HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Wilbur J. Cohen

WILBUR J. COHEN

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
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Wilbur J. Cohen

Wilbur J. Cohen

CHRONOLOGY

1913	Born June 10, Milwaukee, Wisconsin
1934	University of Wisconsin, Ph.B. (Economics)
1934-1935	U.S. Cabinet Committee on Economic Security, Assistant to the Director
1936-1952	Social Security Administration, Technical Adviser to the Commissioner
1951-1952	U.S. Wage Stabilization Board, Chairman of the Tripartite Committee of Health, Welfare and Pensions
1953-1955	Social Security Administration, Director of Division of Research and Statistics
1956-1961	University of Michigan School of Social Work, Professor of Public Welfare Administration
1956	Office of the United States Secretary of Labor, Committee on Pension Costs and the Older Worker, Member
1956-1957, 1959	U.S. Senate Committee on Labor and Public Welfare, Consultant
1957	University of California at Los Angeles, Visiting Lecturer
1959	Advisory Council on Public Assistance, Member
1960	Presidential Task Force on Health and Social Security, Chairman
1960	Michigan State Council of Health, Member
1961-1965	U.S. Department of Health, Education and Welfare, Assistant Secretary
1961-1962	Catholic University, Lecturer

1965-1968	U.S. Department of Health Education and Welfare, Under Secretary
1968-1969	U.S. Department of Health, Education and Welfare, Secretary
1968	President's Committee on Mental Retardation, Chairman
1969-1978	University of Michigan School of Education, Dean
1976	Health Volunteers for Carter-Mondale, Cochairman
1976	Carter Task Force on Education, Member
1978-	University of Michigan School of Education, Dean Emeritus
1978-1980	National Commission on Unemployment Compensation, Chairman
1979-1981	National Commission on Social Security, Member
1980-	University of Texas Lyndon Baines Johnson School of Public Affairs, Sid W. Richardson Professor of Public Affairs

Wilbur J. Cohen

MEMBERSHIPS and AFFILIATIONS

American Association of Colleges of Teacher Education

American Association of University Professors

American Hospital Association, Honorary Membership, 1968

American Public Health Association, Fellow,
Member Governing Council, 1970-1973

American Public Welfare Association, Director, 1962-1965
President, 1975-1976

Council on Social Work Education
House of Delegates, 1959-1962, 1974-1977

Haifa University, Board of Governors, 1971-

Industrial Relations Research Association
Member Executive Board, 1969-1972

Institute of Gerontology (University of Michigan-Wayne State University)
Cochairman, 1969-1978

Institute of Social Research (University of Michigan)
Member Executive Committee, 1969-1972

International Association of Gerontology

International Conference of Social Workers
U.S. Delegate, 1968

International Social Security Association
Vice Chairman of Council, 1964
Delegate 1961, 1964; U.S. representative, 1968

J. F. Kennedy Center for the Performing Arts
Trustee, 1968

National Academy of Science, Institute of Medicine, 1972-

National Association of Social Workers

National Conference on Social Welfare
President, 1969

UN Conference of Ministers Responsible for Social Welfare,
Delegate, 1968

AWARDS

Jane Addams-Hull House
Award, 1975

Adelphi College
Doctor of Humane Letters, honorary, 1962

Arthur J. Altmeyer Award
Department of HEW, 1972

American Public Health Association
Bronfman Public Health Prize, 1967

American Public Welfare Association
Terry Memorial Merit Award, 1961

Association of Physical Medicine, 1965

Blue Cross & Blue Shield Associations Award, 1979

Brandeis Univesity
LL.D. honorary, 1976

Central Michigan University
LL.D., honorary, 1976

Cleveland State University
L.H.D., honorary, 1970

University of Detroit
LL.D., honorary, 1969

Florida State University
D.H., honorary, 1972.

Golden Ring Council of Senior Citizens
Wilbur Award, 1968

Group Health Association
Distinguished Service Award, 1956

U.S. Department of Health, Education and Welfare
Distinguished Service Award, 1956

International Social Security Association Award, 1979

Blanche Itelson Award, 1962

Kenyon College
LL.D., honorary, 1969

Florina Lasker Award, 1961

University of Louisville
D.S.S., honorary, 1969

Merrill Palmer Award, 1975

Michigan State University
LL.D., honorary, 1975

John Lendrum Mitchell Gold Medal, 1934

Murray-Green Award, 1968

National Association for Mentally Retarded Children Award, 1965

National Conference on Social Welfare
Distinguished Service Award, 1957

National Council of Senior Citizens
Forand Award, 1969

Ohio State University
L.H.D., honorary, 1970

Rockefeller Public Service Award, 1967

Roosevelt University
D.H., honorary, 1978

University of Wisconsin
LL.D., honorary, 1966

Wisconsin State University, Stevens Point, Award, 1968

Yeshiva University
LL.D. honorary, 1967

Wilbur J. Cohen

BOOKS

1948	Readings in Social Security (ed. with William Haber)
1957	Retirement Policies in Social Security
1960	Social Security: Programs, Problems, and Policies (ed. with William Haber)
1962	Income and Welfare in the United States (with David Morgan and H.E. Brazer)
1972	Social Security: Universal or Selective (With Milton Friedman)

COHEN:

I was born in Milwaukee, Wisconsin on June 10, 1913. I went to elementary and secondary school there, graduating from Lincoln High School in June 1930. I intended to go to the University of Chicago, where I had won a history scholarship in competition with a large number of other students, but during the summer of 1930 I became aware of the Experimental College in Madison. I went there to visit it, and became completely enamored of it. So I gave up my scholarship to the University of Chicago and went to the University of Wisconsin.

It was a very fateful decision, because at Wisconsin I ultimately became interested in economics. I took a course with Professor Edwin E. Witte. Later he became the executive director of President Roosevelt's Cabinet Committee on Economic Security. He employed me as his research assistant in 1934, which, of course, became an area of interest during my entire adult life. Thus the decision in the summer of 1930, having read an article in the Milwaukee Journal about the Experimental College at the University of Wisconsin, completely changed the course of my entire life.

At the University of Wisconsin I studied during the first two years at the Experimental College with Professor Alexander Meikeljohn and from that experience I became interested in education. This ultimately resulted in my being Dean of Education at the University of Michigan when I completed my work at the Department of Health, Education and Welfare in 1969. So in more ways than one, my decision to go to the University of Wisconsin decided the course, interest, and priorities of my entire professional life.

