrees. Too many of the public health school students throughout the country are doing part-time jobs while they are getting their degree on an allegedly full-time academic schedule. I couldn't have done that in medical school. I would have flunked out. The fact that you could hold down a major job while taking a full program at the School of Public Health to me meant, until proven otherwise, that the educational program in the school lacked sufficient rigor. To be rigorous the program would have to be longer, would have to be tougher, and that's what it would be.

P.S. I got the opportunity. I was selected--over some objections from some of the faculty here, incidently. I tried to double the length of the program. I receive little support. The authorities practically went along with me by increasing it about fifty percent, from two semesters to three semesters. It still wasn't what I wanted so I went down to the business school at Columbia and I met with the then acting dean. I proposed a five

semester eighty credit joint M.P.H./M.B.A. degree program between the business school and the public health school. I wanted to identify those courses that were held in common at the two schools, so that rather than take them twice, students could just take them once. "The deal would be," I said,"You are going to both schools simultaneously and saving a calendar year. But if you go to two schools sequentially, there is one additional year for the M.P.H., and a M.B.A.

We had put together a curriculum satisfactory to both of the schools. We were able to do this quickly, by academic standards,and for political reasons that were internal to the schools it was possible to get this through the faculty senate and circumvent the usual obstacles. We did this in about a year. We got this program going. The first students we tried to recruit were suspicious of the program.If they had wanted to be in the business school,they would have enrolled in business school, some said. Now, in contrast, we have to beat the applicants to the joint M.P.H./M.B.A. program off with a baseball bat.

The program, as you know, has been copied elsewhere. To our knowledge the original prototype started here at Columbia. We have graduated about seventy or eighty students, with both degrees, since the program began, and these graduates have all done well in spite of the tight job market.

I added something else to this. I was unhappy with the functional illiteracy of some of our graduate students in America. I am irritated by bad English. I don't get irritated by bad English as a second language of an immigrant. But somebody who is native-born and has a degree from an Ivy League school, or the equivalent, should write and speak with reasonable grace and felicity! I think that bad English is unacceptable, and I blame the

schools. Every school blames the school the student came from. The graduate school blames the colleges, and the colleges blame the high school.

So I said, "I don't want anyone running around with a Columbia degree who can't write a decent memorandum, who can't write a simple declarative sentence."

"So what do you want?"

"I want what some other schools have. I want a master's thesis."

They agreed with but one qualification. "Don't call it a master's thesis, call it a master's essay."

So, now we have a master's essay which means at the very least the student is obliged to make an exhaustive review of the literature. Some of them rarely have gone to a university library before. Some of our graduate school students had to be taught--literally had to be taught--how to use the library. To me it's inconceivable how they got this far, with allegedly good to excellent college records.

I would say the major imprints I've left on the curriculum here have been in length and quality. From the beginning I declared war on all Mickey Mouse courses. Some of them had crept into the curriculum during the heyday of the 1960s, you know, courses that professed love for the poor and minorities and the downtrodden and the oppressed but courses of little intellectual substance--courses where the students sit down, wear their hearts on their sleeve, exchange ideological cliches back and forth. This is no real course! This is just Mickey Mouse. That kind of course is not tolerated in the medical school and shouldn't be tolerated in the public health school. There should be intellectual discipline.

We got the M.P.H./M.B.A. program started. That was for five semesters,

followed by a year of residency. The degrees were withheld until the residency was completed. I had some question about whether even that was adequate, but that was the most I could get at the time.

The AUPHA--Gary Filerman and his minions--came in two weeks after I got here and put the school on probation. I got there at the right time. For curricular deficiencies they put us on probation for two years. I couldn't be blamed for the past. After two years they came back, reaudited us, took us off probation, commended us for what we had done, and approved us for five years.