I began taking economics in 1932, and graduated in the economics program in 1934, and after a brief vacation went to Washington, D.C. to work for Professor Witte. There in Washington, in the Walker-Johnson Building, which housed the Federal Emergency Relief Administration, we worked in Harry Hopkin's offices while he was in Europe, and we started the work of the President's Committee on Economic Security. I did a lot of the research work during '34. In 1935 one of my responsibilities for Professor Witte was to monitor the legislation going through the House Committee on Ways and Means and the Senate Committee on Finance. That started an interest in the legislative process for me, which was to continue throughout my life. I gave a great deal of time in the ensuing 45 years following the course of the work of these two very major and important committees in Congress, not only with regard to Social Security, but also with regard to national health insurance, tax policy, welfare, and other programs.

In 1935 when the Social Security Act became law, I went to work for Arthur J. Altmeyer, who had been the Second Assistant Secretary of Labor, and who was appointed to the Social Security Board by President Roosevelt. I had been offered a job with Frank Bane at the American Public Welfare Association to

handle unemployment insurance, but preferred to stay with the Social Security Board. During the first few months we were paid through the Federal Emergency Relief Administration because the appropriation bill for Social Security had been filibustered to death by Senator Huey Long in August 1935, and it was not until February 1936 that the Social Security Board got a regular appropriation. I stayed with them until January 1956, when I left to become a professor at the School of Social Work of the University of Michigan.

I was a professor of Public Welfare Administration and stayed there until January 1961, when I became Assistant Secretary for Legislation in the Department of Health, Education and Welfare, and I was on leave for eight years from the University of Michigan, during which time I became the Under Secretary in 1965, and ultimately the Secretary in 1968 by appointment of President Lyndon B. Johnson.

I, of course, spent a good deal of time between 1934 and 1938 on Social Security, but in 1938 Mr. Altmeyer and the government began to give priority to health insurance matters, deriving from the fact that no health insurance component had been included in the law in 1935. Mr. Altmeyer brought I.S. Falk into a major role in this area, and so in 1938 and 1939 I became interested and concerned in the research and the planning on national health insurance as Mr. Altmeyer's assistant.

In the ensuing period, beginning about 1940-1941, I cooperated with Mr. Altmeyer and Dr. Falk in the development of hospitalization insurance and health insurance bills, ending up with the assistance in the design and drafting of the Wagner-Murray-Dingell Bill in 1943, which was the first nationwide federal comprehensive social insurance program covering national health insur-

ance as well. So I would say my interest and major concern in health matters began about in 1940 and has remained a major factor ever since, some nearly 40 years.

I continued to follow, of course, the progress of national health insurance from 1941, when, I believe, the first national hospitalization insurance bill was introduced by Senator Theodore Green and/or Congressman Thomas Eliot, and/or both, and through the whole period until 1950, when in a sense the Wagner-Murray Dingell Bill was stymied, and other plans developed. Dr. Falk and I in 1945 were working with Mr. Samuel Rosenman in the White House, helping him write President Truman's first national health message of 1945. That was a very memorable and historic occasion. So my participation in the drafting of the first national health insurance bill in this country and the first presidential message exclusively devoted to health were two historic experiences which had a great deal to do with my future interest and concern.

In and about 1950, after it appeared that the Wagner-Murray-Dingell bill, and the Truman health proposal were not going to go anywhere, Mr. Oscar Ewing, who was then the Federal Security Administrator, asked Mr. Altmeyer whether he had anybody to help him in developing some kind of an alternative or substitute. Mr. Altmeyer assigned that responsibility to me. I checked around with various staff members, and after talking with them, I produced a memorandum which included in it what we would now call Medicare. When Mr. Ewing received that memo, he was very enthusiastic about that idea and he asked us to draft it up. That major responsibility fell to Mr. I. S. Falk. So in 1950-51, Mr.

Falk and I spent a lot of time designing, with the help of other staff members, what ultimately became Medicare, and it was introduced in Congress.

We were not able to get any of the major members of Congress to introduce it, like Wilbur Mills or the Chairman of the Ways and Means Committee. We had to take whatever we could. A number of other people outside the committee, like Congressman Emanuel Celler and Senator James Murray on the Senate side, originally introduced the bill, but while it was reintroduced each session, it never got anywhere until 1957, when Congressman Aime Forand, a member of the Ways and Means Committee from Rhode Island, introduced it and thus gave it major public attention. There were hearings on it, and this resulted in making it a major issue in the 1960 campaign. Kennedy called a special session of Congress in 1960, which included consideration of Medicare, but Medicare didn't pass. But Congress did pass the Kerr-Mills bill, and that, of course, set the stage for the strong support of Kennedy and Johnson for Medicare and the criticisms of Kerr-Mills which eventually resulted in the Medicare and Medicaid bill of 1965.

Having been Secretary of Health, Education and Welfare, of course my interests are quite broad in the sense that I am interested in Social Security, national health insurance, health delivery matters, welfare reform, and education. In one way, I believe they are all interrelated, because health and education and welfare all have common goals in improving the quality of life of human beings. My major interest, of course, had been Social Security, and in that sense that's how I came into the whole health field, through the Social Security door. Over the years I have tended to spend a good deal of time on health matters and have tried to find incremental ways of improving health protection to the American people.

With the adoption of Medicare and Medicaid, I then became interested in building and improving upon that fundamental basis. My major interests have been in expanding health protection to cover mothers and children, which I sometimes have called Kiddie Care, which is the other end of the population spectrum from Medicare for older people. On the other hand, I strongly believe in the need to improve the Medicaid system because it's very inequitable and doesn't cover all the needy people in every state under the same conditions. I am in favor of some kind of federal underpinning to the federal role in financing of Medicaid.

I have always felt that the type of health protection that would win the greatest support of the American people is some kind of major medical insurance coverage or what is sometimes referred to as catastrophic health coverage. I think that's a very natural point of view for most people who are working, and even low income people who need to be covered in case they have some very major heavy costs. However, I also feel that we must not simply deal with heavy costs, important as they are, but also begin to work in the field of preventive health care. I believe, therefore, that pulling together a program for castastrophic health coverage, with coverage for mothers and children, are two of the highest important priorities in terms of the objective of ultimately covering everybody for all health care, irrespective of whether it is in the public sector or the private sector or in some kind of combination.

And the third possible improvement, which I think goes along with care for mothers and childrens and with catastrophic health coverage, is some way to

make the Medicaid for the poor and the disadvantaged more uniform, more standardized, more equitable throughout the United States.

Now, if we did these three things it would not bring about the millenium, but it would certainly bring about a greater degree of equity and adequacy and improve the medical care and health conditions of the American people. There are a number of problems: How to finance such a program and how to administer it. There are many other issues of health policy that need study and research and consideration. The entire question of how to modify the reimbursement provisions, the health delivery system, the relationships between the providers and the consumers, the handling of disputes and grievances, the decentralization of the administrative responsibilities, and how to control costs and constrain overutilization, and deal with fraud and abuse -- all of these various questions and problems are very important and need continual re-examination. I believe that there is no single, simple, satisfactory solution to these problems of financing and administering a national health program. They have to constantly be reexamined and readjusted; each generation has to take a fresh look at the problem and make such changes as they think are desirable. There will also always be a great deal of controversy on how these matters are to be handled.

I think that we will be discussing health policy, national health insurance, changes in the health delivery system, medical care costs and constraints, for a long time. With the energy shortage, the inflationary costs, unemployment, meeting the problems of health care, education, social security and welfare are indeed going to become very, very difficult questions. We will need a great deal more thought and a great deal more analysis, and some

very effective political leadership for us to keep improving the quality of life and meeting these problems with due regard to their financial administrative aspects.

WEEKS:

Please discuss the way Social Security was established.

COHEN:

The Social Security program was the very major result of the Great Depression of 1929. That Depression really completely demoralized not only the American economy, but by 1932 it had really demoralized America's faith in itself, its institutions, and its people.

The result was that many people felt that they'd lost everything, that the fact that they had saved and worked hard, didn't result in their being able to sustain themselves. It was the most catastrophic blow that could be imagined. As a result, when Roosevelt became President of the United States in 1933, there were pending in Congress a number of bills on unemployment insurance and or old age assistance; later came the Townsend Plan and other ideas. Roosevelt's advisors recommended that instead of going forward piecemeal on these ideas, that we study them in a comprehensive way. Harry Hopkins and Frances Perkins were leaders in that enterprise, and it was as a result of their suggestions and others that a Cabinet Committee on Economic Security was established.

Mr. Altmeyer, who came from Wisconsin, and Mr. Witte, who came from Wisconsin, were two of several of the very important leaders who worked with the committee. That committee really developed the outline of the major provisions that became the Social Security Act of 1935.

However, Roosevelt, Witte, Altmeyer, Perkins were not people who were merely theoreticians. They had all been people who had given a lot of thought to the history of social reform; they had been administering programs; they had had contacts with legislators; and they realized that the Social Security program of 1935 would only be a beginning. Franklin D. Roosevelt, when he signed the act, called it a cornerstone in a developing program, and he recognized that there would have to be other changes coming along much later.

The act was passed in Congress in the short time of less than eight months -- for such a monumental undertaking it was certainly a tremendous, successfully developed, legislative event, which could only have taken place with the backdrop of the Depression and under the leadership of Franklin D. Roosevelt.

Immediately upon the passage of the act, though, Mr. Altmeyer decided that he had to begin research and studies leading to its improvement. Just a couple of days after the act was passed, he was able to get President Roosevelt to establish the Interdepartment Committee on Health to study how the health insurance and other aspects could be developed. In addition, Mr. Altmeyer began to set up a research staff himself, which ultimately was headed by Mr. Falk, so that studies relating to health, disability, and death benefits, and unemployment insurance benefits, and changes in the welfare program early became a major part of the board's research and planning work under Mr. Altmeyer's leadership. That, of course, is where I played my major role as an advisor and an assistant to Mr. Altmeyer. Ultimately I was the Assistant Director of the Bureau of Research and Statistics, and then later the Director of the Bureau of Research and Statistics, between 1953 and '56, when I left to come to the University of Michigan. So I had my hand in practically every ma-

jor planning effort, particularly those that led to the idea of a comprehensive Social Security program of 1943, and health insurance of 1943, and the Medicare program in 1951 and the welfare reform, disability insurance, unemployment insurance.

During that period of time, of course, we were still under the fearful impact of the Depression, which was still vivid in the memory of many people, and despite the fact of the war and the postwar period, the adults who were living during that period had been fearful of the possibility of another depression, and were certainly willing to see the Social Security Act improved. The amendments of 1950 were the first post-war major improvements in the program, followed quickly by improvements in 1952, 1954, 1956, 1958, 1960, and 1961, all prior to the Medicare program. It was a rapid increase in social concern and improvement of the program, which was quite different from the situation now, when we are currently talking more about constraints and priorities and costs and limiting the federal government's role.

WEEKS:

Will you talk about the development of Medicare and Medicaid?

COHEN:

Medicare was a program that took something like 14 or 15 years to evolve. Of course, it evolves out of the entire controversy over a comprehensive national health insurance. While Medicare was being fought in the front line trenches between those who favored it and those who opposed it, there was also the entire issue of what to do about people who were not covered by Medicare or, if they were covered by Medicare and their coverage was not sufficient to take care of everything. That's how Medicaid evolved.

Medicaid evolved in the sense that the welfare system for low income and indigent persons was not adequate in the United States. In fact, it did not even exist in the United States in any comprehensive way. Beginning in 1950, various changes were made in federal legislation in the welfare program, which was the beginning of what we would later call Medicaid, namely, about vendor payments for medical care for persons who were on the welfare rolls or whose incomes were somewhat higher, but not able to pay for heavy medical care costs. So with the various increases beginning in 1950 that authorized payments for medical care in the welfare program, it was inevitable, when the Kerr-Mills program was established in 1960 and the Medicaid program in 1965 (which superseded the Kerr-Mills program), that it would be primarily related to the welfare program. Also since the welfare program was primarily related to the state operations, financed partially by federal funds and with federal standards, the Medicaid program became a federal-state system, whereas Medicare became primarily a federal system. That's how these two programs evolved.

The most unusual aspect of the Medicare program was the fact that in the Congressional consideration in the House Committee on Ways and Means, as a result of certain discussions between Wilbur D. Mills and John W. Byrnes, the Republican minority member on the Ways and Means Committee from Wisconsin, the entire idea of covering physicians services on a voluntary basis became added to the program. This we now call Part B, whereas the hospitalization insurance which was compulsory in its coverage, was called Part A.