I figured that this was the strategic moment to leave school on a temporary basis. That's what brought me back to public service--back to the health department as City Health Commissioner. Then I saw a second phenomenon that I hadn't seen the first time. This second time inter alia I was chairman of the Executive Committee for CHP. I looked around and asked, "Who are the health planners?" I was unenthusiastic about the quality of the planners. Everybody had suddenly become a health planner. I concluded that M.P.H. degrees by themselves were not enough and the urban planning people with master's degrees in urban planning were also not enough.

I said, "The generalization I am drawing from this is that the typical American master's degree isn't enough. I said, "I'll go back to my model, my M.P.H./M.B.A. model, when I get back to Columbia.

When I returned to Columbia after three years as Health Commissioner, I said we would have a joint M.P.H./M.A.(U.P.) program. There had been some preliminary discussion and negotiation of the subject. I made the same deal with the Dean of the School of Architecture and Urban Planning as I had done before with the business schools. That is the program I currently head now,

(the M.P.H./M.S.Urban Planning), where the students go for five semesters for the two degrees. These are the degree in public health and the degree in the techniques of urban and social planning.

The bulk of our students are still single degree M.P.H.s. As I've mentioned, I agitated, with no success so far, in support of expanding the M.P.H. program to four semesters. In all equity I think the five semesters of the joint program should be expanded to six semesters. Since the semesters are trimesters, four months, the length of the didactic program would still be only two calendar years, with no prolonged vacations. I think that is what we should aim for.

My concept of administrators differs from Lenin's premise. In one of his writings he said, in effect, that if you can't be a productive worker--because of physical disability--you can become an administrator. Lenin's attitude is the attitude here in this country. If you can't do, you teach. There is the comment by George Bernard Shaw; "Those who can, do: those who can't, teach." We have an American addition: If you can't teach, you become an administrator. If you can't even become an administrator, you become a consultant, I suppose.

I argue to the contrary. The reason we are in the hell of a mess that we are in in this country, in general, is not because we lack technology. We have techonology we haven't used yet, but we sure have lousy administration. It's true in the business world. We have poor administration.

WEEKS:

How do you connect your academic work with the field of practice? Do you offer consultative services that your students can enter into?"

BELLIN:

Here in New York City the way it's worked is that some people on the faculty have oscillated between public life and Academe. I've done that three times in my carrer so far. Professor Frank van Dyke of our school did it. He has worked on some of the insurance legislation for the state of New York. He had a two year leave of absence from Columbia to help set up the New York City CHP. Ray Trussell worked in the non-academic world of elevating standards of proprietary hospitals and set up the municipal hospital affiliation program. If you don't get periodic injection of real life experience, you may become afflicted with the "Good-by Mr. Chips syndrome." You may be tolerated by the student body as a lovable eccentric, but you become increasingly ineffective as a teacher.

WEEKS:

How do the students get their experience?

BELLIN:

A good forty or fifty percent of the students come to us with previous and relevant professional experience. They are primarily M.P.H. candidates. Before you got here I was sitting in at my colloquium on contemporary dilemmas in health planning. I have IOUs all over the city that I call in and get excellent lecturers gratis. You can do that in New York City. If there is a reportable phenomenon in the literature there is practically always a breathing example of that phenomenon someplace here in New York. I don't care what phenomenon you describe, we have somebody here in New York City who has lived it or has managed it and can speak about it with authority to the students.

WEEKS:

We have kind of a nice thing in the University of Michigan Program in Hospital Administration. It is called community service. The faculty is willing to study and advise any health institution in Michigan on any problem it may have. Faculty and students enter into this and furnish this help just for the travel and incidental expenses.

BELLIN:

That's what the land grant colleges have done in agronomy over the years. It is very useful thing to do.

WEEKS:

It's a wonderful way for the students to get into the act.

BELLIN:

What I have here, for example, is a case where a representative of the mayor called me some time ago and said, "We need someone to handle the development of a unified emergency medical services for the city. Will you chair the committee?" I agreed to do so.

WEEKS:

This has been a good session, I hate to have the time run out.

Interview in New York City

May 7, 1980

INDEX