This was rather unexpected on everyone's part, and thus led to a good deal of interest because it had not been expected. The most interesting aspect of that is that the Part B was financed initially about half from general reve-

nues and half from the beneficiaries, and today the general revenues portion has reached about 70%.

As a result, we have a very important general revenue financing into that part of the Social Security and Medicare programs which I believe in due time will lead to other considerations of changing the financing of Social Security by the possible injection of additional general revenues to alleviate the rising payroll tax costs which is a concern of many people.

In the political and legislative development of this program, the opponents to Medicare largely overlooked the Medicaid program and did not pay too much attention to it at the time, and thus it got the reputation of being a kind of sleeper provision. Those of us who were working in the development of legislation, like myself, of course, paid a good deal of attention to it because I was primarily responsible for the design of the Medicaid program. The people outside were not very conversant with it, and, thus, from the political and operational standpoint, the Medicaid program has had a very difficult and checkered career. Since it's a state-by-state program that differs in every state, it has a lot of inequities and inconsistencies in it which have been the topic of a good deal of consideration ever since. That, of course, could be remedied by having some kind of federal standards or federal financing that would assure at least some kind of a broad gauge across-the-board program. I think eventually something like that will come about, especially as we expand the health insurance programs, whether voluntary or in the public sector, to cover more people. It should reduce the extent to which the poor have to rely on Medicaid, but to the extent that there are poor people, there will have to be a broadening of that program and an underpinning of financing so that it will be more equitable.

WEEKS:

I understand you have long been experienced with prepaid group practice of HMOs.

COHEN:

I married my wife, Eloise Bettel, in Washington in 1938, and shortly thereafter we both became members of Group Health Association in Washington, D.C. This is a group practice organization, now referred to as a health maintenance organization or an HMO. Consequently, I have always been interested in group practice, and I have been a member of Group Health Association for 40 years. We retained our membership even when I have lived outside of Washington. I was on the board of directors for a couple of years, and thus have had some familiarity with the administration and other problems of group health organizations. I was chairman of the personnel committee that dealt with salaries, pensions, and other perquisites of the personnel of a group practice clinic; I got a good deal of experience from that responsibility and it has helped me in my understanding of the problems of both the providers and the consumers of medical care. Early in the Kennedy administration I advocated and obtained the approval of the President to recommend making loans to group practice organizations, which was a forerunner of the later interest in HMOs. All during that period of time, there was a good deal of undercover opposition from the medical profession to group practice, to HMOs, which ultimately resulted in the Nixon administration developing legislation -- which I was very glad to see -- that attempted to stimulate HMOs. However, the fundamental opposition or neutrality of physicians and patients has not resulted in the tremendous expansion of HMOs which either I or Secretary

Richardson had hoped. This still remains an important area of work and at the present time I am helping to try to establish an HMO on the campus of the University of Michigan, which would include faculty and staff members of the University of Michigan and possibly other members of the community. It has been an uphill struggle, but I still think it's a good idea. While I don't believe it is possible for every doctor and every consumer to be in an HMO, I am hoping that more communities will have that option so that individuals who want to be in an HMO can do so. I consider myself one of the early advocates of HMOs, and I believe it's something that ought to be encouraged. In any national health insurance system, I hope there would be incentives for people to join HMOs so that more comprehensive care could be given at a reasonable cost without overutilization but at the same time giving an individual the maximum amount of medical care in relation to his or her need and at a quality and cost that would be satisfactory.

WEEKS:

You were active in the 1976 presidential campaign, weren't you?

COHEN:

In 1976 I helped organize a campaign committee called Health Volunteers for Carter/Mondale. I was the cochairman of the group, along with Dr. Harvey Sloan of Louisville, Kentucky. We worked very hard to raise funds and provide support in the health area for the election of Mr. Carter and Mr. Mondale. I felt that Mr. Carter and Mr. Mondale would support a comprehensive, but at the same time practical incremental approach to national health insurance coverage.

However, when Mr. Carter got in office, he elected to put welfare reform ahead of national health insurance. I think that was a grave mistake. I

think it was a mistake of judgment; I think it was a mistake in tactics. As a result, during the first couple of years the welfare reform movement was stymied and the national health insurance movement became confused with differences of opinion between Senator Edward Kennedy and President Carter, and between Mr. James C. Corman in the House and Senator Kennedy, and as a result, at least as of the time I am discussing this now, in August 1979, there has been no real progress on either welfare reform or national health insurance. I believe the President should have put health insurance first, because this is of greater and wider interest on the part of all of the Americans while welfare reform is only of interest to a very small proportion. President Nixon was unsuccessful in getting welfare reform through. I think President Carter should have realized that. I think he and his associates were more intrigued by the idea that if Nixon couldn't get it through, they could. As a result, I think that the national health insurance program has been set back very significantly and many of the alternatives that we are considering today are less satisfactory than those of the earlier period. I think if that's what happens that a great deal of the criticism will fall on President Carter or Secretary Califano. But time will tell what that will be.

WEEKS:

You have seen the national health insurance movement develop over the years, I understand.

COHEN:

I would like to say a few things about the historical development of national health insurance which have had an important bearing on our entire

evolution of ideas and programs and legislation.

A most significant development occurred when the Committee on the Costs of Medical Care made its report in 1932. At that time Dr. Morris Fishbein was the editor of the Journal of the American Medical Association, and he wrote a rather significant editorial commenting on the report indicating that any kind of health insurance proposal was "socialism, Communism, inciting to revolution." His characterization of health insurance, whether voluntary or public, served to set the dominant ideological and controversial note for some 33 years after that, a third of a century. During that time, anyone who advocated national health insurance was usually tarred with the epithet of being a socialist or a Communist or a radical. It was not until the passage of Medicare in 1965 that those who advocated some kind of a program were able to overcome that kind of criticism. It was extremely unfortunate, because by injecting that kind of emotional element into the discussion, many of the technical, professional, and substantive issues were overlooked in the battle of the ideological terminology. It's interesting, however, that Morris Fishbien, before he died, told me that he thought Medicare was a very acceptable and reasonable program and that none of what he really said in 1932 had come to pass, at least with respect to the Medicare program. So I say Morris Fishbien was able later to revise his approach, which some others were not able to do. Nevertheless, it was only with the passage of Medicare that the fateful criticism of socialism/Communism was erased. Nobody was socialized or Communized by the passage of Medicare, despite the fact that such fateful predictions were made.

Secondly, one of the significant byproducts or even major aspects of the whole effort for national health insurance has been the development of voluntary insurance. It is rather interesting that the Blue Cross movement was on the verge of developing at that very time that the Committee on the Costs of Medical Care was in operation and was making its report. Moreover, the voluntary hospital insurance movement did not really start by any insurance company or actuaries or even national health policy. It started by the felt needs of these teachers in Texas, and there was a great deal of doubt about the wisdom of having any kind of broad scale voluntary health insurance movement in the early '30s. Many objections were made that there was no real statistical, actuarial, administrative base to any health insurance plan, voluntary or compulsory, and there were a lot of people that were very skeptical that a practical plan could be developed -- developed successfully. But widespread interest in insurance and the interest in national health insurance by the people pushed the voluntary sector of our society to develop plans, and out of that grew the Blue Cross movement eventually, the Blue Shield movement, and even later on the development of commercial private insurance in the health field. So I would argue that much of what has happened in the voluntary field has been an outgrowth of the public interest and public controversy over national health insurance.

Once the Wagner-Murray bills of 1939, 1940, 1941 and the development of the Hill-Burton legislation, which began in 1940 and the law passed in 1946, came about, there was a great deal more interest in doing things in the health field. I think this has been a typically incremental American way of going at a problem, not with some kind of overall plan that Congress really had, but a

more or less ad hoc, incremental, adaptive plan arising out of the felt needs of people and the adjustment of various institutions to fill a role that had not existed. It may not be the most efficient way, it may not be the way that results in the greatest cost containment, and it may not be the way that limits overutilization, but it is typically American in that it has evolved piecemeal in a way that is more or less acceptable to the American people. Whether, after all the parts of this jigsaw are in place, someone will try to rationalize it in a much more efficient way, that remains to be seen.

WEEKS:

You came to Washington to work for the director of the Cabinet Committee on Economic Security from which the Social Security evolved. How did you become interested in health matters?

COHEN:

My interest in health matters has developed in may different ways. In 1951-52, I was chairman of the Tripartite Committee on Health, Welfare and Pensions of the United States Wage Stabilization Board. This board was established, during the Korean War when there was a wage freeze in effect, to allow employers to contribute to health, welfare, and pensions outside of the wage freeze. As chairman of the board, I helped develop the policy and to administer it, which of course gave a great boost to the private sector development of health and other interrelated fringe benefit plans.

Then I was also the chairman of the Michigan Public Health Study Commission in 1956-57 by appointment of the then Governor G. Mennen Williams, in which I surveyed all of the public health activities in Michigan and thus got

to really know how public health programs operated in a state like Michigan. In 1959 I was a member of the Federal Advisory Council on Public Assistance, which studied certain areas of administration of programs for the poor, in which it was pretty obvious that one of the great defects was the lack of adequate medical care and its financing for poor people. This really resulted in my helping to draft, as I did, the Kerr-Mills bill and ultimately the Medicaid bill. Then, in 1960, President Kennedy appointed me the chairman of his Task Force on Health and Social Security, in which, with a number of other people, I recommended not only Medicare, but federal aid for construction of medical schools, and tuition grants for physicians and other health personnel. Later on, I was largely responsible in HEW for developing both the mental retardation program, eventually becoming chairman of the President's Committee on Mental Retardation in 1968, and then, of course, being co-chairman of Health Volunteers for Carter/Mondale in 1976.

So I would say in this brief rundown, I have had a number of different experiences in the health field. As a matter of fact, last year, by appointment of Republican Governor William Milliken, I was chairman of a task force that studied abuse in mental health institutions and mental retardation institutions in Michigan. All these various experiences of many different types have made me conscious of the importance of studying our health care programs and our health care needs very carefully and working very diligently in trying to improve the situation. This is with full realization that while we have a good system in the United States, it is not perfect, it can be improved. If the providers and the consumers of medical care (employers, labor, and the public), and the universities and the research people would cooperate together, we could improve our health care system.

WEEKS:

One of the interesting developments of Medicare has been the fiscal intermediary. Will you discuss this?

COHEN:

I have strongly taken the position that under any kind of national health insurance plan, whether a partial one like Medicare or a comprehensive one, that the payment process should be handled by fiscal intermediaries such as Blue Cross, Blue Shield, and commercial insurance companies. I believe that this is a very practical way of handling some of the day-to-day administrative problems and to forge an effective relationship between the public and the private sector. I believe that there are administrative functions in a public national health plan that can be assigned or delegated to the private sector. I believe that the fiscal intermediary aspect has worked reasonably well under Medicare; certainly not perfectly, but reasonably well. I believe it can be improved. I believe it will be improved. I think that it is the model for how we ought to handle the administrative aspects in any kind of a national health insurance system.

WEEKS:

Financing health care has been major problem. What are your thoughts on this?

COHEN:

One of the very big economic and fiscal and political problems is how to finance national health insurance in relation to the financing of Social Security. It is very obvious that very large, substantial costs are involved in

financing Social Security and national health insurance. I believe that while the wage-related benefit aspects of Social Security should be largely or even wholly financed out of payroll taxes, it does not follow that health benefits, which are not as closely wage-related should be financed by payroll taxes. Therefore, I would first, pay a great deal of the cost of Medicare Part A out of general revenues. Part B is already financed at the present time some 70% out of general revenues, originally having been started on a 50-50 basis. I would go along with the idea in principle, certainly, that the combination of Part A and Part B of Medicare should be financed 70% out of general revenues, with the remainder coming preferably from a payroll tax during the person's working lifetime; but if that were not possible, then at least some part of it being paid by the persons covered who are old or disabled.

In considering the financing and the costs of health insurance, it must be remembered that the present day costs of health coverage come primarly from employer contributions, which may either be deemed to be a deferred wage on the part of the employees in the business who are covered, or being passed on to the consumer in the sense of higher prices for the products they buy. Secondly, the individuals themselves contribute some of the cost through premiums that they may pay, and there are certain out of pocket expenditures. All of these are not exactly the most progressive form of taxation, as for instance when the older person in Part B of Medicare pays, he or she pays a flat amount which is completely unrelated to either income or health condition. I believe, therefore, it would be possible and desirable to develop a much more equitable and progressive financing mechanism for paying for national health insurance, if a large part of it was paid for out of general revenues. By

that I mean federal general revenues. Or even a federal earmarked income tax. That would be more equitable and at the same time would relieve some of the burden of the payroll tax which is now borne for the Medicare program.

In any case, paying for the cost of Social Security and health coverage in the future is going to be a very big problem because, I would gather, the total cost of both pension plans, public and private, and health plans, public and private, might easily be 25% or 35% of the total payroll. Now, there's no real escaping very large costs of these two programs, quite irrespective of whether they are public or private. This is due to the fact that our population is aging, more people are living longer, we are able to preserve lives of people with chronic illness, and the net result is a gradually larger and larger cost upon the economy and the body politic. While some people approach the problem by saying, "How can we reduce these costs?" I'm not that optimistic that these costs can be reduced very substantially in the near future, although in the long run some cost constraints might be feasible. But I do agree, if we can concentrate on preventing unnecessary utilization, undesirable utilization, large expenditures that are solely related to keeping the person alive an extra day or an extra week, and shifting some of our services to preventive care and other aspects, that we could keep some of those costs within a narrower limit. After all is said and done, the cost is going to be substantial. When cost is added to the whole problem of dealing with old age and disability services, I believe that we are faced in the next 25 to 50 years with a number of difficult problems.

Now, if the economic productivity of our nation continues to go up, then we will have an easier time to deal with these costs. If our productivity

remains stagnant or stable, or we are under various kinds of inflationary pressures and high unemployment, of course our problems are going to be more difficult.

I am still hopeful that with the inventive genius of our American enterprise system we can deal with the problems.

I do not think we can solve every one of these future problems now. I think, therefore, that we will have to go along on an incremental and tentative basis, trying to indicate to the American people that we must take a step at a time and try to adjust our programs to the changing realities, but without undermining people's confidence in the ability of the economic and political system to handle these problems.

WEEKS:

One of the problems with Medicare B is that many physicians will not accept the Medicare schedule of fees as full payment for services. Can this problem be solved?

COHEN:

One of the difficult problems that has developed under Medicare Part B with regard to physician's service, has been to encourage all physicians to take what is called "assignment" so that the individual would be assured that the full cost of the service would be paid for, subject only to the deductible and co-insurance provisions. Many physicians prefer to charge the individual and have him pay the amount directly to the physician, and then have the individual claim the difference from the Medicare program. This puts a tremendous burden on many people, particularly people of modest or low incomes, where the

differential is rather substantial. I have always hoped that there would be some way we could encourage physicians to take assignment, so there would be a better relationship, both economic and otherwise, between the doctor and the patient. However, many physicians feel it is simpler and easier to deal directly with the patient rather than with a Medicare agency. In addition, both psychologically and from a professional standpoint they think it tends to make for a more responsible relationship between the doctor and the patient.

I have suggested a number of times that perhaps more participating doctors would take assignment if there were some incentive or "carrot" that would encourage them to do so. One of the suggestions I have made is that a doctor who took assignment would have part or all of a certain malpractice insurance coverage provided to him or her through the Medicare system as a basis for taking assignment on all patients. I don't know how much that would cost, but it wouldn't cost any more than it does now for doctors to have malpractice coverage, and I am sure it would cost less. But whether it cost the same or more or less, the assurance that the individual doctor had that he had a substantial malpractice coverage and the assurance to the patient that the full amount of the physician's fee would be covered, subject only to the coinsurance element, would, I think, bring a better relationship all around to physicians and Medicare patients, and, therefore, I think it ought to be carefully explored.

WEEKS:

What part should preventive medicine play in health care?

COHEN:

I strongly believe that we must give more emphasis to preventive medicine in any kind of health program. I do not argue for preventive medicine on the grounds that it is going to save more money. As a matter of fact, the greater the extent of preventive medicine, the more we are going to save people's lives and enable them to live longer, but in my opinion they will be more productive and they will perhaps be somewhat more satisfied with life, and in this way I think it is certainly to their advantage.

I, therefore, believe that the greatest priority ahead of us is to concentrate on providing a full range of medical services to mothers and children. Start right off so that every child that is born a wanted child, a well child, and if the child is born with any difficulties, that those are as promptly as possible dealt with, that diagnostic and remedial and therapeutic services are available to every mother and every child and thus to have every child in the best possible health condition when that child goes to school at the age of six.

Another aspect is there is no mother, no father, no parent who knows ahead of time whether a child is going to be born with any defects or not. That is a hazard, that is a risk that ought to be dealt with in an insurance coverage way. There is no evidence that birth defects are any respecter of age, income, race, or anything else, with the possible exception that we know that the older the mother is when the child is born, the more likely the child is to be born with some kind of possible birth defect. I think, therefore, that we ought to have an insurance system in this country that covers every mother from the time the mother is first recognized as pregnant with a full prenatal care, with full postnatal care for the mother and child, and with all of the

services for the child certainly immediately upon birth, with full immunization and services at least up to the age of two, and as quickly as possible up to the age of six, and then assurance that any kind of crippling or disabling condition is handled in a proper and comprehensive way that would take the financial burden off the parents. It's difficult enough for a parent to deal with the anxiety and difficulty of having a child that is born with a defect without having to complicate it with serious catastrophic health costs. I think, therefore, that a comprehensive program of coverage for mothers and children, combined with a major medical coverage for all families, would take a good deal of burden off the American family.

WEEKS:

I understand you advocate health education?

COHEN:

It is not possible through any kind of national health program, no matter how comprehensive, no matter how carefully worked out, to deal with all the problems of health and medical care without the full cooperation of individuals. We must have an effective health education program, a counseling program and dissemination of research findings so that individuals will be given an incentive to maximize their own health condition, their good health condition. There is no question that it is undesirable, at least in my mind, for people to smoke, and I believe that the more individuals take responsibility for cutting out the smoking, the better off they will be, and everyone will be. Perhaps this is not possible to completely eliminate smoking, but I would certainly support campaigns to encourage young people not to start

smoking, and for pregnant women not to smoke, and to deal more effectively with the smoking problem. If people, when they get to age 70 want to smoke, I suppose I would have to say that that's no great hazard, but I would discourage people smoking before they retire, and I would also, of course, try to do everything I could to encourage people to avoid taking any kind of addictive drugs, and to be very careful about the excessive use of alcohol.

One of our big problems, of course, is the problem of peole who drink alcohol and drive their cars. This is the cause of accidents both of themselves and to innocent persons who may be on the street or on the road or driving another car. I believe that that is one of the indications of moral irresponsibility. It is true that if you smoke you probably are only substantially hurting yourself except to the extent that you are blowing smoke in somebody's eyes, throat or nose, but when you drink alcohol and drive, it is a high probability that you will kill, injure, maim innocent people who have nothing to do with you whatsoever. So I think that we ought to make a special effort to cut down on alcohol drinking while driving and develop some kind of a free taxicab service so that people when they are filled with alcohol will not drive their own cars, but will take a taxi home or to their office or whereever they are going. I think even if we paid for the taxicab rides, we would save more money than the cost of the accidents and the misery that it costs many families.

Of course, I think that individuals should have access to their physician at an early stage, and to hospitalization. I think a reasonable amount of exercise and the proper sleep, and especially good nutrition at the earlier stages are completely necessary in general. Therefore, I believe that any

national health program, voluntary, compulsory, public or private, partial or comprehensive, must have a tremendous, significant health education component. We need that very badly and I hope that will be considered a part of any such program in the future.

WEEKS:

When you consider the many years for the legislative process to produce Medicare, for example, have you any comments on the process?

COHEN:

I have spent nearly 45 years being concerned with the legislative process at the federal level related to health, education and welfare including very close relationships with the legislative process in the field of social security and health. It is, of course, not a perfect process whatsoever. In fact, it has many difficulties and many things that produce faulty results. But somewhat like Sir Winston Churchill said with regard to democracy, it is better than all the other systems that seem to exist. I believe the federal legislative process produces, on the whole, a fairly good result. Certainly not the millenium, certainly not perfect results, but an accommodation to the tremendously varied attitudes that exist in the American economic, political, social, religious, and regional ethos. I am sure it can be improved by the election of responsible and competent legislators and by improving, bettering relationships between the executive and legislative branches of government, but I believe that it will always be imperfect. The imperfection results from the fallibility of mankind, and there is no real way to completely solve that problem since every individual has an Achilles heel and collectively we tend

to have several serious Achilles heels in working out difficult problems that relate to health, education and welfare.

I believe that this process of participation and accommodation is reasonable, and one should not think of the word "compromise" as being a pejorative term. All life is a matter of compromise and adjusting your objectives to other people's objectives. Marriage has to be a compromise between two or more people trying to run a rather complex relationship. It is obviously the same in legislation at the federal, state or local level. Somehow the idea has gotten around that because you have to make compromises in the legislative process, that is a bad process or result. Of course, it can be bad under some circumstances. It can be good under some circumstances. Viewed in the broader sense, matters like health policy are so intimate, are so emotional, and so many people have different conceptions about how policy ought to be handled that it is difficult to see how one model or one conceptual formulation of a system or an institution or arrangement is going to satisfy everybody. Therefore, I think there has to be some accommodation, there has to be some compromise, there have to be some options and alternatives. There has to be some opportunity for people to participate in the process of grievance solution and reexamination of the fundamental principles from time to time. Certainly, personalities get involved in this kind of a thing. When you have strong minded people in the legislative process whether they are Senator Edward Kennedy or President Lyndon Johnson, or Wilbur Mills, or Senator Robert Kerr from Oklahoma, you are going to have some impact of personality on programs and policies. I don't see how to avoid this. As long as you've got human beings in the process, those human beings are going to express

themselves in terms of their interests, their aspirations, their political future, their goals, their ideals, their background, their experience, their state and local interests. It seems to me that this is inevitable.

I believe, therefore, that the essential aspect of the legislative process is for everybody who is concerned to have some way to make their suggestions known, and then for the democratic legislative process to work its will, but recognizing that there always can be opportunity for re-examination, re-evaluation and change, if people feel strongly enough about that process.

WEEKS:

Have you run into personal confrontation because of your position on social legislation?

COHEN:

During the tempestuous and controversial debate over Medicare, I was one time invited to speak to the Wayne County Medical Society at Detroit, Michigan. This event occurred probably about 1957 or 1958. At the conclusion of my talk, two experiences occurred that have remained in my memory.

The first was a question from a physician, who wanted to know why, since I was not a physician, had I been so influential in formulating health and medical care policies that affect medical care and health. I answered that because of the controversies many physicians were unable or unwilling to involve themselves in a controversy at least publicly since it would adversely affect his/her career. In fact, I said, "I know there are many doctors who at one time took a public stand only to find their colleagues in the medical profession discriminated against them subsequently in relation to referrals,

staff privileges, appointments on various types of committees, and in general in the attitude in which they were held in public esteem." So I indicated in answer to the question that it could be expected that a number of nonmedical people would play an important role in the formulation of policies, especially economic, financial and administrative policies, due to the unwillingness of physicians to participate in the process. In addition, of course, since doctors work many times very long and very hard, it had to be recognized they did not have the time as well to make a financial and time sacrifice away from their practice to engage in meetings and discussions, and certainly in the controversies which existed. So that I would assume that unless the American Medical Association worked out some way that individuals could give time to it, we would continue to see a very major part of the planning process being handled by nonphysicians.

On the other hand, it should be pointed out that this was not the same case with regard to hospitals. The American Hospital Association and hospital administrators were much more willing during the 1950s and certainly in the early 1960s, to give time, energy, and thought to the relationship of hospital insurance coverage under any kind of a public plan, as compared with physicians in relation to the coverage of physician services. I think the American Hospital Association and its officers and hospital administrators gave a lot of time and thought without regard to taking a political point of view for or against a particular type of plan, but recognizing that if there was going to be a plan, it behooved the hospital people to be sure it operated on a sound basis that would respect the physician and the hospital's autonomy and also assure high quality of care. I would give a great deal of credit to people

like Ed Crosby in Chicago and Kenneth Williamson, who was in Washington office, and a host of other people who were working with them, and many of the hospital adminstrators who were officers at that time, in recognizing that hospitals did have, and hospital administrators and people with hospital experience had a sort of a public responsibility to contribute their knowledge, experience, ideas to the development of a sound plan. And that's one of the reasons why I believe that Medicare Part A has worked as well as it did, mainly that, insofar as it was feasible and possible, the best ideas went into the formulation of the plan for hospital coverage. That's not to say that the plan was perfect, that's not to say that there haven't been a lot of problems, but I think a great many problems were avoided by this participatory process which involved the best brains and the best thinking for nearly 13 or 14 years between the American Hospital Association and the persons like myself and others who were responsible for the formulation of the legislation and its provisions.

I also believe that one of the reasons that the physicians of the country were shocked when Medicare worked as well as it did, is that they didn't realize how thoughtful and careful the people who had been working on these plans had been in the design of even Part B. That's not to say Part B was formulated perfectly either, but I think the physicians and the AMA never realized that the thinking that went into the development of the idea by such persons as Robert Ball, and Arthur Hess, and Alvin David, and Alanson Willcox and Irvin Wolkstein and myself at the time, and their assistance was as thoughtful and considerate and professional as it was. They have some kind of a mistaken idea that the government was composed of people who maybe didn't know what

they were doing, but within this group of people, and the staffs of the Social Security Board and the administration, were some of the best and thoughtful people of our time. I am sure the program can be improved upon. I believe the AMA didn't realize, like the AHA did, that there were some real able, thoughtful, considerate, public-minded people who had the quality of medical care and the professional interests of hospitals and doctors and patients in mind. That was hard for them to realize that that was so.

The second experience that I had at the Wayne County Medical Society occurred when I was leaving the hall. As I walked up the aisle, one of the physicians was standing there and he engaged me in some conversation. He said, "Professor Cohen, I enjoyed your talk very much," and I thought he was on the verge of complimenting me for what I had said because it appeared that he was interested. But I think his interest was related to the fact that my talk only served to underscore his objections to the Medicare plan because he said, "Professor Cohen, if at any time you ever needed surgery, I would be glad to do it for you free. I would open you up on the operating table -- and I would leave you right there!"

The net result was very scary to me, but from that I realized that physicians -- or at least some physicians -- felt very strongly in opposition to the Medicare program. I was always, therefore, subsequent to that, very careful and at least in my professional life, despite the difference of opinion with physicians, I never criticized them in a belligerent or antagonistic way about their opposition. I don't mean to say I didn't oppose their recommendations, but I did not try to undermine public confidence in the physician or the hospital. I did not try to criticize them, as some people did, to say

they were putting their economic interests ahead of their professional interests. I did not believe that was completely true. But I always recognized that in some way we had to win the support of a considerable group of physicians for some kind of an insurance program. It may be that we couldn't get a majority of physicians, but we had to get a respectable proportion of outstanding doctors, particularly, who would be supportive, and then we had to get a respectable portion who were neutral, who didn't necessarily think that what was going to happen was bad, but they were going to be watchful waiters to see if that was good. That was the whole strategy that I employed during the period of 1961 to 1965 when in effect I was in charge of the legislative strategy of this plan for Presidents Kennedy and Johnson.

WEEKS:

Conversely to AMA and physicians attacking proponents of health legislation were there attacks on AMA, physicians, and other opponents of health insurance legislation?

COHEN:

There were in the Kennedy administration, especially in 1962 and 1963, a group of people who wished to attack physicians, who wished to attack Wilbur Mills, who wished to attack the opposition, and they tried their best to go in that direction. They were especially critical of me in voicing their objections to people like Larry O'Brien and Kenny O'Donnell and others in the Kennedy administration to supersede me in handling this particular legislation strategy. Fortunately, Wilbur Mills was in such a key position that he was able to forestall this in the Kennedy administration.

Certainly when President Johnson was president, he did not look favorably on any kind of such undermining of my role in the legislative strategy to get the program through Congress, because he recognized that a lot depended on the relationship with Wilbur Mills and on Wilbur Mills' role. So that particular problem that I had in '62-'63 vanished in 1964-65. The years 1962-63 were a very difficult time for me.

The point I'm making now, though, relates to the fact that I was very conscious that our strategy and our tactics had to be related to moderating the controversy and the confliction with the doctors, rather than exacerbating it. Not only that, but, since I was convinced that we were ultimately going to win passage of Medicare, I did not want to endanger the subsequent relationships with the medical and hospital groups. I knew that the only group that could give medical care was physicians, and the only place you could put sick people was in a hospital. We needed their future support.

Subsequently, when I met with doctors and hospitals in many meetings, I made the point that they didn't need to love the law that was passed, they only needed to obey it. I pointed out that once the law as passed by Congress and the President, it was the law of the land, and under our constitutional system you were expected to obey the law. If you did not like the law, you were certainly free to go to Congress to get it changed or repealed, but until it was changed or repealed you had to obey it. But you didn't have to say that you loved it. All you had to do was make a reasonable effort to see that it would work successfully.

I think that was the basis of my strategy, that was the basis of my tactics. I think that was the basis of my philosophy. And I don't think I would

revise it or change it one iota. I think it resulted in the passage of Medicare and Medicaid, and while in the course of history probably both of them will be changed and maybe some day they will be no longer be identifiable in that respect, I have always felt that my historical contribution to the formulation of national health policy was rather significant at a key time. I really have no desire to apologize nor to say that it might have been done differently. Of course, it might have been done differently and might even have been done better. Somebody else might have done it better than I did, but it so happened that I was there at the moment of history. I tried to do what I thought was the most reasonable and sensible thing. In recent years the kinds of criticisms and controversy I was involved in in the 1950s and 60s have now passed into the memory of people.

A year or so ago I was invited to meet with the American Medical Association. They felt that I had not been as bad as they thought I was when viewed in historical perspective against Joe Califano; they told me I was a reasonable secretary of HEW. That shows you are sometimes looked at in relative terms. When this year I received the award from Blue Cross/Blue Shield for my contri- bution and when I previously had received an award from the American Hospital Association, I began to realize that the American political process is a great one. Even though you have a big controversey and a big fight, the democratic process, give and take, does in the long run become a reasonable one and reasonable people can see in the light of history what has be done.

So I guess I would say that other people coming along in the future will improve upon the program. They may change it for better or for worse. It may get bigger or different, it may cost more or less, but I believe what we built

in the initial stages of 1965 will turn out in the course of time to have been extremely important in the way that we in the United States deal with the development of national health policy.

Interviews in Ann Arbor

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